Drs. Cook, Kneen, Devonport, Broadhead, Fox, Morris & Hamilton

Quality Report

Saltash Health Centre
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Cornwall
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Website: http://www.saltashhealth.co.uk/

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

Saltash Health Centre was inspected on 3rd March 2015. This was a comprehensive inspection.

Overall the practice is rated as good for the five domains of safe, effective, caring, responsive and well led. It was also rated as good for providing services for five of the six population groups; with a rating of outstanding for the population group families, children and young people.

Our key findings were as follows:

Patients reported having good access to appointments at the practice and liked having a named GP which improved their continuity of care. Same day appointments were available. The practice was clean, well-organised, had good facilities and was well equipped to treat patients. There were effective infection control procedures in place.

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

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

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

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

Summary of findings

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

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

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

We found examples of outstanding practice:

The practice had been recognised as being young people friendly and had been EEFO approved. EEFO is a word that has been designed by young people, to be owned by young people. Part of this scheme is the use of a green card. This is a local collaboration between the practice and the local secondary school whereby a young person can request a green card from the school office allowing them to access medical services without the need to be asked lots of questions by teaching staff. The young person is then seen without the requirement to be given an appointment and is able to see a GP/nurse or associated health professional during the school lunch hour on the school premises. The scheme was set up to improve young peoples' accessibility to health services.

The practice produced a business plan to NHS Kernow CCG and successfully set up a school outreach clinic called TicTac which holds daily lunchtime drop in sessions at the local secondary school. GPs and practice nurses attended the school on a rota basis with the other local practices to staff these clinics.

The practice was engaged in a programme called "Living Well," which utilises Age Concern to visit and assess an older persons needs and put in place volunteers/helpers to improve their quality of life. This could be practical help with cleaning, shopping, transport or aimed at addressing their social needs by providing companions, clubs to attend, someone to visit and read them the paper once a week. This system ensures that social needs are being addressed along with the medical needs of the patient.

Practice nurses and health care assistance carried out complex leg ulcer dressings in the practice, which included complex layer bandaging. The practice took over this service as the provision in the community was reduced and it meant that by attending the practice it was more convenient for patients, rather than having to travel to the hospital. The practice received no additional funding for this; the patient participation group (PPG) provided the funds for a Doppler machine and other equipment to facilitate this service.

Action the provider SHOULD take to improve:

The provider should introduce a system to record and identify learning of GP appraisal and re-validation outcomes.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

Patients we spoke with told us they felt safe, confident in the care they received and well cared for.

There were sufficient numbers of staff working at the practice. Staffing and skill mix were planned and reviewed each day by a member of staff so that patients received safe care and treatment at all times.

Staff turnover was low. Recruitment procedures and checks were completed on permanent staff as required to help ensure that staff were suitable and competent.

Significant events and incidents were responded to in a timely manner and investigated systematically and formally. There was a culture to ensure that learning and actions were communicated following such investigations.

Staff were aware of their responsibilities in regard to safeguarding and the Mental Capacity Act 2005 (MCA). There were safeguarding policies and procedures in place that helped identify and protect children and adults who used the practice from the risk of abuse.

There were arrangements for the efficient management and storage of medicines within the practice. Prescription stationary was stored and used effectively and in an appropriate way and clear audit trails were in place to show who held the prescription pads.

There were clear processes to follow when dealing with emergencies. Staff had received basic life support training. Emergency medicines were available.

The practice was clean, tidy and hygienic. Arrangements were in place that ensured the cleanliness of the practice was consistently maintained. There were systems in place for the retention and disposal of clinical waste.

Are services effective?

Good

The practice is rated as good for providing effective services.

Systems were in place to help ensure that all GPs and nursing staff were up-to-date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines. GPs and nursing staff used clear evidence based guidelines and directives when treating patients. Evidence confirmed that these guidelines were influencing and improving practice and outcomes for patients.

Summary of findings

The practice used the national Quality Outcome Framework (QOF- a national performance measurement tool) scheme. Data provided data to show that the practice was performing equally or slightly higher when compared to neighbouring practices in the Clinical Commissioning Group (CCG).

People's needs were assessed and care was planned and delivered in line with current legislation. This included assessment of capacity and the promotion of good health. Staff had received training appropriate and in addition to their roles. Effective multidisciplinary working was evidenced.

Regular completed audits were performed of patient outcomes which showed a consistent level of care and effective outcomes for patients. We saw evidence that audit and performance was driving improvement for patient outcomes.

There was a systematic induction and training programme in place with a culture of further education to benefit patient care and increase the scope of practice for staff.

The practice worked together efficiently with other services to deliver effective care and treatment.

Are services caring?

Good

The practice is rated as good for providing caring services.

Feedback from patients about their care and treatment was consistently positive. We spoke with six patients, three representatives from the patient participation group (PPG) and two members of the Friends of Saltash Heath Centre group. We also received two comment cards and read the practices' friends and family survey and survey data from 2011 – 2012 and 2012 - 2013. Patients described the practice as caring and said they trusted the GPs and knew them well.

We observed a person centred culture and found strong evidence that staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. We found many positive examples to demonstrate how people's choices and preferences were valued and acted on. The practice were accredited and recognised as providing a supportive and caring environment for young patients.

Accessible information was provided to help patients understand the care available to them.

Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions.

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

The practice acted on suggestions for improvements and changed the way it delivered services in response to feedback from the patient participation group (PPG). The practice reviewed the needs of its local population and engaged with external health care professionals and agencies to secure service improvements where these had been identified.

Patients told us it was easy to get an appointment on the same day and appreciated the extended appointment times.

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for well led.

The practice had a formal vision and strategy which included providing a supportive accessible service within the confines of a rural community.

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. There were systems in place to monitor and improve quality and identify risk. The process of clinical governance was robust and there was a culture of wanting to improve and learn following any significant event or complaint. Action and learning was shared with the whole team.

The practice learnt from events and complaints and welcomed feedback from patients through the suggestion book and surveys. The practice had an active patient participation group (PPG) who considered themselves to be a critical friend of the practice. Staff had received induction training, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

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

All registered patients aged 75 and over had an allocated GP but also had the choice of seeing whichever GP they prefer. Patients were invited to attend for influenza, pneumococcal and shingles vaccinations, which were provided at the practice.

Older patients with complex needs were managed jointly with the community matron. The GPs requested home visits and coordination of both medical and social care by the community matron and district nurses, in an aim to support the frail elderly to maintain independence and good health.

The practice identified patients with cognitive impairment. In addition to referral to secondary care dementia services, the practice liaised with and referred to the community dementia practitioner who provided practical support to patients and their families.

Vulnerable older patients had an active care plan. The practice had started a complex geriatric programme targeted with the aim to improve functional status, preventing institutionalization and reduce mortality.

The practice was engaged in a programme called "Living Well," which utilises Age Concern to visit and assess an older persons needs and put in place volunteers/helpers to improve their quality of life. This could be practical help with cleaning, shopping, transport or aimed at addressing their social needs by providing companions, clubs to attend, someone to visit and read them the paper once a week. This system ensures that social needs are being addressed along with the medical needs of the patient.

People with long term conditions

Good

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

Systems were in place to identify patients with long term conditions. Patients with complex or multiple conditions had a named GP who was responsible for their overall care. The named GPs were responsible for reviewing these patients health and care needs.

Patients were offered regular diabetes, chronic obstructive airways disease (COPD), and asthma reviews checks with the practice nurses. Patients with particularly complex long-term conditions were discussed at the monthly multi-disciplinary (MDT) meetings to

allow sharing of information between health care professionals both within the practice and the allied teams. These included the district nursing team, community specialist palliative care nurse, community matron, dementia liaison nurse and health visitor. Details of these meetings were minuted and then distributed to all members of staff including those not present at the meeting.

Housebound patients with long term conditions were visited/ reviewed by the GP or Community Matron where appropriate. Specific clinical management plans were set up by the Community Matron and individualised for patients to manage chronic conditions from asthma/angina to anxiety/falls/diabetes/UTI at home.

The practice was supported by out-reach nurses (heart failure nurse, respiratory nurse, diabetes specialist nurse, Parkinson's nurse) with access to rehabilitation, e.g. stroke team, pulmonary rehabilitation and cardiac.

Patients with multiple long term conditions received contact from their named GP within three days of discharge from hospital and had a review of their care plan.

The practice worked with the Community Matron and palliative care nurse (MacMillan) to support end of life care planning and hospital admission prevention. The practice held monthly Gold Standard Framework meetings to discuss patients on their palliative care register. Alerts were also put on patient medical records to enable anyone dealing with them to understand they might have urgent need for care. Systems were in place to notify the out of hours provider about patients nearing end of life to ensure their wishes for end of life care are adhered to.

Awareness training on visual impairment and on the difficulties faced by deaf and hard of hearing patients took place. The practice had large print practice leaflets. There were hearing loops at reception and in the waiting room.

Families, children and young people

Outstanding ☆

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

Parents told us that the GPs and nurses were responsive to the needs of their children.

Systems were in place to identify children at risk from physical, emotional abuse, or neglect. All members of the family have the same identification within the records to ensure that the risk to other siblings is reduced. This was in line with the recommendations from the Royal College of General practitioners (RCGP) Safeguarding Children and Young People Toolkit.

Summary of findings

All staff at the practice had received safeguarding training. The practice also had a children and young person safe guarding lead.

The practice was EEFO approved and registered at Level 2. EEFO quality standards ensure that the practice is young people friendly and respects young people's rights to talk to someone in confidence and at times that are best for them. Part of this scheme is the use of a green card. This is a local collaboration between the practice and the local secondary school whereby a young person can request a green card from the school office allowing them to access medical services without the need to be asked lots of questions by teaching staff. The practice produced a business plan to NHS Kernow CCG and successfully set up a school outreach clinic called TicTac which holds daily lunchtime drop in sessions at the local secondary school. GPs and practice nurses attended the school on a rota basis with the other local practices to staff these clinics. Appointments were also available outside of normal school hours to accommodate school-age children.

The practice had baby changing facilities and also a room available for women wishing to breast feed in private.

There were a wide variety of contraception services available at the practice including insertion of coils, implants and contraceptive injections.

Antenatal care was provided by community midwives, although the surgery conducts new born baby checks and 6 week post natal checks.

Childhood immunisations were routinely carried out and children are actively called when immunisations were overdue. The practice also provided "school-leaver" immunisations and HPV vaccinations for young girls.

Systems were in place to notify the school nurse/health visitor when any child registers with the surgery to ensure they are not missed to follow up.

The practice also hosted "Kooth" Young People's counselling service in the surgery on Monday evenings.

Working age people (including those recently retired and students)

Good

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

The practice has a higher than CCG average list of patients in the working age group. The practice provided online services for both

appointment requests and repeat prescription requests. This allowed those people whom are working to order these items during times when the practice is closed. Patients told us this system worked well.

Telephone consultations were offered for those patients who were unable to make it to the practice with queries which can be dealt with over the telephone. A text message service was available to remind patients of their appointment details.

The practice offered the national "choose and book" service via DRSS referral management service for patients referred on to secondary care for further investigation and treatment. This gave patients the choice of location and time over where they will receive their treatment.

There was extended opening hours until 8pm every Monday and from 7am every Wednesday. These clinics were advertised on the website, in the practice handbook and on the waiting room monitors.

Health promotion was provided both during consultations, on the website and on the waiting room monitors. The practice provided national NHS Health Checks to patients aged between 40 and 74 years of age to identify risks of ill health later on in life. This was run by the practice nurse team and GPs.

The practice conducted NHS health checks for those patients in the 40-74 age group (who are currently not on a disease register). Individual risk assessments were offered, tailored to the need of the patient that included a lifestyle assessment. The risk score was discussed with the patient with the aim of providing motivational lifestyle interventions and sign-posting high risk individuals to appropriate services to meet their individual needs.

Smoking cessation clinics were held every week.

Dermatology clinics were held every two weeks at the practice to reduce patients having to be referred to secondary care for dermatology appointments.

The GPs in the surgery carried out minor surgical procedures and joint injections.

The practice had an integrated physiotherapy service on site with an acute low back pain care pathway.

People whose circumstances may make them vulnerable

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

Good

Summary of findings

The practice had a register to identify patients with a learning disability. GPs provided learning disability health reviews. A carer usually attended these reviews for support and to ensure the patient's views and concerns are taken into consideration. If necessary, these patients were visited at home if they chose.

The practice had a protocol for safeguarding of vulnerable people and had an appointed adult safeguarding lead. All members of staff had received training in safeguarding and were aware of how to identify abuse and knew what action to take if abuse was suspected. There was easy access to guidance when information was required. Adults being identified as vulnerable had an appropriate easily identifiable note on their electronic records to make this easily recognisable to any health care professional meeting with that person.

A number of patients registered at the practice lived in care homes and an appropriately trained and qualified health care assistant conducted reviews in their homes.

Two GPs held clinics for patients with substance abuse problems. There was also a weekly clinic with a specialist drug and alcohol misuse counsellor.

The practice had a language identification chart and use of a telephone and consultation translation service when needed.

People experiencing poor mental health (including people with dementia)

Good

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

The practice had systems in place to identify patients with mental illnesses. Patients with an enduring mental illness were offered an annual review with the lead GPs in mental health issues. These reviews were an opportunity to ensure the patients mental and physical health needs were being addressed and managed. The GPs used these appointments to develop care plans for use in times of crisis.

Patients with dementia were also offered annual health reviews. These patients were either visited in their own homes or alternative place of residence for this review.

The practice worked with the local community mental health team, with a representative attending the monthly multi-disciplinary meetings.

Summary of findings

The practice used the Saltash Health Centre Care Pathway for patients suffering from depression and anxiety. In Saltash there was a dementia café as well as a singing group, which patients were signposted to join through information in the waiting room.

Patients presenting with depression were actively recalled for follow up within two to four weeks and then seen regularly. All patients on the mental health register were recalled annually.

There were counselling sessions each week in the practice run by Outlook Southwest, commissioned to provide psychological therapies.

Summary of findings

What people who use the service say

We spoke with six patients during our inspection. We also spoke with three representatives of the practice patient participation group (PPG) and two members of the Friends of Saltash Health Centre group.

The practice had provided patients with information about the Care Quality Commission prior to the inspection. Our comment box was displayed and comment cards had been made available for patients to share their experience with us. We collected two comment cards, both contained positive comments.

We also looked at surveys the practice had conducted over the last two years. The PPG collated these findings and drew up an improvement action plan in consultation with the GP partners and practice manager. Patients told us about their experiences of care and praised the level of care and support they consistently received at the practice. Patients said they were happy, very satisfied and said they had no complaints and received good treatment. Patients told us that the GPs and nursing staff were excellent.

Patients were happy with the appointment system. We were told patients could either book routine appointments four weeks in advance or make an appointment on the day. They told us the receptionists tried to fit them in where possible. Parents said emergency appointments for children were treated with priority.

Patients knew how to contact services out of hours and said information at the practice was good. Patients knew how to make a complaint. None of the patients we spoke with had done so but all agreed that they felt any problems would be managed well. Other patients told us they had no concerns or complaints and could not imagine needing to complain.

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

Patients found it easy to get repeat prescriptions.

Areas for improvement

Action the service SHOULD take to improve

The provider should introduce a system to record and identify learning of GP appraisal and re-validation outcomes.

Outstanding practice

We found examples of outstanding practice:

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The practice produced a business plan to NHS Kernow CCG and successfully set up a school outreach clinic called TicTac which holds daily lunchtime drop in sessions at the local secondary school. GPs and practice nurses attended the school on a rota basis with the other local practices to staff these clinics.

Summary of findings

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Drs. Cook, Kneen, Devonport, Broadhead, Fox, Morris & Hamilton

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The team also included a GP specialist advisor and a practice manager specialist advisor.

Background to Drs. Cook, Kneen, Devonport, Broadhead, Fox, Morris & Hamilton

Saltash Health Centre was inspected on Tuesday 3rd March 18 February 2015. This was a comprehensive inspection.

The practice provided primary medical services to approximately 13,000 patients. Saltash Health Centre provides primary medical services to people living in Saltash, Cornwall. It is situated in the town of Saltash, close to local amenities.

There was a team of eight GP partners. Some of the GPs work part time. Collectively their working hours are the equivalent of employing 7.5 staff. GP partners held managerial and financial responsibility for running the business. In addition there was a practice manager, five practice nurses, three health care assistants, two phlebotomists and a team of administrative and reception staff.

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

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, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?

Detailed findings

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

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

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

Before conducting our announced inspection of Saltash health centre, we reviewed a range of information we held about the service and asked other organisations to share what they knew about the service. Organisations included the local Healthwatch, NHS England, and the local Cornwall Clinical Commissioning Group.

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

We carried out our announced visit on Tuesday 3rd March 2015. We spoke with six patients, three GPs, two members of the nursing team, a health care assistant and two phlebotomists, the practice manager and 14 office/admin team members. We also spoke with three representatives of the patient participation group (PPG) and collected two 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.

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

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example staff used the practice computer system to access relevant documentation and said all events and complaints were discussed at the weekly management meetings.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last eighteen months. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We looked at significant event record that had occurred over the last 18 months. Significant events were discussed as they arose and coordinated by the practice manager. They were also a standing item on the monthly practice management meeting agenda to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so. Staff said there was a no blame culture operated at the practice.

There were systems in place to make sure any medicines alerts or recalls were actioned by staff. The practice kept a record of all its prescribing errors and stated that they reviewed these for trends so that lessons could be learnt and procedures changed if necessary to reduce the risks in future. These errors were recorded and managed using the serious adverse events system. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated using email and the computer message system. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at clinical meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. For example, GPs were trained to level three and nurses to level two. We asked GPs, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible using the practice policies located on the computer system.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary higher level training to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients and their families, where appropriate, on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans.

There was a chaperone policy and notices for patients if they wishes to request a chaperone in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). We discussed with the practice manager the benefit of providing additional signage in the waiting area and/or at the reception desk to allow patients

time to consider whether they wishes to have a chaperone present, before they entered the consulting room. All nursing staff, including health care assistants, had been trained to be a chaperone.

Medicines management

There were suitable arrangements for the safe storage of medicines. This included vaccines that required to be kept refrigerated. There was monitoring of temperatures to ensure medicines were kept at the required temperatures to ensure effective use. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure.

There were processes in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. For example, how staff who generate prescriptions were trained and how changes to patients' repeat medicines were managed safely and effectively.

Patients said they had received enough information about their medications which included side effects and how to take the medicine.

Cleanliness and infection control

The premises were clean and tidy. The practice employed their own cleaning staff who followed the cleaning schedules in place and maintained cleaning records. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy. Staff received induction training about infection control specific to their role and received annual updates. Infection control audits had been conducted, we read the last audit completed in August 2014. Any improvements identified for action had been completed on time. These actions had included reducing the routine changing of disposable curtains in consulting rooms to six monthly from annually, as per good practice guidelines.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms and toilets.

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal).We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales and blood pressure measuring devices.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Good

Are services safe?

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Nursing staff said they tried to cover for each other where possible but also had a small team of nurses to use where needed.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

The GPs were able to provide examples of responding to emergencies of patients including those with long term conditions and mental health crisis.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available and records confirmed that it was checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis (shock) and hypoglycaemia (low blood sugar levels). Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised fire drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. Staff said guidelines were discussed at clinical and management meetings where the implications for the practice's performance and patients were discussed and required actions agreed. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines and discussions with specialist health care professionals when appropriate.

The GPs and practice nurses told us they lead in specialist clinical areas, for example, diabetes, leg ulcer, chest and breathing conditions, dermatology, lower back pain and substance abuse. GPs told us this supported all staff to continually review and discuss new best practice guidelines. Our review of the clinical meeting minutes confirmed that this happened.

Data from the local CCG showed that practice's performance for antibiotic prescribing was comparable to similar practices in the area. Other data also showed that the practice had not been noted to be outliers in any other prescribing data.

Patients with specific conditions were reviewed to ensure they were receiving appropriate treatment and regular review. For example, blood pressure monitoring. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes.

National data showed that the practice was broadly in line with referral rates to secondary and other community care services for all conditions. The exceptions were with lower than average reporting for gastro-intestinal, liver and cardiology cases. We discussed this with the GPs and practice manager who said they would discuss the practice referral rates for these conditions with other practices in the local commissioning group to understand what was the source of the statistical information regarding referrals and if this was related to or unrelated to patient care.

Interviews with GPs and practice nurses showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures).

The practice showed us examples of the clinical audits that had been undertaken in the last three years. The practice was able to demonstrate the changes resulting since the initial audit. For example, audits had been completed over three yearly cycles for inadequate cervical smear rates and Warfarin medication prescribing and blood monitoring for people prescribed this medication. The audits enabled the practice to set targets for smear uptake rates and to improve outcomes for people prescribed Warfarin. Rationales for audits were based on evidence from cited heath journal papers and showed that the rationale for the audit cycles was having a positive impact upon patient health.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national) clinical targets.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question

Good

Are services effective?

(for example, treatment is effective)

and, where they continued to prescribe it, outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice had a palliative care register and had held weekly multidisciplinary team meetings to discuss the needs of complex patients and monthly to discuss palliative care and safeguarding.

Practice nurses and health care assistance carried out complex leg ulcer dressings in the practice, which included complex layer bandaging. The practice took over this service as the provision in the community was reduced and it meant that by attending the practice it was more convenient for patients, rather than having to travel to the hospital. The practice received no additional funding for this; the patient participation group (PPG) provided the funds for a Doppler machine and other equipment to facilitate this service.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the GPs. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. GPs appraised one another. There was no formalised record of GP appraisals being shared with the practice manager. This is recommended to enable monitoring should there be any recommendations as a result of the appraisal system. Our interviews with staff confirmed that the practice was supportive in providing training and funding for relevant courses.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines and cervical cytology. The nurses with extended roles who managed patients with long-term conditions such as asthma, chronic obstructive pulmonary disease (COPD), diabetes, leg ulcer dressings and coronary heart disease were also able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. All staff we spoke with understood their roles and felt the system in place worked well even during staff absences.

The practice held multidisciplinary team meetings weekly to discuss the needs of complex patients and monthly meetings to discuss patients with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information sharing

The practice used electronic systems to communicate with other providers. For example, the computer system used by the practice could be accessed by other health care professionals and out of hours providers to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals. The practice made referrals through the Choose and Book system. (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). Staff reported that this system was easy to use.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record (SystmOne) to coordinate, document and manage

Good

Are services effective?

(for example, treatment is effective)

patients' care. All staff were fully trained on the system, which had been recently installed. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act (MCA) 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. GPs and nurses were able to share specific scenarios where capacity to make decisions was an issue for a patient and what action had been taken. For example, during childhood vaccination clinics or during annual learning disability health needs reviews.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually, or more frequently if changes in clinical circumstances dictated it. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies and Fraser guidelines. These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's written consent was documented and stored in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure. Consent for other procedures, including immunisations and cervical screening were recorded using set templates within the patient records.

Health promotion and prevention

New patients were offered a health check and any health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic blood pressure checks, and offering smoking cessation advice to smokers.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Patients appreciated that the GPs offered this service.

The practice had numerous ways of identifying patients who needed additional support. For example, the practice kept a register of all patients with a learning disability and 100% had been offered an annual physical health check in the last 12 months. The practice has also revised their coding system for identifying carers. The rationale behind this was to more readily identify patients with caring duties to enable both patients and their carers' health need to be discussed at the virtual ward round multi-disciplinary team meeting.

The practice ran an integrated physiotherapy service on site with an acute low back pain care pathway.

The practice also had links to Saltash leisure centre (situated opposite the practice) to promote physical wellbeing with exercise referrals and also links with other agencies / groups to improve physical health, for example, falls prevention.

The practice conducted lung function/spirometry tests where needed. The practice had set up an active "Breathers Group" in Saltash, which is a self-help group for patients with chronic obstructive pulmonary disease (COPD). They met regularly and sessions included a gentle exercise programme run by a specially trained advisor. The group was chaired by a member of the Saltash Health Centre patient participation group (PPG).

The practice ran a link with the library (next door to the Health Centre) on "Reading on Prescription" for patients with mental health problems / dementia to access reading material recommended by the counsellors at the practice.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all childhood immunisations was in line with or above the average for the CCG, and there was a clear policy for following up non-attenders by the named practice nurse.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. We read the practices' friends and family survey and practice patient survey data from 2011 – 2012 and 2012 - 2013. Patients described the practice as caring and said they trusted the GPs and knew them well. Surveys showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. All comments were very complimentary and showed that the patients were extremely likely or likely to recommend their friends and family.

Patients completed CQC comment cards to tell us what they thought about the practice. We received two completed and spoke with six patients. Patients stated that they thought the practice offered an excellent service and staff were efficient and helpful.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager.

Care planning and involvement in decisions about care and treatment

Patients we spoke with on the day of our inspection 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 they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day of our inspection and the comment cards we received showed that they were given enough emotional support.

Notices in the patient waiting room, on the TV screen and patient website also 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. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

The practice had a very active 'Friends' group. This included fund raising for equipment at the practice.

The practice was engaged in a programme called "Living Well" which utilises Age Concern to visit and assess an older persons needs and put in place volunteers/helpers to improve their quality of life. This could be practical help with cleaning, shopping, transport or aimed at addressing their social needs by providing companions, clubs to attend, someone to visit and read them the paper once a week. This system ensured that social needs are being addressed along with the medical needs of the patient.

Staff told us that if families had suffered 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. Patients we spoke with who had had a bereavement confirmed they had received this type of support and said they had found it helpful.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The practice welcomed feedback from patients and external bodies and used significant events, complaints and near misses to improve the services provided. Response to these events was prompt.

The practice implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). This had included improving communication about the extended appointments and opening times.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the office areas informing patents this service was available.

One GP had responded to a need in the community to offer a local specialised dermatology service. Dermatology clinics were held every two weeks at the practice to reduce patients having to be referred to secondary care for dermatology appointments, thus reducing the distance patients had to travel for this service.

The practice had been 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 community services to make sure they are young people friendly. The practice had been awarded a higher level for being approachable and showed the practice had met the quality standards. For example, confidentiality, consent, easy to access services, welcoming environment and staff trained on issues young people face. This is a local collaboration between the practice and the local secondary school.

The practice had produced a business plan to NHS Kernow CCG and successfully set up a school outreach clinic called TicTac holding daily lunchtime drop in sessions at the local secondary school. GPs and practice nurses attended the school on a rota basis with the other local practices to staff these clinics. The aim is to improve access to healthcare advice and engage with the local community school, to improve emotional and mental health and wellbeing, reduce unwanted teenage pregnancy, reduce childhood obesity, help young people give up smoking, reduce substance misuse and alcohol abuse and to promote collaborative and multi-agency working. Positive health statistics regarding the effectiveness of the scheme were seen.

The premises had been adapted to meet the needs of people with disabilities. There was level access and a designated accessible toilet which had been fitted with grab rails.

The practice had open spaces in the waiting room which provided turning circles for patients with mobility scooters or wheelchairs. Corridors and doors were wide making the practice easily accessible and helping to maintain patients' independence.

We saw that the waiting area was large enough to accommodate patients with prams and allowed for easy access to the treatment and consultation rooms. There were quiet areas for breast feeding mothers and baby changing facilities available.

Access to the service

Appointments were available from 08:30 am to 6pm on weekdays. There was extended opening until 8pm on Mondays and from 7am on Wednesday mornings.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

The practice had extended some appointment times for patients who required longer sessions. This also included appointments with a named GP or nurse.

Patients in nursing/care homes were reviewed routinely and also reviewed within seven days of admission to the

Good

Are services responsive to people's needs?

(for example, to feedback?)

home or upon any discharge from hospital. There was a dedicated GP for each nursing home who attended every week and who had overall responsibility for the care of the patients in that home.

Patients were pleased with the appointments system. They confirmed that they could see a GP on the same day if they needed to.

Listening and learning from concerns and complaints

The practice viewed complaints as part of the quality improvement process. There was a 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. The practice manager was the designated responsible person who handled all complaints in the practice.

Posters and website 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. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at the 15 complaints received in the last 12 months and found and saw they were satisfactorily handled. The complaints were dealt with in a timely way with openness and transparency. The practice captured and made a record of verbal expressions of dissatisfaction within its complaints record. This is good practice as it enabled minor situations of dissatisfaction to be resolved at an early stage preventing escalation to formal written expressions of complaint.

The practice reviewed complaints at the monthly practice meeting and all 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. For example, prescription administration error complaints had resulted in a review of the patient's prescriptions, an apology to the patient and action by dispensary staff and GPs.

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

Staff were able to describe the vision, values, strategic and operational aims of the practice. Staff said one of the main strengths of the practice was the morale and team atmosphere. There were clear lines of accountability and areas of responsibility. Staff knew what their responsibilities were in relation to these.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at a sample of these policies and procedures. All policies and procedures we looked at had been reviewed annually and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control one GP partner was the lead for child safeguarding and another GP partner was the lead for adult safeguarding. We spoke with 23 members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. Audits were performed in response to significant events, complaints, prescribing data and clinical data results. The GPs also conducted audits in response to the service they provided and for areas of interest to them. For example, the GP responsible for minor surgery produced detailed audit findings for complications and effectiveness.

The practice held monthly management meetings where governance issues were discussed as standing agenda items. We looked at minutes from previous meetings and found that performance, quality and risks had been discussed.

The practice manager showed us the contracts for, systems, records and processes to identify and reduce risk in the environment where they had control. Staff were aware of their roles in these processes. For example, nurses knew about how to safely dispose of clinical waste and the fire marshals knew how to respond in the event of a fire.

Leadership, openness and transparency

Staff described a clear leadership structure where the GP business partners and practice manager had a central role in the coordination these roles. We spoke with staff and they were clear about their own roles and responsibilities. They all told us they thought the practice was well led and felt well supported and knew who to go to in the practice with any concerns. Staff appreciated the social activities that took place to improve morale and team building.

Staff said that team meetings were held regularly. They told us in addition issues were discussed and sorted as they happened too. Staff told us that there was an open culture within the practice and said they had the opportunity and were happy to raise issues at team meetings.

The practice manager was responsible for human resource policies and procedures. We reviewed the recruitment policy and induction programme which were in place to support staff. We were shown the electronic information that was available to all staff, which included sections on employment and whistleblowing. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, suggestions, friends and family test and any complaints received. We looked at the results of the annual patient survey and saw that patients from the patient participation group (PPG) agreed that providing a duty nurse and duty GP during practice opening days would improve people's access to services when they needed it. Patient we spoke with praised the accessibility of appointments at the practice.

Are services well-led?

Good

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

The practice had an active patient participation group (PPG). The PPG included representatives from some but not all of the population groups. A representative said they were going to try changing the meeting time to attract younger members. The PPG had collated responses from recent friends and family tests to show impartiality with interpreting the results. Representatives said communication was good with the practice and they appreciated being kept up to date by the practice manager.

The practice had gathered feedback from staff through face to face discussions, appraisals and through staff meetings. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring.

The practice had completed reviews of significant events and other incidents and formally shared action and learning from these events with the staff group to ensure the practice improved outcomes for patients.