Mullion Health Centre

Inspection report

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

Ratings

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

Overall summary

This practice is rated as Outstanding overall. (The previous inspection was in February 2015 where we rated the practice as good overall)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Outstanding

Are services responsive? – Outstanding

Are services well-led? - Good

We carried out an announced comprehensive at Mullion Health Centre on Monday 23 and Tuesday 24 April 2018 as part of our inspection programme.

At this inspection we found:

- The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.
- Medicines were managed well at the practice and prescribing rates and patterns were kept under review to ensure safety and cost effectiveness.
- Improvements within the dispensaries had taken place since the last inspection and were being monitored to further reduce any potential risks to patients and improve the quality of the service provided.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence- based guidelines.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Patients gave strongly positive feedback about the care and treatment they received. Results from the July 2017 national GP patient survey, friends and family test results and independent survey results were all strongly positive. For example, in the national survey, the practice had performed better than Clinical Commissioning Group (CCG) and national averages for all 23 questions. Patients found the appointment system easy to use and reported that they were able to access care when they needed it.
- There was a strong focus on continuous learning and improvement at all levels of the organisation. Staff said the practice was a good place to work and added that the leadership team were supportive and encouraged career development and learning to help improve patient safety.
- There was evidence of systems and processes for learning, continuous improvement and innovation. The practice had taken part in many local pilots to test new methodology.

We saw areas of outstanding practice:

Feedback from multiple sources - patients who use the service, those who are close to them and stakeholders - was continually and strongly positive about the way staff treat people, the service received and access to services. People commented staff “go the extra mile” and the care they receive exceeded their expectations.

The practice had recognised the geographical locations and isolation of the practice branches, the needs of the local population and associated restrictions for some patients accessing healthcare. The GPs and staff had reviewed this and offered additional support and services to reduce the need for long journeys, improved access to services. For example:

- Offering Saturday morning appointments with an aim to reduce unplanned hospital admissions and optimise care in the community,
- Providing same day interventions such as oxygen concentrators and antibiotics to elderly patients in need who would otherwise require admission to hospital
- providing a wide-range of soft-tissue and joint injections to its own patients, and to neighbouring practice patients to reduce secondary care burden and improve patient access.
- Providing a doppler service for patients with peripheral vascular disease (leg ulcers).

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

Population group ratings

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

Our inspection team

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

Background to Mullion Health Centre

Mullion Health Centre is a GP practice which provides services for approximately 7927 patients. The main practice is situated in the rural and remote village of Mullion, Cornwall. There are three additional branches situated in the hamlets of Constantine, Lizard and Ruan Minor. These three branches have dispensaries. The practice provides dispensing services for patients who live further than one mile away from a pharmacy. This is approximately half of its population. (Constantine approximately 2000 patients, The lizard 1000 and Ruan Minor 1000.)

The practice population area is in the sixth decile for deprivation. In a score of one to ten, the lower the decile the more deprived an area is. The practice distribution and life expectancy of male and female patients is equivalent to national average figures. The practice had a significantly higher than average number of patients aged over 75 and 85 years, (13% of the practice list were over the age of 75 years compared to the national average of 8% and 4.2% of the patient list were over the age of 85 compared with the national average of 2%). Average life expectancy for the area is similar to national figures with males living to an average age of 82years and females living to an average of 84 years.

There is a team of seven GPs (two female and five male). Of the seven GPs six were partners and one was a salaried GP. The whole time equivalent (WTE) of GPs is just under six WTE.

The team also includes a practice manager, deputy practice manager, IT manager, two secretaries, three administration staff, eight reception staff, four healthcare assistants/phlebotomists, four practice nurses, six dispensary staff and two cleaning staff.

Patients using the practice have access to community staff including community nurses and health visitors. Patients could also access counsellors, depression and anxiety services, alcohol and drug recovery workers, voluntary services and other health care professionals.

The practice is a training practice for GP Registrars (doctors training to become a GP) and has received positive feedback from the medical school.

The GPs provide medical support to three residential care homes and a large nursing home in the area and provide weekly ‘ward rounds’ and annual health reviews for these patients.

The practice is registered to provide regulated activities which include:

Treatment of disease, disorder or injury, surgical procedures, family planning, maternity and midwifery services and diagnostic and screening procedures and operate from the location of:

Mullion Health Centre, Nansmellyon Road, Mullion. Cornwall, TR12 7DQ.

There are three branch surgeries located at:

Constantine Surgery, Bowling Green, Constantine, TR11 5AD

The Lizard Surgery, The Green, The Lizard, TR12 7NZ and

Ruan Minor Surgery, Glebe Place, Run Manor, TR12 7JW

We visited Mullion Health centre, Constantine Surgery and The Lizard Surgery on this inspection.

Good

Are services safe?

We rated the practice as good for providing safe services.

Safety systems and processes

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

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

Risks to patients

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

- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness, busy periods, untoward emergencies and epidemics. For example, recent inclement weather had resulted in staff, patients within the community and GPs appropriately and safely prioritising patient care and delegating work and home visits.
- There was an effective induction system for temporary staff tailored to their role.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections including sepsis. Information screens within patient waiting rooms helped patients to recognise the symptoms of sepsis and provided guidance about what actions they should take. Staff had access to written guidance in each treatment and consultation room.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

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

- The care records we saw showed that information needed to deliver safe care and treatment was available to staff. There was a documented approach to managing test results. The practice used an electronic system for blood samples which allowed more efficient ordering, processing and follow up of test results for patients. The practice had been identified positively as above average users of this service enabling more patients being able to access faster test results and more accurate follow up treatment.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made timely referrals in line with protocols.

Appropriate and safe use of medicines

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

- The embedded checking systems for managing and storing medicines, including vaccines, emergency medicines and equipment minimised risks.
- The practice had reviewed its antibiotic prescribing and taken action to support good antimicrobial stewardship in line with local and national guidance. The GPs had identified prescribing rates of antibiotics and antimicrobials had been higher than local averages. The GPs had discussed this and managed to reduce prescribing rates over the last year by 3%. The practice recognised there was still more work to be done but had processes in place to keep antibiotic prescribing under review.

Good

Are services safe?

- Patients' health was monitored in relation to the use of medicines and followed up on appropriately. Patients whom required regular monitoring received reviews to reduce risks due to medicine complexities were involved in regular reviews of their medicines. Medicine monitoring at the practice was provided by a allocated staff member and lead GP. The practice had a GP prescribing and dispensing lead and a dispensary manager. These staff were responsible for the medicines management in the practice.
- The practice had clear monitoring systems in place and submitted a quarterly return for any controlled drugs (medicines that require extra checks and special storage because of their potential misuse) concerns. There had been no concerns.

The practice had a dispensary in all three of the branch surgeries for patients who lived further than one mile away from a pharmacy.

At the inspection in February 2015 we found dispensary staff had been issuing medicines, including acute prescriptions and controlled drugs before the printed prescription had been signed. This was identified and immediately stopped at the time of inspection. At this inspection we found these changes had continued which ensured no controlled drug or acute medicine was prepared or issued before a GP had signed the prescription to demonstrate approval. All of the medicines we saw which were waiting for collection, including repeat prescriptions, controlled drugs and acute medicines had been approved and signed for by a GP. A risk assessment had been completed for prescription signing. A standard operating procedure was in place for this process. Further reviews and conversations were taking place to further minimise risk of medicines previously provided on repeat prescription being prepared and dispensed prior to GP signature.

There were processes in place within each dispensary on a day to day basis which were led by dispensary staff to keep patients safe.

- The practice had signed up to the Dispensing Services Quality Scheme (DSQS), which rewards practices for providing high quality services to patients of their dispensary
- There was a named GP responsible for the dispensary.
- Practice records demonstrated all members of staff involved in the dispensing process were appropriately qualified and their competence was checked regularly by the lead GP for the dispensary.
- The practice held stocks of controlled drugs in each practice (medicines that require extra checks and special storage because of their potential misuse). We checked processes used and saw these were securely managed. There were also safe arrangements for the destruction of controlled drugs.
- Significant events and complaints regarding dispensed medicines were kept and followed significant event processes.
- Standard Operating Procedures were produced and kept under review.

Track record on safety

The practice had a good track record on safety.

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

Lessons learned and improvements made

The practice learned from and made improvements when things went wrong.

- Staff understood their duty to raise concerns and report incidents and near misses and told us that leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong.
- The practice learned and shared lessons, identified themes and took action to improve safety in the practice.
- The practice acted on and learned from external safety events as well as patient and medicine safety alerts.

Please refer to the Evidence Tables for further information.

Good

Are services effective?

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

Any Quality Outcomes (QOF) data relates to 2016/17. QOF is a system intended to improve the quality of general practice and reward good practice. For this period the practice had obtained 100% of points available and had comparable exception reporting. For example, 6% compared to local averages of 7% and national averages of 6%. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.

Effective needs assessment, care and treatment

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

- Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- The practice used many templates within the computer system to prompt staff to capture and record investigation and test results. These included diabetic screening, asthma reviews and templates for childhood immunisations.
- Staff used appropriate tools to assess the level of pain in patients.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- The practice had a higher than local and national prevalence of older patients. (13% of the practice list were over the age of 75 years compared to the national average of 8% and 4.2% of the patient list were over the age of 85 compared with the national average of 2%). These patients often lived in rural and isolated villages. The practice had a low threshold for home visits where older patients could not access the practices and transport services.
- Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. The practice used an appropriate tool to identify patients aged 65 and over who were living with moderate or severe frailty. Those identified as being frail had a clinical review including a review of medicines. Patients aged over 75 were invited for a health check. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP and nursing team worked with other health and care professionals to deliver a coordinated package of care.
- Practice staff held joint clinics with a diabetes specialist nurse from Cornwall Partnership Trust for assistance in managing patients with complex diabetes. The practice had identified a desire in the practice to improve diabetes care, in view of its current impact on the NHS both nationally and locally, and had arranged for additional training for all appropriate clinical staff to improve treatment for these patients.
- Staff who were responsible for reviews of patients with long term conditions had received specific training and educational updates.
- GPs followed up patients who had received treatment in hospital or through Out of Hours services.
- The practice had arrangements for adults with newly diagnosed cardiovascular disease including the offer of medicines to lower cholesterol for secondary prevention, people with suspected hypertension were offered ambulatory blood pressure monitoring and patients with atrial fibrillation were assessed for stroke risk and treated as appropriate.
- The practice was able to demonstrate how they identified patients with commonly undiagnosed conditions such as diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension).

Good

Are services effective?

- A GP at the practice worked with Cornwall Hospice Care to provide easily accessible advice on prescribing for patients at the end of their life. This had been made widely available electronically to both improve efficiency and safety of prescribing in the practice and nationally.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates in 2016/17 for the vaccines given was 88% for children aged 1 with a completed primary course of 5:1 vaccine. This was outside the national target percentage of 90% or above. The practice had proactively identified this and were monitoring rates for 2017/18. Uptake rates had improved to 90% to date. All other childhood vaccine rates were over the 90% target range. The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance. The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation.
- Receptionists were aware of 'red flag' sepsis symptoms that might be reported by patients and knew how to respond if the symptoms were apparent.

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

- The practice's uptake for cervical screening was 75%, which was below the national 80% coverage target for the national screening programme but in line with the current 72% coverage achievement for the national screening programme. The staff recognised the uptake trends matched the lower national rates and were ensuring opportunistic health education took place. There were systems in place to follow up patients that did not attend screening appointments.
- The practices' uptake for breast and bowel cancer screening were higher than the national average. For example, 76% of females between the ages of 50 and 70 had been screened for breast cancer in the last 36 months compared with the national average of 70%. Additionally 64% of patients between the ages of 60 and 69 had been screened for bowel cancer in last 30 months compared to the national average of 55%.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including homeless people, patients with addictions and those with a learning disability.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.

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

- The practice assessed and monitored the physical health of people with mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services. There was a system for following up patients who failed to attend for monitoring and administration of long term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- 92% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This was higher than the national average of 84.
- 90% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive agreed care plan documented in the previous 12 months. This was comparable to the national average of 90%.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example, 95% of patients experiencing poor mental health had received discussion and advice about alcohol consumption. This was comparable to the national average of 91%.

Good

Are services effective?

- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- The practice offered annual health checks to patients with a learning disability.

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. For example, the advice in April 2017's MHRA (Medicines and Healthcare products Regulatory Agency) alert highlighted that there was evidence that women were still not aware of the risks associated with a medicine used for epilepsy in pregnancy. As a practice the GPs elected to review all women of reproductive age prescribed the medicine. The audit found only two patients within childbearing age on this medicine. Both patients had undergone discussion with a GP regarding contraception in the previous 12 months. The IT prescribing system was checked and found to have a failsafe prescribing system which alerted clinicians to the concerns about this medicine each time patient's records were accessed. The findings of the review were disseminated among the clinical staff.

- The practice used information about care and treatment to make improvements.
- The practice was actively involved in quality improvement activity. Where appropriate, clinicians took part in local and national improvement initiatives. For example, an out of hours project offering appointment access on a Saturday morning.

Effective staffing

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

- Staff had appropriate knowledge for their role. For example, to carry out reviews for people with long term conditions, older people and people requiring contraceptive reviews.
- Staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.
- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff said they had received eLearning mandatory training in the last 12 months. Spreadsheets were maintained to monitor this and reminders were included within staff bulletins and practice meetings
- Staff were encouraged and given opportunities to develop.
- Practice nurses and health care assistants had access to a Cornwall 'Rolling Nurse' programme of training and education for practice nurses in the area.
- The learning and development needs of staff were discussed at appraisal or on an ad hoc basis as required. The practice was currently supporting a health care assistant (HCA) to become qualified as an AP (Assistant Practitioner) on a two year course. Two members of staff had moved from the practice to commence nurse training.
- New practice nurses were supported to complete induction and training development, and supervision roles. The dispensary manager provided the same service for dispensing staff.
- The practice provided staff with ongoing support both formally and informally. This included an induction process, one-to-one meetings, appraisals, coaching and mentoring and support for revalidation. The practice manager had recognised that not all administration staff and reception staff had received appraisals in the last year. An action plan was in place to address this by the end of April 2018. Staff spoken with told us they had dates for appraisals booked and added that they felt supported within their roles. Staff added that the open door approach of the GPs and practice manager helped with this supportive working atmosphere.
- The induction and development process for healthcare assistants (HCA) included the requirements of the Care Certificate. However, these had not been required as there had been no new HCAs employed since April 2015.
- The practice ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

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

Good

Are services effective?

- We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for people with long term conditions and when coordinating healthcare for care home residents. They shared information with, and liaised, with community services, social services and carers for housebound patients and with health visitors and community services for children who have relocated into the local area.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

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

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their own health such as through social schemes and voluntary services. For example, the practice referred patients to the carers group, friends group and memory café.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health such as stop smoking and tackling obesity campaigns.

Consent to care and treatment

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

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately.

Please refer to the Evidence Tables for further information.

Outstanding ☆

Are services caring?

We rated the practice as outstanding for caring.

The practice was rated as outstanding for caring because:

- Feedback from people using the service, those who were close to them and stakeholders was strongly positive about the way staff treat people. People thought that staff "go the extra mile" and the care they received "exceeded their expectations".

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from patients was positive about the way staff treated people.
- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.

Results of the July 2017 national GP patient survey showed the practice had performed significantly better than CCG and national averages for all 23 questions. For example:

- 97% of respondents stated that they would definitely or probably recommend their GP surgery to someone who had just moved to the local area compared with a local average of 84% and national average of 77%.
- 95% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 92% and the national average of 89%.
- 100% of patients who responded said they had confidence and trust in the last GP they saw; CCG - 97%; national average - 95%.
- 96% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG - 90% national average - 86%.
- 99% of patients who responded said the nurse was good at listening to them; CCG - 93%; national average - 91%.
- 99% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG - 93%; national average - 91%.

These findings were reflected in the NHS friends and family test results. Of the 104 test results to date 102 were extremely likely or likely to recommend the practice.

All 30 comment cards received contained detailed comments and examples and were consistently positive about the staff group, access, care and treatment received. There were no negative comments received.

The practice had completed an Improving Practice Questionnaire in April 2016 which gave an overall satisfaction rate of 93%. For all 28 questions the practice score was higher than the national mean score. For example:

- Questions about respect shown resulted in a score of 92 compared to the national average of 84.
- Questions about ability to listen resulted in a score of 91 compared to the national average of 82.
- Questions about reassurance given resulted in a score of 88 compared to the national average of 79.

We spoke with 11 patients who were all positive about the care and treatment they received. We were given examples about where the staff had 'bent over backwards' or 'went above and beyond' to ensure they received the care they needed. We were given examples to demonstrate this:

- GPs calling into patients home on the way home to check on their wellbeing.
- Unprompted telephone calls to patients to review progress with treatment/issues.
- GPs running eight miles in the snow to get to work because roads were impassable.
- Practice staff promoting and supporting the transport service provided by the friends of the practice
- Practice staff supporting each other and members of the community when negative personal circumstances were experienced.

Involvement in decisions about care and treatment

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

- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.

Outstanding ☆

Are services caring?

- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.
- The practice proactively identified carers and supported them.

We spoke with 11 patients who told us they were 'pleased' 'grateful' and 'thankful' for the high standard of care they received. Patients said they felt informed in decision making processes and were empowered to suggest treatment options.

Results from the national GP patient survey (July 2017) showed patients responded positively and consistently to questions about their involvement in planning and making decisions about their care and treatment. All of the results for GPs and nurses were above local and national averages:

- 95% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 90% and the national average of 86%.
- 93% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG - 87%; national average - 82%.
- 95% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG - 91%; national average - 90%.
- 98% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG - 89%; national average - 85%.

Privacy and dignity

The practice respected patients' privacy and dignity.

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

The practice proactively identified patients who were carers and employed a carer's support coordinator who was based at the practice. Practice staff said because the community was close knit staff knew patients well. We saw many patients were known on first name terms by staff. Patients said they appreciated this personal touch. We spoke with one carer who added that they appreciated the work provided by the carer support coordinator. The practice's computer system alerted GPs if a patient was also a carer. 326 (About 4%) carers were registered as 'carers' on the practice clinical system.

The carers support worker ensured that the various services supporting carers were coordinated and effective. This included hosting a monthly carers meeting, holding social events including trips and coffee mornings and organising speakers to attend the group.

One of the branch surgeries had a very active 'Friends of Constantine group' which was hosted at the practice. The group was supported by the practice. The volunteers performed fundraising events to buy additional equipment including additional automated external defibrillators (used to attempt to restart a person's heart in an emergency). Four defibrillators had been issued to the practices and wider community with education sessions being provided internal and external healthcare professionals.

Please refer to the Evidence Tables for further information.

Outstanding ☆

Are services responsive to people's needs?

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

The practice was rated as outstanding for responsive because:

- Patients appreciated the access to appointments and services in a way and at a time that suited them.
- The practice had recognised the geographical restrictions, the needs of the whole population group and difficulty for some patients accessing healthcare. The staff offered additional support and many services to reduce the need for long journeys to secondary care and improve access to locally based services.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs.
- The GPs worked with the emergency services and first responders by attending emergency call outs to patients in the area. This was done because the nearest ambulance often took 20 minutes to attend to patients. The practice was able to give examples of successful resuscitation and attendance to offer pain relief whilst transport to hospital was in progress.
- During recent snowy weather staff had responded to the needs of the patients. This included patients using 4x4 vehicles to transport GPs to patients and staff expecting to sleep at the practice so patients could access care and treatment and pick up medicines.
- Patients could access any one of four branches throughout the working week and could book longer appointments to cover more than one issue per visit. The practice had an open request policy for home visits due to the large proportion of elderly and frail patients and the lack of local public transport.
- Advance appointments up to six weeks in advance were available. Extended hours opening were offered two evenings per week between 6.30pm and 8.20pm at the Mullion and Constantine branch surgeries.
- There was an online appointment booking system. Patients registered to use this service could book appointments with a GP up to one month in advance.
- The practice was located in a popular holiday destination and provided services for temporary patients. We saw many positive comments in thank you cards, emails and letters regarding this additional service.
- The facilities and premises at all four sites were appropriate for the services delivered and had appropriate facilities for patients with reduced mobility.
- The practice provided effective care coordination for patients who are more vulnerable or who have complex needs. They supported them to access services both within and outside the practice.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.
- The practice took part in a local Prime Ministers challenge fund project to provide out of hour GP services on a Saturday morning with an aim to reduce unplanned hospital admissions and optimise care in the community. These included face to face appointments, home visits and telephone consultations. Patients who had used this service gave positive feedback. There was no data to support the effectiveness at the time of the inspection but we were given several examples of where this benefitted individual patients and had reduced hospital attendance.
- The practice had the use of 12 beds at the local community hospital in Helston where patients could be admitted if their medical needs were appropriate. Patients had also been discharged here from the local acute hospital for rehabilitation. Consequentially patients received hospital based care from their own GP enhancing their discharge back into the community. Patients were also admitted to the community hospital for palliative care at the end of their life and received multi-disciplinary team input from both a GP at the practice, the nursing team and a community specialist palliative care nurse. This service was currently under review as fewer practice patients were able to access the beds.
- The friends group had set up a transport service for patients at the practice. The practice had supported this service by managing the DBS check process to vet the suitability of volunteers and offering a telephone transferring service to the volunteers. This involvement helped ensure patients were supported safely by appropriately screened volunteers

Outstanding ☆

Are services responsive to people's needs?

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice dispensary provided medicines in blister packs for older patients with memory problems or had other medicines management needs and liaised with local pharmacies to provide this service for non-dispensing patients.
- One of the GPs provided a weekly 'ward round' for patients living in a large 56 bed nursing home. This had improved communication with the patients, families and staff and had contributed towards lower than average unplanned hospital admissions and emergency room attendances. For example, in 2016/2017 the practice had reduced Accident and Emergency attendance by 1.91% and in 2017/2018 this reduction had reduced to 6.67%. These were the third lowest rates in the locality.
- Older patients with complex needs were managed jointly with the community matronto support of the frail elderly patients aimed to maintain independence and good health.
- The practice worked alongside the local Acute Care at Home team (LCAH) and ambulatory oxygen supplier to provide same day interventions such as oxygen concentrators and antibiotics to elderly patients in need who would otherwise require admission to hospital.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment where possible, and consultation times were flexible to meet each patient's specific needs.
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.
- The practice provided a wide-range of soft-tissue and joint injections to its own patients, and to neighbouring practice patients to reduce secondary care burden and improve patient access. This had a proven, audited, success and safety rate. For example, since the service commenced in January 2015 233 patients had been treated by one of the GPs. 201 of these patients had seen positive results and had not required further treatment. Only four patients had shown no improvements in symptoms and had been referred for further interventions accordingly.
- The staff at the practice provided a Doppler service for patients with peripheral vascular disease (leg ulcers). This prevented these patients travelling to the nearest Doppler assessment service over 30 miles away.
- The practice promoted and referred patients to a 'Leg Club' at Helston community hospital. The practice had been involved in the development and support of this service which had improved patient care, education and reduction in social isolation for patients.
- An additional service was provided by staff at the practice for patients with indwelling intravenous lines used for prolonged treatments. This reduced the need for a 50 mile round trip.
- The practice held virtual lipid clinics. These were clinics where patients with high blood fats, and associated risk of developing heart disease, were able to receive screening, health education and medicine advice. This improved patient care in a timely way to high risk patients, decreasing waiting times providing better access for appointment availability for face to face consultation when required.

Families, children and young people:

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.
- The practice had accreditation with SAVVY Kernow (formerly called EEFO). Savvy Kernow is a countywide service for young people, addressing problems which stop young people from accessing the services they need. The Savvy Kernow logo demonstrated young people could expect a certain standard of service that had been tailored to their needs.
- The phlebotomists at the practice were experienced in taking blood from children and had offered this service to 26 children in the last 12 months removing the need to travel to the nearest service over 30 miles away.

Outstanding ☆

Are services responsive to people's needs?

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

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, extended opening hours, online services and text messaging services.
- Constantine branch surgery provided a weekly Thursday late-night surgery and Mullion health centre provided a weekly rolling rota late-night surgery.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including homeless people, patients with drug and alcohol addictions and those with a learning disability.
- There was an alcohol detoxification bed at Helston Community Hospital which is run by one of the GPs. This allowed for inpatient care local to family and home to provide ongoing support in addition to the weekly outpatient clinics held by Addaction at the practice.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode. Patients with no fixed abode were able to use the practice address for correspondence.

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

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- Patients who failed to attend were proactively followed up by a phone call from a GP.
- Patients with an enduring mental illness were offered an annual review with their preferred GP. A third sector organisation provided in-house psychological therapies at the practice.
- GPs promoted and referred patients to a memory café in Mullion to support patients with memory problems and their carers.

Timely access to care and treatment

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

- Patients had timely access to initial assessment, test results, diagnosis, treatment and dispensary services.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- Patients reported that the appointment system was easy to use and added that they were pleased with the appointment service. Patients told us they could always get a same day appointment if necessary, request a telephone call or home visit. Parents and guardians said children were seen as a priority. Other patients told us they could always get an appointment on the same day or within a couple of days if they chose a specific GP.
- Comprehensive information was available to patients about appointments on the website and within the practice. This included how to arrange urgent appointments and home visits and how to seek medical assistance when the practice was closed.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment were all consistently better than local and national averages.

- 97% of patients who responded said they could get through easily to the practice by phone; CCG – 76%; national average - 71%.
- 99% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment; CCG - 90%; national average – 84%.
- 99% of patients who responded said their last appointment was convenient; CCG - 87%; national average - 81%.
- 80% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 80% and the national average of 87%.
- 93% of patients who responded described their experience of making an appointment as good; CCG - 80%; national average - 73%.

We spoke with 11 patients whose views reflected these survey findings. Patients praised the reception team and said they 'bent over backwards' to get appointments at a time convenient to the patient.

Listening and learning from concerns and complaints

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

Outstanding ☆

Are services responsive to people's needs?

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

Please refer to the Evidence Tables for further information.

Good

Are services well-led?

We rated the practice and all of the population groups as good for providing a well-led service.

Leadership capacity and capability

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

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.
- There was a clear proactive approach to seeking out and embedding new ways of providing care and treatment to patients in the rural and often isolated community.
- The GP partners had made a conscious decision to ensure GP/patient ratios were kept at manageable levels to ensure 'quality' patient care could be provided. There had been no issues regarding the recruitment of GPs. Many partners had previously been at the practice as GP trainees and chosen to return because of the leadership style and culture of the practice.

Vision and strategy

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

- There was a clear vision and set of values. The practice had a realistic strategy and supporting business plans to achieve priorities.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The practice planned its services to meet the needs of the practice population.
- The practice monitored progress against delivery of the strategy.

Culture

The culture developed at the practice was used to drive and improve the delivery of high-quality person-centred care.

- There was a low turnover of staff at the practice and GP recruitment was easy. Many of the partners had worked at the practice before or had been GP trainees in the past.
- Staff stated they felt respected, supported and valued. They enjoyed and were proud to work in the practice.
- The practice staff focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. Staff said there was support given when things went wrong and were involved in the investigations. There were discussions taking place about widening the involvement of all staff. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. The majority of staff had received regular annual appraisals in the last year with remaining staff given dates to receive an appraisal in the next two months. Staff said they had received informal support when the required and could request learning and development at any time. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff. Staff said their colleagues and leaders supported them both professionally and personally.
- The practice actively promoted equality and diversity. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.
- Communication was effective at the practice and organised through structured, minuted meetings. These included partner meetings, clinical meetings, staff meetings, multidisciplinary team meetings, patient

participation group meetings, nurses meetings, administration team meetings, notifications on the computer system and an open door policy used by the GPs and practice manager.
- The practice used monthly staff bulletins to communicate with staff. These updates included praise, information regarding changes in policies, reminders to complete training, news of new health screening programmes and services and information regarding the practice computer system.
- Patients also received a quarterly newsletter with updates on practice news, health promotion and staff changes.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management across all four sites and all three dispensaries.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective.
- The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control.
- Practice leaders had established policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

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

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety across all four sites.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Practice leaders had oversight of national and local safety alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of continued action to change practice to improve quality.
- The practice had plans in place and had trained staff for major incidents.
- The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care. For example, a recent decision to stop a service provided at a local community hospital had been discussed with the patient group and with staff members.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

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

Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high quality sustainable services.

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture.
- There was an active patient participation group (PPG) who met three to four times a year and were used as a patient voice. The PPG representatives said the practice

Good

Are services well-led?

manager attended each meeting and added that the group had influenced changes at the practices and had been consulted in decisions being considered by the practice.
- The practice monitored a community Facebook page to get views from patients. For example, the Facebook page had contained many positive comments from patients regarding the care and treatment received during recent snowy weather.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There was evidence of systems and processes for learning, continuous improvement and innovation.

- The practice took part in a local Prime Ministers challenge fund project to provide out of hour GP services on a Saturday morning with an aim to reduce hospital admissions and optimise care in the community.
- There was a focus on continuous learning and improvement. Staff said they were supported in their education. We heard of examples where staff had been supported to develop and had left to do degrees in nursing.
- Staff knew about improvement methods and had the skills to use them.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.

Please refer to the Evidence Tables for further information.