Fowey River Practice

Quality Report

Rawlings Lane
Fowey
Cornwall
PL23 1DT
Tel: 01726 829272
Website: www.foweyriverpractice.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

Fowey River Practice was inspected on Tuesday 3 February 2015. This was a comprehensive inspection, which focussed on the Fowey practice and Polruan branch practice, which had a dispensary.

Overall the practice is rated as good.

Specifically we found the practice to be good for providing well-led, effective, caring and responsive services. It was also good for providing services for all the population groups with exception of people with mental health which is rated as outstanding.

Our key findings were as follows:

- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- There was a strong commitment to providing well co-ordinated, responsive and compassionate care for patients.
- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care. Urgent appointments were available the same day and staff were flexible and found same day gaps for patients needing routine appointments.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

Summary of findings

- Audits were used by the practice to identify where improvements were required. Action plans were put into place, followed through and audits repeated to ensure that improvements had been made.

We saw several areas of outstanding practice including:

- The practice is contributing to nurse education in the region with the aim of promoting primary medical services as a career option when general practice is facing significant challenges in recruiting nurses. Fowey River practice is one of few practices in the peninsula providing placements for trainee practice nurses. Placements for pre-registration nursing students were due to start shortly after the inspection.
- The practice takes a truly holistic approach to assessing, planning and delivering care and treatment to people who use services. GPs at the practice had been recognised for leading research on advanced care planning for people with advanced dementia. GPs had disseminated this information across the primary care sector and in particular with practices in the Kernow Clinical Commissioning group. Since carrying out the research, the implementation of advanced care plans at the practice had reduced unplanned admission to hospital for people with dementia by 40% over the course of two years.

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.

Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff and the practice demonstrated they reviewed resources in line with patient needs. Recruitment practices required improvement to ensure that staff were fit to work at the practice or safe to carry out chaperone duties.

Are services effective?

Good

The practice is rated as good for providing effective services.

Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Fowey River Practice is a training practice and the quality of training and support provided for trainee GPs and doctors was rated highly by trainees. The practice was contributing to the vocational training of new practice nurses and had a contract to start providing pre-registration nursing students placements. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals taking place. Staff had support to develop their skills to improve performance and provide effective health monitoring for patients at the practice. Staff worked with multidisciplinary teams, which included strong links with other health and social care professionals supporting patients at the end of their lives.

Are services caring?

Good

The practice is rated as good for providing caring services.

Data showed that patient satisfaction was consistent with national levels in several aspects of care and treatment. Patients said they felt supported and were treated with understanding, dignity and respect. When needed they were given information and staff

Summary of findings

ensured they understood their choices about care and treatment. Staff treated patients with kindness and respect, and maintained confidentiality. Information to help patients understand the services available was easy to understand.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day and those at the end of their life were able to contact their own GP out of hours. The practice performance for delivering appointments exceed what was expected. On average 476 patient appointments were delivered each month, compared with 312 appointments expected for the list size.

The practice had good facilities and was well equipped to treat patients and meet their needs. The practice had embraced working with the patient participation group, with whom it values and regularly meets with. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints with staff and other stakeholders was evident and had improved the service.

Are services well-led?

Good

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

Fowey River practice had a clear vision and strategy. There was a strong collaboration and support across all the staff and a common focus on improving quality of care and people's experiences. The practice had strong links with the Peninsular Medical School Deanery, providing placements for medical students, trainee GPs, trainee practice nurses and pre-registration nurses. There was clear proactive approach to seeking out and embedding new ways of providing care and treatment. There was a clear leadership structure and staff felt supported by management. There were systems in place to monitor and improve quality and identify risk. Patient feedback was actively sought and making a difference to the service. Staff had received inductions, 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.

Patients over 75 years represented the highest patient group on the practice list. All of the older patients had a named GP, which had been confirmed in writing to the patient. Some of these patients reside at home or in one of the three nursing homes supported by the practice.

Personal Care Plans (PCPs) had been completed for all patients that may have a higher risk of emergency hospital admission; this information had been gained from local intelligence and reports which enabled closer monitoring of this group of patients. As a research practice, Fowey River Practice had submitted an application to Kernow Clinical Commissioning Group (CCG) for funding to do some further research aimed at improving patient experience of end of life care.

There was a named GP lead for adult safeguarding and safeguarding policies. Safeguarding issues relating to vulnerable older people were a regular item for discussion at weekly GP meetings.

The practice worked collaboratively with other agencies, including Age concern, a local befriending group, food bank and the Fowey community hospital. The practice GPs were responsible for the medical management of patients at the community hospital.

Community based nurses were based at the practice, which meant that GPs could liaise quickly with the end of life specialist nurse and community nursing team. Both teams shared a 'watch' list of patients at risk so that early interventions such as additional support and monitoring could be put in place to avoid unplanned admission to hospital.

Older patients taking multiple medicines were encouraged to attend poly pharmacy clinics with a pharmacist working alongside a GP to ensure prescribing was in line with current practice and that risks were reduced for patients. The dispensary at Polruan-by-Fowey and local chemists that work with the practice ran home delivery services for housebound or very ill patients.

People with long term conditions

Good

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

Summary of findings

New patients joining the practice were signposted at registration for an appointment with the appropriate GP who specialised in particular long term conditions.

The practice had a long history of promoting nurse led chronic disease management, success in the work done with patients suffering from asthma had resulted in an award from a nationally known organisation. The practice was amongst one of the first in the area to use leg ulcer compression techniques, which was promoted by commissioners. Nursing staff had undergone specific training and updates for particular long term conditions. Patients with chronic obstructive pulmonary disease were reviewed during the summer months when they were less likely to be suffering an exacerbation of their condition. Assessing these patients 'at their best' was seen as important and helped staff to recognise any slight change in symptoms that may lead to more prompt treatment. Similarly, annual assessment of patients with asthma were not undertaken during the hay fever season. The practice had carried out an audit to determine whether there was enough nurse time allotted for annual check appointments.

Those patients with chronic obstructive pulmonary disease were informed about the local Eden walking group and encouraged to participate as a way of maintaining their tolerance to exercise.

Staff, including a health care assistant have received training at the practice about the symptoms, management and treatment of patients with chronic disease. Patients with more than one condition make a single appointment which is adapted to meet their needs.

The practice worked collaboratively with the community nursing team and end of life nurse specialist who all attended multidisciplinary meetings there. Near patient testing (NPT) was carried out at all three practices and a pharmacist ran poly pharmacy clinics for patients on multiple medicines to ensure the potential risks were reduced for them.

Families, children and young people

Good

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

Families were given choice and flexibility for appointment times in order to increase baby vaccination rates, notification of the need for vaccine was given from birth and appointments given four weeks later. Records had been closely monitored by the nursing staff and showed that there were no babies registered at the practice who had missed their vaccines. This had proven effective when the national recall system had failed on one occasion.

Summary of findings

The practice fast tracked poorly babies and children so that they were seen immediately by a GP for assessment and treatment where needed.

There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. The practice shared the building with the health visiting team and had a named child safeguarding lead and deputy. Regular multidisciplinary meetings were held enabling the team to have a good knowledge of this group of patients and ensured joined up working. Clinics were held at the practice for mothers, babies and young children which were run by midwifes and health visitors. The practice signposted families living in disadvantaged circumstances to the local food bank when support was needed.

The practice was designated as a young person friendly practice having achieved quality standards for information and support available. Two young people at the practice had joined the Patient Participation Group (PPG) and had taken responsibility for running the virtual group to seek patient feedback.

The Nurse Practitioner Partner had specialised in family planning and long term contraception, for example hormone implants and coils which were offered at the practice for female patients. Information about contraception and promotion of health was also targeted for young people. Young people had access to information and could request chlamydia screening and be seen by a practice nurse specifically trained in these areas.

Working age people (including those recently retired and students)

Good

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

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. Appointments were flexible and adapted to fit in with patients who were unable to visit the practice during usual working hours. The practice was proactive in offering a full range of health promotion and screening that reflects the needs for this age group. For example, an audit had been undertaken regarding cervical screening, this had identified that out of the 371 smear tests three were inadequate, one pot had expired and one was lost, all five patients had been recalled and the test repeated.

Summary of findings

Nurse led clinics focussed on health promotion and patients were offered health checks and extended opening hours. A travel advice and vaccination service was available for patients going on holiday to far flung places.

Patients had the facility to order repeat medication and book appointments on line or request a telephone consultation. The practice worked with local chemists, enabling patients to choose where they wished to collect prescriptions from.

People whose circumstances may make them vulnerable

Good

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

The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks for people with a learning disability and 100% of these patients had received a follow-up. It offered longer appointments for people with a learning disability and their carers for reviews. Home visits by GPs were carried out where needed, including those patients living in two local care homes. The practice liaised with the learning disability nurse specialist to ensure information was communicated in a person centred way, for example in easy read or picture formats.

The practice worked closely with the community matron to arrange visits to vulnerable patients to assess and arrange any equipment or other assistance needed by the patient and their carers.

Systems were in place to help safeguard vulnerable adults. The practice welcomed all patients to the practice and had systems in place to temporarily register and communicate with homeless people. Due to the location, it was rare for homeless people to present at the practice for support and treatment.

Carer checks were carried out and the practice hosted a carer support worker clinic every month to support patients. Carers were signposted to various local charities depending on the type of support needed and included Age concern, a befriending scheme and food bank.

People experiencing poor mental health (including people with dementia)

Outstanding

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

The practice had received a National Patient Safety Award in relation to dementia care and advance planning. The research that led to this award was influencing how GPs in the primary care sector

support patients with their on-going care and support needs. All of the staff had received training on the Mental Capacity Act and deprivation of liberty safeguards. Patients told us that as carers they were well supported and their views considered.

Flexible services and appointments were available, which enabled patients experiencing poor mental health to have longer appointments up to an hour at quieter times of the day, avoiding times when they might find this stressful. Patients who may be likely to forget to make appointments had their next appointment agreed with them and written down before they left the practice.

Shared care arrangements were in place for patients with complex mental health needs. The practice worked closely with the community mental health team and regularly reviewed each patient. Every patient had a care plan and risk assessment, which was reviewed.

Staff were skilled in recognising and responding to patients experiencing mental health crisis, providing support to access emergency care and treatment. The practice worked collaboratively with the community mental health team and consultant psychiatrists from the mental health partnership trust.

The team had a close working relationship with community mental health professionals who attend multidisciplinary meetings at the practice. Comprehensive mental health assessments were completed and the practice had a dementia practitioner working at the practice to support patients and their carers. A lead named GP was responsible for overseeing a list of patients diagnosed with or suspected to have early onset dementia. Patients and their carers were signposted to various services including the local memory clinic.

Health education, screening and immunisation programmes were offered as appropriate. This included alcohol and drug screening. Staff had extended their qualifications, which meant that two GPs and the nurse practitioner were able to deliver a home detoxification service for people who are addicted to alcohol.

The practice hosted other clinics at the practice, which meant that patient travelling time was reduced and offered more convenient access to counselling services. The services each had a specific focus including depression and anxiety and addictions.

Summary of findings

What people who use the service say

The practice sought feedback from patients in several ways. Patients participated in the GP Patient Survey for 2014 for Fowey River Practice and 162 forms were returned. This is a response rate of 44%

Three surveys, including the 2014 national GP survey showed that results for Fowey River Practice was better in all areas compared to the clinical commissioning group (CCG) and national average. Patient satisfaction was rated at 89.4% compared with the national average of 86% in the 2014 GP survey. The practice was using the Friends and Family test as a marker of continuous feedback and had been analysing this each month.

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 experiences with us. Twenty three patients gave feedback at the inspection, in person (21) or in writing (8). All of the patients confirmed they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.

In written feedback, the overarching theme from patients in their responses was that received compassionate care from all of the staff at the practice. They told us that staff took time to listen and often went beyond what was expected of them. GPs were described as being committed and passionate about what they do. Patients told us they were confident about the advice given and medical knowledge of their GPs. The appointment system was said to work well, and when patients needed an urgent appointment they were able to see a GP on the same day.

These findings were reflected during our discussion with the patient participation group (PPG) members. The members explained that the group had a good working relationship with the GP partners and the practice manager. Membership included two young people who had taken responsibility for running the virtual PPG online. The group had been enabled to be independent and had developed a statement of aims. These aims included increasing patient involvement, facilitating the improvement of services through direct involvement in strategic planning with the practice, raising awareness of health promotion and fostering patient loyalty and support for the practice.

The majority of patients who gave verbal feedback gave high praise for the treatment and support they received at the practice. Patients stated they were very happy and were treated with respect and dignity. They told us that the GPs and practice nurses were excellent and thorough when it came to diagnosis, treatment and on-going monitoring of long term health conditions.

Four sets of parents told us the staff treated their children with respect. We were told the staff were good at communicating with children and young people, which in turn helped reduce any anxieties they might have had about visiting the practice. The parents verified that young children were seen quickly at any time of the day which meant they didn't have to wait for appointments.

Patients felt listened to and the majority told us they had no serious complaints but remarked that customer care could be further improved by reception staff. The majority knew how to make complaints and were confident that if they did have any concerns they would be acted upon. Information about complaints was available in the waiting room although not easy to see. The practice guide for patients also contained this information.

Patients were satisfied with the facilities at the practice. The building was highlighted as being accessible for people using mobility aids, safe, clean and tidy. Patients told us staff used gloves and aprons where needed and washed their hands before treatment was provided.

Patients told us they found it easy to get repeat prescriptions and could often pick these up from a local pharmacy of their choice the same day or next day or at the Polruan dispensary.

Summary of findings

Outstanding practice

- The practice is contributing to nurse education in the region with the aim of promoting primary medical services as a career option when general practice is facing significant challenges in recruiting nurses. Fowey River practice is one of few practices in the peninsula providing placements for trainee practice nurses. Placements for pre-registration nursing students were due to start shortly after the inspection.
- The practice takes a truly holistic approach to assessing, planning and delivering care and treatment to people who use services. GPs at the practice had been recognised for leading research on advanced care planning for people with advanced dementia. GPs had disseminated this information across the primary care sector and in particular with practices in the Kernow Clinical Commissioning group. Since carrying out the research, the implementation of advanced care plans at the practice had reduced unplanned admission to hospital for people with dementia by 40% over the course of two years.

Fowey River Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor, two CQC inspectors including a CQC pharmacy inspector, a practice manager specialist advisor and an expert by experience.

Background to Fowey River Practice

Fowey River Practice is contracted to provide general medical services to people living in Fowey and the surrounding villages. The practice includes two branch practices situated in Polruan and Par. The branch practice at Polruan has a dispensary, which we inspected on the same day. We did not inspect the Par branch practice. The practice provides services to a diverse population. At the time of our inspection there were 7183 patients registered at the service.

Transport links within the area are limited, with Polruan accessible by boat from Fowey. The nearest main hospital is in Truro approx. 23 miles away. Fowey River Practice covers coastal villages, which are rural, with high percentage of agriculture and mid-range social deprivation. The practice provides primary medical services to a diverse population and supports patients living in adult social care homes in the area.

There are five GPs; four partners and one salaried GP at the practice. Fowey River Practice is a training practice, with two GP partners approved to provide vocational training for GPs, second year post qualification doctors and medical students. When we inspected there was one trainee GP on placement at the practice. The nursing team comprises of a nurse practitioner, two practice nurses and two health care assistants. The team work across all three practices.

The practice is EEFO approved (Young people friendly service). Friendly, confidential and teenage specific services are available and run by a named advanced nurse practitioner at the practice. Emergency contraception, coils and implants, free condoms, contraceptive advice and any health or well-being advice is provided as needed. Appointments are available on Saturdays by request or after school or college. Urgent same day appointments and telephone advice are available. Young people are able to choose who they wish to consult with.

Patients using the practice also have access to community staff including district nurses, health visitors, and midwives.

Fowey River Practice is open from 8.30am until 6.30pm Monday to Friday. The Polruan practice is open Monday-Friday 8.30am-12pm. The Parr practice is open Monday to Friday 8.30am to 1pm and 2pm to 6.00pm. When the branch practices are closed, patients from Par and Polruan are able to attend the main practice at Fowey for appointments. For working patients, extended hours appointments are made by appointment. These are before 8.30am, later in the evening or on a Saturday morning. The times, days and location varies from week to week. Repeat prescriptions and appointments can be booked on line via the practice website, in person or by telephoning the practice.

During evenings and weekends, when the practice is closed, patients are directed to an Out of Hours service delivered by another provider. This is in line with other GP practices in the Kernow clinical commissioning group, which includes taking over the phone lines from 6pm.

Detailed findings

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. 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

Before visiting the practice, we reviewed a range of information we held about the service and asked other organisations, such as the local clinical commissioning group, local Health watch and NHS England to share what they knew about the practice. We carried out an announced visit on 3 February 2015.

During our visit we spoke with two GP partners, nurse partner who is an advanced nurse practitioner and prescriber, a practice nurse, health care assistant, GP registrar and medical student and administrative and reception staff. We inspected the dispensary based at Polruan and met two dispensary staff there. We also spoke with ten patients who used the practice and two representatives from the patient participation group (PPG). We observed how patients were being cared for and reviewed 21 comments cards where patients shared their views about the practice, and their experiences. We also looked at documents such as policies and meeting minutes as evidence to support what staff and patients told us.

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

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. Staff explained they would report the issue and would complete a document which was then managed by the GPs and practice manager for action. Issues were reviewed at the monthly clinical governance meetings.

There were clear systems and processes in place which kept staff informed about national, professional guidance and legislation, for instance protocols about research based practice and information from the National Institute for Health and Care Excellence was placed on the computer shared drive for staff to access.

Learning and improvement from safety incidents

There were systems for reporting, recording and monitoring significant events and accidents. At the end of each day the nursing staff and GPs held an informal debrief meeting to discuss any events that may have occurred that day to capture any action or learning points. Staff also used electronic forms on the practice intranet and knew who to report significant events to. The practice manager verified that these were collated and discussed with GP partners. An example shared with us related to an emergency bag used by GPs when attending patients at home, which was found to be missing equipment used to give intravenous fluids to patients. The matter had been investigated and led to improvements in the way this equipment was checked and maintained. The practice had introduced checks to be carried out immediately after use as well as monthly checks of the emergency bag.

National patient safety alerts were disseminated by email to practice staff. We were given an example of increased cardiovascular risks related to the prescribing of a particular medicine. The practice undertook a search for patients who were on this particular medicine following the alert and where appropriate had discontinued or given an alternative medicine. Staff told us that the particular medicine was now only prescribed to patients for short courses and patients were closely monitored whilst on it.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. The senior GP partner was the designated safeguarding lead for the practice.

There were two dedicated GP leads for safeguarding vulnerable adults and children. Both had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil this role. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, 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.

There was a system to highlight vulnerable patients 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. We saw that codes linked family members on the patient record system. There was active engagement in local safeguarding procedures and effective working with other relevant organisations including health visitors and the local authority.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms and on the practice web site. (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). All nursing staff, including health care assistants, had been trained to be a chaperone. Reception staff did not act as a chaperone if nursing staff were not available. All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. (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).

Medicines Management

We checked medicines stored in the dispensary at Polruan branch practice and found they were stored securely and

were only accessible to authorised staff. Medicines requiring cold storage were stored in a medicines refrigerator and there was a clear policy for ensuring that these medicines were kept at the required temperatures. At the time of our inspection the temperature in the dispensary was within the recommended temperature range for storing medicines, however there were no records of temperature monitoring kept. Systems were in place to check that medicines were within their expiry date and suitable for use. Expired and unwanted medicines were disposed of in line with waste regulations.

There were clear operating procedures in place for dispensary processes. Systems were in place to ensure all prescriptions were signed before being handed to patients. The practice had a system in place to assess the quality of the dispensing process and had signed up to the Dispensing Services Quality Scheme, which rewards practices for providing high quality services to patients of their dispensary. Any errors or 'near misses' were recorded, monitored and actions put in place to reduce the risks of any recurrence. The dispensary did not hold stocks of schedule 2 controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse).

Blank prescription printer forms were held securely in the dispensary, and a system was introduced during our inspection to record and monitor when these were received and used, allowing an audit trail to be maintained of the whereabouts of these forms in the Polruan dispensary/practice. We found that this system was not in place at the Fowey River Practice. The practice manager told us this would be implemented across this practice and the Par practice, which was not inspected on this occasion.

There were systems in place to ensure any medicines alerts and recalls were actioned. Suitable recommended emergency medicines and emergency equipment were kept at the Polruan dispensary/practice and there were systems in place to ensure these were regularly checked.

At Fowey River Practice, we found that vaccines were stored at required temperatures and records of fridge temperature checks confirmed the cold chain had been maintained. There was no delay in refrigeration when new stocks of medicines arrived and a hand held fridge was used for transferring stock to the Par and Polruan practices.

Medical gasses were stored and used safely and in-line with national guidance; nursing staff showed us the safety equipment and confirmed the arrangements for delivery and usage of the medical gasses used.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. Appropriate action was taken based on the results. For example, the practice had purchased specialised equipment and trained a healthcare assistant to take blood samples to monitor the effects of anti-clotting medication. Normally this was done at the hospital and results available to the following day. Instead, patients at Fowey River practice received an instant result and were then able to make the necessary changes to the dose of their medicine. Another benefit for patients was the access they had to immediate advice and support if this was needed.

Cleanliness & Infection Control

The premises at Fowey and Polruan practices were clean and tidy. There were cleaning schedules in place and cleaning records were kept. Patients in comment cards (21) and in person (8) as well as staff 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 and carry out staff training. All staff received induction training about infection control specific to their role. Staff told us that surfaces were cleaned after each patient and at the beginning and end of each appointment session. Staff knew what to do in the event of any spillages and there was a spillage kit available. We saw evidence that the lead had carried out audits for particular areas of the practice and that any improvements identified for action were completed on time.

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. 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. Coverings on examination couches were changed between each patient, privacy was provided by suitable screening and

consultations were not interrupted. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury. Sharps were disposed of securely in appropriately colour coded and labelled bins.

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.

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 told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. Equipment was tested and maintained regularly and records demonstrated this was happening each year. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place and certain types of equipment were calibrated for accuracy for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer.

Staffing & Recruitment

Information provided by the practice showed that staff retention at Fowey River Practice was high. All of the staff told us they enjoyed working at the practice and new staff had been recruited.

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. This included a policy which was followed when using a locum GP to cover leave or other absences. The practice used an approved agency and tended to use a named locum GP to provide continuity should the need arise. Six 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 the appropriate checks through the Disclosure and Barring Service (These 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).

Other records seen demonstrated that professional registration checks for the rest of the team were being carried out. These included annual checks of the Nursing and Midwifery Council register and revalidation dates for GPs were known and being monitored with the General Medical Council.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a duty rota system in place to respond to urgent patient needs and emergencies. There was also an arrangement in place for all members of staff to cover each other's annual leave and periods of sickness. Locum staff were used where needed. Staff told us there were enough staff to maintain the smooth running of the practice and to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring Safety & 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. Health and safety information was displayed for staff to see and there was an identified health and safety representative. Records seen showed that appropriate checks were carried out, for example fire safety equipment had been tested in the last 12 months. Staff training records demonstrated that all staff had completed an induction and fire training, including a drill.

Staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. There were emergency processes in place for patients with long-term conditions. For example, emergency appointments/telephone consultations were always available each day and patients referred onto specialists such as midwifery services for acute pregnancy emergencies. All young children were offered an

appointment, immediate if necessary, without the need to be triaged. Rescue medications and emergency equipment was easily accessible and the location known by clinical staff.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records demonstrated that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency).

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, suspected meningitis, hypoglycaemia, severe asthma, overdose, nausea and vomiting and epileptic fit. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All of 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. GP partners told us that a specific risk for the Polruan branch surgery was flooding when there were spring tides. The impact of this regular occurrence had been assessed and part of the planning to deal with this demonstrated that the practice was keen to facilitate continued medical services access in Polruan for vulnerable patients living in the village. The business plan contained relevant contact details for staff to refer to. Staff explained that the practice worked collaboratively with two other practices in the area. They told us they would liaise with these practices in the event of an emergency that meant Fowey River Practice could not operate.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Fire safety equipment used in emergencies was regularly maintained. The last fire drill had taken place in September 2014.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

GPs and nursing staff were able to give clear rationale for their approaches to treatment. They were familiar with current practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. Weekly meetings were held at which the latest guidelines and research was discussed. The practice ran dedicated chronic disease review clinics and had produced several care pathways for the management of patients with long term conditions to support the nursing team in delivering this.

The GPs told us they lead in specialist clinical areas such as respiratory disease, end of life care, diabetes and dementia. Practice nurses had additional qualifications which allowed the practice to focus on specific conditions. For example, two of the practice nurses held a diploma in asthma and chronic respiratory disease were responsible for managing the care of patients with these long term conditions. Data for the local CCG showed that the practice performance for monitoring patients with long term conditions for the year 2014 was comparable with other practices in the area. For example, the ratio of expected to reported prevalence of Coronary Heart Disease was 77.7% compared with the national average of 72.2% demonstrating that the practice was identifying and monitoring patients with heart disease.

Data from the local CCG of the practice's performance for antibiotic prescribing demonstrated that this was comparable to similar practices with 31.9% versus the national rate of 28%. The practice had also completed a review of case notes for patients with high blood pressure which showed all were receiving appropriate treatment and regular review. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. The practice reviewed patients every week and had on site meetings with other health and social care professionals supporting them.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. Data showed unplanned admissions for vulnerable patients at Fowey River practice was at 15.6% which was comparable with the national average of 13.6%. Data seen also showed that 100% patients with suspected cancers were referred and seen within two weeks. Educational meetings with clinical staff were reviewing all patients newly diagnosed with cancer so that any potential learning was brought to the meeting. Designated staff dealt with results from investigations and demonstrated that these were seen on the same day by the GP who referred the patient for the investigation or duty doctor.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs 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. Staff showed us information which was in easy read and picture formats, which they used to enable patients with learning disabilities to be fully involved in making decisions about their care and treatment. Patients in written and verbal feedback gave us examples of this. Patients verified in writing (21) and in person (11) that they were treated as individuals and their views respected when they saw their GP or nurse for an appointment.

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling reviews, and managing child protection alerts and medicines management. The information was then collated by the practice manager to support the practice to carry out clinical audits.

Management, monitoring and improving outcomes for people

The practice showed us a copy of the last teaching practice report by the Peninsula Medical Deanery, which demonstrated that GPs used an evidence based approach and utilise every opportunity to review and improve their practice. GPs showed us four clinical audits that had been undertaken in the last three years. Following each clinical audit, changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved. For example, GPs had analysed why the number of unplanned admissions of patients at the practice was slightly higher than average. The audit looked at a seven month period of admissions to determine why patients were being admitted. This identified that the highest group was older patients. The team of GPs utilised the Kings Fund research findings with the aim of early intervention and reducing the number of

Good

Are services effective?

(for example, treatment is effective)

unplanned admissions for older people. The practice had implemented risk tools, detailed coding systems, measures to support continuity of care and self-management for vulnerable patients.

Audits seen also confirmed that the GPs who undertook minor surgical procedures were doing so in line with their registration and National Institute for Health and Care Excellence guidance. 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. For example, GPs had carried out two audits looking at patients taking a short term medicine primarily used to treat rheumatic conditions. They wanted to ensure that patients had been prescribed this medication appropriately and that potential risks were mitigated through regular blood screening. Thirty seven patients were identified and their notes reviewed. In the first audit cycle in March 2014, the results showed that the practice was following current prescribing and monitoring guidelines for 100% of the patients regarding taking blood tests before and 4 weeks after initiation. However, monthly monitoring of these patients needed further improvement. The practice made several changes including extending access for working people to appointments for blood tests. Designated staff were assigned the task of monitoring all patients on this medication and recalling them for blood tests. The second cycle completed in November 2014 showed that the practice performance was at 100% for all aspects of monitoring patients and was therefore meeting the required standards as set out in NICE guidelines.

There was a protocol for repeat prescribing which was in line with current national guidance. Repeat prescription requests were reviewed daily and signed off by a 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 followed. The IT system had recently been updated so that relevant medicines alerts were flagged up when the GP was prescribing medicines. This enabled the GPs to prescribe according to current guidelines with the most cost effective medicines.

The practice worked to the gold standards framework for end of life care. The nearest hospice to the practice was in St Austell, so the team of GPs worked closely with the palliative care team to support patients to be at home and receive services there. A palliative care register was held and reviewed regularly. This included monthly multidisciplinary meetings to discuss the care and support needs of patients and their families.

The practice had systems in place to monitor and improve outcomes for vulnerable patients. For example, a register of patients with learning disability was held. A lead GP oversaw the needs of people with learning disabilities. Information for the previous 12 months submitted to the showed that 100% patients had a physical health check. These were done at the practice, or at the patient's home. The practice supported patients with learning disabilities living at two care homes and carried out home visits to see people there. Staff told us they used accessible information in picture and easy read formats for patients attending these appointments. We saw that patients had a personalised care plan and there was a designated administrator responsible for sending out recall information and setting up appointments with people.

The practice nurse had good links with secondary care, for example a direct link to the respiratory nurse specialist at Treliske Hospital to gain advice about patients in pulmonary rehabilitation, or to arrange chest x-ray.

Effective staffing

Staffing at the practice included medical, nursing, managerial and administrative staff. We reviewed training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. Fowey River practice is a training practice providing placements for GPs and trainee doctors. There was a good skill mix across the team, with the GPs each having their own specialist interests areas such as teaching/training, child care, learning disabilities and complex mental health care. Two GP partners were qualified trainers; with one GP an associate dean of the Peninsula Medical School. Each GP also had specific interests in developing their skills and disseminating this to the team. All GPs were up to date with their yearly continuing professional development requirements and all had revalidated or had a date for revalidation. Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practice and remain on the performers list with the NHS England.

Good

Are services effective?

(for example, treatment is effective)

All staff undertook annual appraisals with the practice manager and/or a GP, which included identification of individual learning needs. Training and opportunities for development had been taken by the practice nurses who spoke of the importance of learning and sharing good practice, they had attended practice nurse meetings locally, involving nurses from seven other practices, for joint learning and developments days, one example being an update about meningitis. The practice enabled their nurses in attending a Cornwall based practice nurse conference to support their development.

The nursing staff received their clinical appraisal from the nurse practitioner partner and/or a GP at the practice. The nurses had received extensive training for their roles, for example, seeing patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease as well as the administration of vaccines and undertaking cervical smears. Healthcare assistants held extended roles, which included delivering health screening for patients over 40 years, carrying out blood checks of patients on anti-clotting medicines, 24 hour blood pressure monitoring, for which they had all received training.

At the end of each day at the practice staff held a debrief meeting to discuss any events that occurred and to capture any concerns or issues, this gave staff opportunity to share problems and encourage a healthy work life balance.

Reception staff had received training relevant to their role, examples include confidentiality and safeguarding. Work station assessments had been completed and staff told us they felt the practice looked after their welfare at work. There were always two receptionists present every day, with cover arrangements in place between the Parr and Fowey practices.

Working with colleagues and other services

GPs worked with other service providers to meet people's needs and manage complex cases. Blood results, X-ray results, letters from the local hospital including discharge summaries, out of hour's providers and the 111 service were received both electronically and by post. There were policies in place outlining the responsibilities of all relevant staff in passing on, reading and actioning any issues arising from communications with other care providers on the day they were received. All of the GPs were responsible for seeing these documents and results and for taking action required. Staff understood their roles and felt the system in place worked well and our observations supported this.

Results and discharge summaries were followed up appropriately and in a timely way. For example, we looked at the electronic inbox and saw that all patient results and summaries were being dealt with as soon as the information was inputted and tasks set within the system for GPs to review. The practice also had a tracking system for all referrals made and we saw these were followed up promptly if the patient had not received an appropriate appointment.

The practice worked effectively with other services. Meetings were held with the health visitor and school nurse to discuss vulnerable children every month. Every month there was a multidisciplinary team meeting to discuss high risk patients and patients receiving end of life care. This included the multidisciplinary team such as physiotherapists, occupational therapists, health visitors, district nurses, community matrons and the mental health team. The practice had a list of vulnerable adults and worked closely with community professionals.

Information Sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals. Special notes were shared with the 111 and Out of Hours services for patients with complex needs who needed continuity of care and treatment overnight.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. 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

GPs at the practice had been recognised for leading research on advanced care planning for people with advanced dementia. GPs had disseminated this information across the primary care sector and in particular with practices in the Kernow Clinical Commissioning group. Since carrying out the research, the implementation of advanced care plans at the practice had reduced unplanned admission to hospital for people with dementia by 40% over the course of two years.

Good

Are services effective?

(for example, treatment is effective)

All of the staff at the practice demonstrated awareness of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in promoting patient rights. Staff shared recent incidents that had required further assessment of a patient's ability to weigh up and understand information to give informed consent. For example, nursing staff told us about a patient they suspected may have early onset dementia due to subtle changes seen in conversation; the patient was referred to the GP and assessed that same day.

All clinical staff demonstrated a clear understanding of Gillick competencies. 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. Close working links with the school nurse were used to gain a broader understanding of whether a young person had the maturity to make decisions and understand potential risks before advice or treatment was provided. Four parents with children attending the practice confirmed that they were always present during consultations. They told us that all of the staff were good at engaging their child and treating them as individuals.

Procedures were in place for documentation of consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes. This followed current guidelines in terms of content and recorded discussion of risks and benefits with patients. Nursing staff recorded patient consent for procedures such as wound dressing, blood taking or cervical screening and examples were seen.

Health Promotion & Prevention

All new patients registering with the practice were offered a health check with a practice nurse. The GP was informed of all health concerns detected and these were followed up in a timely way. Information about numerous health conditions and self-care was available in the waiting area of the practice. This was young person friendly and accessible for people with communication difficulties in easy read formats. The practice website contained information and advice about other services which could support them. The practice offered new patients a health check with a nurse or with a GP if a patient was on specific medicines when they joined 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 immunisations was comparable with the CCG average for all childhood immunisations. For example, 98.3% of babies at 24 months had been immunised against measles, mumps and rubella.

The annual flu vaccination programme was underway. For patients within the relevant age range a vaccination against shingles was also available and information about this highlighted in the practice newsletter and website. The practice had reviewed the data for flu vaccination uptake for the previous year as this was below (62.4%) the national average of 73.2% for older patients. During the current flu vaccination campaign, additional clinics had been held. The practice had targeted the population living in and around Polruan and ran a tea party with Age Concern to raise awareness and offer flu vaccinations for older people in the area. Staff told us this had increased patient uptake of flu vaccination, but the final outcome of the campaign would not be known for a month or so. Patients were contacted by phone or letter. Available data for the year ending 2014 showed that the practice was comparable with national rates for vaccinating patients at risk, such as those with long term conditions like diabetes.

There was information on how patients could access external services for sexual health advice. The practice had also made chlamydia screening more accessible by creating chlamydia testing packs, which were placed in doctor's rooms and in the toilets in the waiting areas. These were marked for female and male patients and had full instructions about how to use them.

The practice culture among the GPs and nurses was to use their contact with patients to help maintain or improve mental, physical health and wellbeing. Data showed 93.3% of patients who were current smokers with physical and/or mental health conditions whose notes contained an offer of smoking cessation support and treatment within the preceding 12 months. The national average was 95.3%. Nursing staff had noticed a patient had swollen ankles during an appointment about a different health problem whilst we were at the practice and we saw that an immediate referral to the GP was made.

Data showed that the percentage of women aged between 25 and 65 years old whose notes recorded that a cervical screening test had been performed in the preceding 5 years was 80.5% which was slightly higher than the national average of 81.9%.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

Staff spoke passionately about promoting equality and showed genuine care and concern for their patients The reception desk had two hatches available, one opening in to the waiting room, the other situated through some doors from the waiting room, to facilitate more privacy. Telephone conversations in the reception office could not be overheard from the waiting room. Consultation and treatment room doors were closed during consultations and conversations taking place in these rooms could not be overheard. Staff were clear that they operated a 'no interruptions' policy during patient consultation. Reception staff had received training and were able to describe how they recognised if a patient in the waiting room may need prompt attention by a nurse or GP. Reception staff had also received safeguarding training and were able to give an example of how they instigated help for a vulnerable patient not known to the surgery, who had arrived in a distressed state, describing how the patient was dealt with safely and compassionately.

GPs told us that they supported patients living in care homes in the area. GPs said they aimed to promote patient dignity and respect in the way they approached requests for a home visit or repeat prescriptions. They told us they did so by overriding the normal triage system in place at the practice and assessed patients at their home.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 21 completed cards and all were positive about the care and treatment experienced with GPs and nursing staff. The majority of patients (8) we spoke with said they felt the practice offered a good service and staff were caring, helpful and professional. They said staff treated them with dignity and respect. Three out of the eight patients we met felt that customer care at the point of reception could be improved as some staff could appear a little abrupt when dealing with routine matters.

Staff took steps to protect patients' privacy and dignity. Curtains were provided in treatment and consultation rooms so that patients' privacy and dignity was maintained during examinations and treatments. Consultation and treatment room doors were closed during consultations and we did not overhear any conversations taking place in these rooms.

Staff were discreet when discussing patients' treatments in order that confidential information was kept private. There were additional areas available should patients want to speak confidentially away from the reception area. We sat in the waiting room and observed patient experiences as they arrived for appointments. Reception staff were friendly and knowledgeable about patients and treated them with respect.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Staff were able to explain how they diffused situations to avoid further escalation of a patient's frustration or anger.

Care planning and involvement in decisions about care and treatment

Data showed that the practice was performing better with regard to maintaining a palliative care register for patients. GPs told us that treatment escalation plans were always discussed with patients on the register and their wishes about end of life care needs recorded. Minutes of multidisciplinary meeting demonstrated these were being followed for patients.

Patient survey information demonstrated that the practice achieved a better than expected level of patient satisfaction and involvement in planning and making decisions about their care and treatment. For example, data from the national patient survey showed 87.3% of practice respondents said the GP involved them in care decisions which was comparable with national performance on this. Patient feedback in the same survey showed that 84.7% felt that the GP was good at explaining treatment and results, which again was comparable with national statistics.

Data showed that 89.4% patients at the practice, compared with 85.3% nationally, felt that the last GP they saw or spoke to was good at treating them with care and concern. The majority of the patients we spoke with (8) told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. Staff were described as being good at listening to their needs and acting on their wishes. The majority of patients said they had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the 21 comment cards we received was also positive and aligned with these views.

Good

Are services caring?

Patients told us they had been involved in decisions about their care and treatment. Several patients who had arrived for appointments gave us examples of how they had been supported, commenting on how their health condition had improved.

Staff told us that translation services were available for patients who did not have English as a first language.

Patient/carer support to cope emotionally with care and treatment

Patients who were receiving care at the end of their lives had been given confidence that they, or their families, could contact a GP from the practice during the night or at weekends, as the GP contact details were given to them. This provided optimum continuity of care to these patients.

Patients highlighted that staff responded compassionately when they needed help and described as going beyond what was expected of them. The practice was carrying out carers reviews. The practice ran a monthly carers clinic in conjunction a community support worker, to provide practical and emotional support for patients who were carers. Members of the Patient Association and Patient Participation Group (PPG) told us that the practice also had good links with the voluntary sector, including a local drop in centre where patients could get additional support and advice.

The practice was proactive in promoting initiatives aimed to support patients cope with their care and treatment. For example, the practice supported the local expert patient self-help group by disseminating information and hosting meetings in the conference room at the practice.

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. Written information was also displayed in the waiting room explaining the various avenues of support available to carers.

Staff told us that if families had suffered bereavement, they were contacted by a GP. 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. The patients we spoke with told us that the staff were caring and compassionate.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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. For example, the practice held registers for each group including one for vulnerable patients so that the support, care and treatment was patient centred.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. Operational meetings were held at the practice every week with GP partners.

Twenty nine patients, in person or in writing, commented that the prescription system was good. The practice had an online prescription request service, which patients told us worked well. The practice had a dispensary at the Polruan branch so patients could choose whether to have their prescriptions made up there or sent through to a chemist of their choice. The practice had arrangements in place for more vulnerable patients, which included a delivery service of the medicines direct to the patient. All patients said the process was efficient and took a couple of days.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). For example, GPs had changed to main number for the practice to a local one to avoid patients incurring additional costs.

Patients were given ten minute appointments as standard, but longer appointments were available if needed. Those we spoke to said they could get through easily on the phone to make an appointment and that waiting times on their arrival were minimal. Same day appointments were available throughout each day as there was always a duty GP or nurse present at the practice. In addition to Monday to Friday 8.30am – 6pm appointments the practice was open later on a Monday evening and once a month on a Saturday morning. Patients who had more than one medical condition were given one appointment which could involve the nurse, GP and health care assistant, this avoided multiple visits to the practice and demonstrated a more holistic and person-centred approach.

The practice hosted other clinics run by healthcare professionals, reducing the travelling time for patients. For example, patients could be referred to a chiropodist who ran a clinic every Thursday afternoon.

Tackling inequity and promoting equality

Staff were aware of the diverse needs of their patient population. This was particularly relevant in knowing and understanding a patient's belief structure and the impact of this on decisions about health care and treatment, a local example being the Jehovah Witness population.

The practice was situated in a purpose built premises, which was accessible for patients in wheelchairs with ramp access into it. The waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities. The practice had an audio loop in the waiting room for those with hearing aids.

The practice had systems in place to support patients whose circumstances may make them vulnerable. For example, the practice had a register of patients with learning disabilities and monitored their needs closely. GPs told us there were no homeless people registered with the practice, there were no barriers for homeless patients and workarounds were in place to record contact information.

Access to the service

There is good access to services at Fowey River Practice. The opening hours are from 8.30am until 6.30 pm Monday to Friday. The Polruan practice is open Monday-Friday 8.30am-12pm. The Par practice is open Monday to Friday 8.30am to 1pm and 2pm to 6.30pm. When the branch practices are closed, patients from Parr and Polruan are able to attend the main practice at Fowey for appointments. For working patients, extended hours appointments are made by appointment. These are early morning before 8.30am, later in the evening or on a Saturday morning. The times, days and location varies from week to week and is dependent upon patient needs. Repeat prescriptions and appointments can be booked on line via the practice website or in person at the practice.

Good

Are services responsive to people's needs?

(for example, to feedback?)

During evenings and weekends, when the practice is closed, patients are directed to an Out of Hours service delivered by another provider. This is in line with other GP practices in the Kernow clinical commissioning group, which includes taking over the phone lines from 6pm.

There is level access to the building; waiting room provides spacious access for patients using wheelchairs. A TV screen in the waiting room showed a rolling programme of services available, although the volume was not loud enough to hear the information clearly.

The practice recognised the challenges of operating a multisite practice, this included the particular difficulties of access at Polruan practice given the limited space in the building, steep hill and high risk of flooding at high tide during a southerly gale. The practice had increased their home visits to ensure patients who are unable to visit the practice easily received the attention they need.

GPs carried out an average of four home visits each per day, travelling up to 15 miles on rural roads and by boat to reach patients in need. The practice performance for delivering appointments exceed what was expected. On average 476 patient appointments were delivered each month, compared with 312 appointments expected for the list size.

Services normally carried out at the main hospital were available due to equipment having been purchased and investment in additional training for staff. For example, the practice provided 24 hour ambulatory blood pressure and doplar services on site so patients were able to avoid having to travel to the main hospital in Plymouth some distance away. Patients taking anti-clotting medicines, who were monitored closely, were able to get immediate blood results and advice about any changes to the dose of medicine.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. The policy was in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints at the practice. Information about making a complaint was clearly displayed in several areas around the practice.

We looked at an audit covering complaints received from patients between April 2014 and February 2015, all of which had received a prompt acknowledgement and outcome in writing. GPs were open and shared complex complaint examples with us and were open about the learning and changes made to the way complaints were handled. The practice was also able to demonstrate that additional systems had been implemented as a result of patient feedback, for example the regular auditing of content and completeness of patient records.

The practice had taken complaints seriously. For example we looked at how the practice had handled complaints about attitude and saw that conflict resolution training, telephone communication skills and staff meetings had been used to address issues highlighted. Various regular held meetings were used to reflect generally on patient feedback and we saw examples of issues discussed in minutes of these meetings. We looked at complaints and tracked how the practice had handled these and saw that patients had received a prompt acknowledgement, outcome letter and the practice had held resolution meetings with patients.

Are services well-led?

Good

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

Our findings

Vision and Strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's strategy and five year business plan. These values were clearly displayed in the waiting areas and in the staff room. The practice vision and values included to offer a friendly, caring good quality service that was accessible to all patients. We spoke with 17 members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. The majority of the 29 patients we received comments from in person or in writing described the practice as "excellent" and the staff "very caring".

Fowey River Practice is a national research practice and GPs told us that they were committed to providing high quality evidence based care and treatment for their patients. The practice provided on-going training for future GPs and medical students. One of the GP partner's was an associate dean with the Peninsular Medical Deanery, which meant there was a close link with the university and active input in the training of medical staff and development of new knowledge through research to influence other health care professionals. The practice was one of only two in Cornwall providing training placements for practice nurses during their training.

Fowey River Practice is unusual in that the Advanced Nurse Practitioner (female) is also a partner. Under her leadership, the practice had just secured a contract to provide placements for pre-registration nursing students from Plymouth University. The team told us that this was an important development as they wanted to raise the profile of primary medical services as a career option for newly qualified nurses due to the national shortage of practice nurses.

Staff told us they felt they were well supported and enjoyed working at the practice. Morale was high and there was a low turnover of staff.

Governance Arrangements

Statistical data showed that the practice was performing comparatively with the expected national average. In some areas this exceeded the national average, particularly with regard to monitoring vulnerable patients and those with long term conditions. For example, 100% patients with learning disabilities had an annual health check and were followed up according to their specific needs.

There were a number of policies and procedures in place to govern activity. All of these were available to staff on the desktop on any computer within the practice. The practice manager verified that they used the NHS information governance tool kit. The tool kit was developed by the Department of Health to encourage services to self-assess so that they could be assured that practices, for example, have clear management structures and responsibilities set out, manage and store information in a secure, confidential way that meets and data protection. We looked at some of these policies and procedures, which included those covering safeguarding, infection control, recruitment all of which had been regularly updated in light of changing guidance and legislation. These were reviewed regularly and in line with current practice.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and a GP partner acting as lead for safeguarding children and adults. The practice team included a dispensary manager who worked closely with GPs and nurse prescribers to ensure that staff were following current guidance and appropriately monitoring patients. We spoke with 17 members of staff and they were all clear about their own roles and responsibilities. They all told us they felt well supported, knew there was a whistleblowing procedure and who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. In the year 2013-2014 the data showed that there were some areas that the practice was performing slightly under the national average for example regarding flu vaccination rates for patients at risk and under 65 years and those not at risk over 65 years. Staff told us that they had changed the recall system and had a designated administrator for this. Initiatives such as holding a tea party in conjunction with a charity to raise awareness of flu vaccination had proven successful. We looked at performance for 2014-15, which was showing improvement but heard that patient choice continued to prevail. In particular, the practice staff told us that the farming community tended to be stoic about all health matters and rarely engaged in health promotion activities.

Are services well-led?

Good

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

We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes. All of the staff we spoke with knew how the practice was performing in these areas, what the priorities were and were working on these.

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, as a direct result of patient feedback and learning the practice had introduced a regular audit of patient notes. The criteria used determined whether GPs and nurses kept detailed records about consultations, actions and follow up of results in line with professional standards. We looked at two audits carried out in February and December 2014. The latter showed there had been improvement in the standard of documentation with the recording of follow up and diagnosis as an area for continued focus. GPs had accessed training about documentation in patient notes from the medical defence union and were using regular educational meetings as an opportunity to undertake significant case analysis of patient care and treatment.

The practice had arrangements for identifying, recording and managing risks. Risks were discussed at team meetings and updated in a timely way. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. For example, cleaning services were carried out by an external contractor and the practice had copies of the audits completed each month. We discussed the findings from these audits and saw that where action was necessary matters had been followed up.

Leadership, openness and transparency

The practice had a staffing structure, which showed who was accountable for supervising which staff.

Meetings were held regularly and minutes kept and circulated via email to the team. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. Examples of minutes seen for team meetings held in December 2014 and January 2015 showed that there was cross communication. These demonstrated there was strong collaboration and support across all staff with a common focus on improving quality of care and people's experiences. Team away days were held every six months.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, induction policy and management of health and safety which were in place to support staff. Staff told us they had received an induction that covered health and safety matters such as fire safety.

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

The importance of patient feedback was recognised and acted upon. The practice used a variety of methods including national and in-house surveys as well as the on-going 'Friends and Family test. The results of patient feedback were monitored regularly with partners and learning disseminated across all staff teams in the various meetings held each month.

There was an active Fowey River patient participation group (PPG) with 19 members and a virtual online of group of 100 patients run by two young people who were patients at the practice. Minutes showed that the group met with the practice manager and other practice staff every month. We met with two representatives from the group who told us that patient feedback was taken seriously and acted upon. The PPG had been active in recruiting new members and had representation from several different sectors of the population, including two younger people. The group had active involvement in strategic planning for the practice, which included considering how to deal with the actual risk of flooding at the branch practice at Polruan whilst maintaining services for people living there.

In the last 12 months, the practice had improved the telephone system by changing the number to a local one removing the 0844 number so that patients did not incur excessive charges when phoning in for an appointment or test results. The PPG had tasked themselves with raising awareness about the number of missed appointments each month, which was approximately 260, and to look at ways of addressing this with patients using the practice.

Management lead through learning & improvement

A random selection of staff files showed that annual appraisal were carried out and showed these were done. Staff in interviews confirmed that training needs were identified, present conduct discussed and future plans agreed upon. Nursing staff confirmed they held evidence of professional training and reflection on specific issues to

Are services well-led?

Good

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maintain registration with the Nurses, Midwives Council (NMC). Clinicians were appraised by clinicians and administration staff appraised by administration staff. Competencies were assessed by a line manager with the appropriate skills, qualifications and experience to undertake this role. For example, the practice had a probationary period and newer staff confirmed this was followed.

The practice undertook a range of audits and professional groups had specific objectives to achieve. GPs and nurses are subject to revalidation of their qualifications with their professional bodies. We saw a cycle of audit taking place at individual level. For example, nurses held records of anonymised cervical screening results, which were peer reviewed. All 'inadequate result' cervical smears carried out for patients were reviewed. Mentoring and support was provided where needed to improve skills and accuracy with such testing. The data showed performance was within the national expected range. The audit had identified that out of the 371 smear tests three were inadequate, one pot had expired and one was lost, all five patients had been recalled and the test repeated.

The nursing team had analysed the outcomes for patients being treated with compression bandaging for leg ulcers and found there had been a significant increase in healing and decreased numbers of patients needing treatment for these.