

# St Blazey Surgery

## Quality Report

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

## Ratings

### Overall rating for this service

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Good 

# Summary of findings

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## Overall summary

### Letter from the Chief Inspector of General Practice

St Blazey Surgery was inspected on Tuesday 3 March 2015. This was a comprehensive inspection. Overall the practice is rated as good.

St Blazey Surgery provides primary medical services to people living in St Blazey and the surrounding areas. Of the 6,350 patients registered at the service, 99% had described their ethnicity as White British. The practice provides services to a predominantly Cornish population and is situated in a semi-rural location. The practice provided health services under a General Medical Services contract (GMS) from the NHS.

The service had a team of four GP partners. Two were male and two were female. GP partners held managerial and financial responsibility for running the business. There were two nurses and two health care assistants at the practice. In addition there was a practice manager, a deputy manager and additional administrative and reception staff.

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

Our key findings were as follows:

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

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

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

# Summary of findings

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

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

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

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

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

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

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

### Are services safe?

The practice is rated good for being safe. Patients we spoke with told us they felt safe, confident in the care they received and well cared for

The practice had systems to help ensure patient safety and staff had appropriately responded to emergencies.

Recruitment procedures and checks were completed as required to help ensure that staff were suitable and competent. Risk assessments had been undertaken to support the decision not to perform a criminal records check for administration staff.

Significant events and incidents were investigated both informally and formally. Staff were aware of the learning and actions taken. There were monthly significant event meetings.

Staff were aware of their responsibilities in regard to safeguarding and the Mental Capacity Act 2005. There were suitable safeguarding policies and procedures in place that helped identify and protect children and adults from the risk of abuse. GPs had been trained to level three in safeguarding which was the highest level. All staff had completed safeguarding training in February 2015.

Medicine management policies had been reviewed in May 2014. There were suitable arrangements for the efficient management of medicines within the practice.

The practice was clean, tidy and hygienic. Suitable arrangements were in place to maintain the cleanliness of the practice. There were systems in place for the retention and disposal of clinical waste.

Good



### Are services effective?

The practice is rated good for being effective. Supporting data obtained both prior to and during the inspection showed the practice had effective systems in place to make sure the practice was efficiently run.

The practice had a clinical audit system in place and seven audits had been completed in the last 12 months. These included audits on prescribing, cervical smears, coil fitting and minor surgery.

Care and treatment was delivered in line with national best practice guidance. The practice worked closely with other services to achieve the best outcome for patients who used the practice.

Good



# Summary of findings

Information obtained both during and after the inspection showed staff employed at the practice had received appropriate support, training and appraisal. GP partner appraisals and revalidation had been completed.

The practice had extensive health promotion material available within the practice and on the practice website.

## Are services caring?

The practice is rated as good for being caring. Data showed patients rated the practice higher than others for many aspects of care. Feedback from patients about their care and treatment was consistently positive.

We observed a patient centred culture and found evidence that staff were motivated to offer kind and compassionate care and worked to overcome obstacles to achieving this. We found many positive examples to demonstrate how patients' choices and preferences were valued and acted on. Views of external stakeholders were very positive and aligned with our findings.

Patients spoke positively about the care provided at the practice. Patients told us they were treated with kindness, dignity and respect. Patients told us how well the staff communicated with them about their physical, mental and emotional health and supported their health education.

The practice had conducted surveys with their patient participation group (PPG) to gather patient feedback. These surveys included questions about how caring the service was. The most recent survey in March 2014 showed patient satisfaction with the service.

Patients told us they were included in the decision making process about their care and had sufficient time to speak with their GP or a nurse. They said they felt well supported both during and after consultations

Good



## Are services responsive to people's needs?

The practice was rated good for being responsive. Patients commented on how well all the staff communicated with them and praised their caring, professional attitudes.

The practice carried out regular surveys in co-operation with its patient participation group (PPG). Results from these and from national GP Patient surveys showed that the practice listened to and responded to patient's needs.

Good



# Summary of findings

There was information provided on how patients could complain. Complaints were managed according to the practice policy and within timescales. There was an accessible complaints system with evidence that complaints were taken seriously and acted upon. There had been six complaints in the last 12 months.

The practice recognised the importance of patient feedback and had encouraged the development of a patient participation group to gain patients' views.

Practice staff had identified that not all patients found it easy to understand the care and treatment provided to them and made sure these patients were provided with relevant information in a way they understood.

Patients said it was usually straightforward to get an appointment at the practice and that they were able to see a GP on the same day if it was urgent.

## Are services well-led?

The practice is rated as good for being well led. The practice had a clear vision which had quality and patient safety as its priority. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. Nursing staff, GPs and administrative staff demonstrated they understood their responsibilities including how and to whom they should escalate any concerns.

Staff spoke positively about working at the practice. They told us they were actively supported in their employment and described the practice as having an open, supportive culture and being a good place to work.

The practice had a number of policies to govern the procedures carried out by staff and regular governance meetings had taken place. There was a programme of clinical audit in operation with clinical risk management tools used to minimise any risks to patients, staff and visitors.

Significant events, incidents and complaints were managed as they occurred and through a formal process to identify, assess and manage risks to the health, welfare and safety of patients.

The practice sought feedback from patients, which included using new technology, and had an active patient participation group (PPG).

Good



# Summary of findings

## The six population groups and what we found

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

### Older people

The practice is rated as good for providing care to older people.

This population group formed a significant percentage of the total number of patients at the practice. 45% of the 6,350 patient population were over 65 years of age. There were four residential care homes in the area, including a nursing home. GPs at the practice worked closely with these services.

The practice GPs provided regular visits to patients in the nursing and residential care homes. Every patient was reviewed annually as part of the practice policy on nursing home reviews.

The practice had regular liaison with a community matron who was responsible for looking after some of the older and most vulnerable patients, providing extra support where needed. The practice and the community matron met up regularly to discuss cases and ensure continuity of care.

The practice held monthly multi-disciplinary meetings to discuss patients at risk of unplanned hospital admissions. This enabled patient's care plans to be reviewed to ensure that safe and appropriate care was being provided.

The practice also discussed any patients that were classed as vulnerable and any adult safeguarding concerns. In order to fully support patients, there was a system in place which ensured that any carer's details were recorded on the patient's records.

Good



### People with long term conditions

The practice is rated as good for providing care to people with long term conditions.

The practice had a significant number of patients who were suffering from long term conditions. The two practice Nurses carried out regular reviews of all patients in this population group. Patients received a letter of invitation when their annual health check was due, or more frequently if appropriate

The practice ensured that each patient was sent at least three reminders to attend the health check. GPs were made aware of any patients who have not responded after these reminders so that appropriate follow up action could be taken. This included phone calls by the GP.

Good



# Summary of findings

Patients with long term conditions were able to request their repeat medications via email as well as more traditional methods. The practice offered electronic transfer of prescriptions so that patients did not have to attend the practice in order to collect their prescriptions.

The practice held regular clinics for patients in this population group. For example, warfarin clinics at the practice provided “in-house” testing so that patients were provided with instant results. In this way, the practice was able to provide patients with a new prescription or update their treatment the same day.

## Families, children and young people

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

Practice nurses carried out regular immunisation and vaccination programmes. Practice GPs provided 24 hour baby checks. They also carried out baby checks when new babies reached the eight week old stage. The practice acted on feedback to not hold specific baby clinics as it was suggested that families should be able to attend at a time to suit them.

The practice had a child friendly waiting room with toys which were easy to keep clean. There was also a wide range of educational health leaflets for parents. All staff we spoke with were aware of child safeguarding procedures and the practice held regular safeguarding meetings with the health visitor and midwife.

Details of children’s attendance at A&E were routinely copied to the health visitor for review and if necessary discussed at GP meetings.

The practice had effective liaison with the local midwife. The midwife held their clinics at the practice following feedback that this was more convenient for expectant mothers, rather than attending the local hospital.

Information relevant to young patients was displayed and health checks and advice on sexual health for men, women and young people included a range of contraception services and sexual health screening. This included chlamydia testing and cervical screening.

Good



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

The practice is rated as good for providing care to working age people.

The practice had taken on board feedback from patients which recognised that patients who worked or were in education found it

Good





# Summary of findings

difficult to access the practice in the traditional ways. As a result the practice offered patients the ability to book their appointments via the internet, request prescriptions electronically and the ability to book telephone consultations at a pre-arranged time.

The practice also held appointments later in the evening three days a week which enabled patients to attend outside of normal working hours.

The practice had considered this population group when they arranged for the “Stop Smoking” advisor to hold clinics at the practice itself rather than locations elsewhere. Patients had responded positively to this and stated that it made access easier.

The practice used its website to inform patients how to make the best use of the health services available. For example, patients could book appointments online. Patients were able to request their prescriptions electronically and have them sent to the pharmacist of their choice via an automated system.

The practice had regular liaison with an independent pharmacy attached to the practice which was open seven days a week until 10pm. This enabled patients in this population group to collect their prescriptions at a time convenient to them.

Late appointments were available on Tuesdays, Wednesdays and Fridays until 7.15pm. This enabled working people to make appointments at a time convenient to them.

## **People whose circumstances may make them vulnerable**

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

The practice considered that vulnerable patients could be of any age. For example, patients may be classed as vulnerable due to homelessness, learning disability, social circumstances, elderly and frail or unable to speak English.

The practice held weekly GP meetings in which they discussed any vulnerable patients that there were concerns about. This included safeguarding concerns. These meetings were minuted and recorded in writing.

The practice monitored all of its patients with learning disabilities. These patients were invited annually in for a yearly health check. The practice had also devised an easy to read practice information leaflet and other easy read materials which helped to ensure that patients understood how to access the services available. The practice also had scale models of body parts which were used to explain care and treatment to patients.

**Good**



# Summary of findings

The practice had a plan in place to obtain easy to read versions of all health information leaflets in its waiting room.

Staff told us that they understood how to arrange language interpretation for any patients who were unable to communicate in English.

The practice had a portable hearing induction loop for patients who used a hearing aid.

The practice held regular palliative care meetings to discuss end of life care. All recent patient deaths were reviewed at these meetings regardless of circumstances in case there was any learning to be shared.

## **People experiencing poor mental health (including people with dementia)**

The practice is rated as good for providing care to people experiencing poor mental health.

The practice maintained registers which showed that they currently had 66 patients who suffered from dementia. There were 48 patients on the practice mental health register. Practice staff kept these registers up to date.

All patients in this population group were invited to have an annual review, including a review of their physical health. The practice invited the local community psychiatric nurse and dementia liaison nurse to its regular multi-disciplinary team meetings so that they could discuss any concerns with the wider team as appropriate. This facilitated a joined up approach to fully support patients in this population group.

The practice liaised with two mental health support groups and provided facilities for them to run clinics from the practice on a regular basis. In addition the practice worked closely with a local consultant psychiatrist. The mental health single point of access team also worked closely with the practice and saw patients on the premises.

The practice supported patients experiencing alcohol and substance misuse by helping support groups to hold clinics at the practice. The practice had acted on feedback which demonstrated having these organisations hold their clinics at the practice made access much easier for patients.

**Good**



# Summary of findings

## What people who use the service say

We spoke with 10 patients during our inspection. We spoke with four representatives of the patient participation group (PPG).

The practice had provided patients with information about the Care Quality Commission prior to the inspection. Our comment box was displayed and comment cards had been made available for patients to share their experience with us. We collected one comment card during the inspection. This contained positive comments. We also looked at national patient survey results and a practice survey undertaken by the PPG in March 2014.

This written evidence stated that the staff took time to listen effectively. Comments highlighted a confidence in the advice and medical knowledge, access to appointments and praise for the continuity of care and professionalism of the staff.

These findings were reflected during our conversations with patients and discussion with the PPG members. The

feedback from patients was positive. Patients told us about their experiences of care and praised the level of care and support they consistently received at the practice. Patients stated they were happy, very satisfied and said they received good treatment. Patients told us that the GPs were caring, responsive and polite.

Patients were happy with the appointment system and said it was easy to make an appointment.

Patients appreciated the service provided and told us they had no complaints but knew how to complain should they wish to do so.

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

Patients found it easy to get repeat prescriptions and said they thought the website was accessible and informative.

# St Blazey Surgery

## Detailed findings

### Our inspection team

#### Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The team also included a GP specialist advisor, a practice nurse specialist adviser, an expert by experience.

## Background to St Blazey Surgery

St Blazey Surgery provides primary medical services to people living in St Blazey and the surrounding areas. The practice provides services to a predominantly Cornish population and is situated in a semi-rural location. The practice provided health services under a General Medical Services contract (GMS) from the NHS.

Prior to this inspection, the CQC intelligent monitoring placed the practice in band one. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

At the time of our inspection there were approximately 6,350 patients registered at the service with a team of four GP partners. Two were male and two were female. GP partners held managerial and financial responsibility for

running the business. There were two nurses and two health care assistants at the practice. In addition there was a practice manager, a deputy manager and additional administrative and reception staff.

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

St Blazey Surgery is open between Monday and Friday 8.30am to 6.30pm. Late appointments were available on Tuesdays, Wednesdays and Fridays until 7.15pm.

Routine appointments are available daily and are bookable up to four weeks in advance. Urgent appointments are made available on the day and telephone consultations also take place.

## 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 St Blazey Surgery we reviewed a range of information we held about the service and asked other

## Detailed findings

organisations to share what they knew about the service. Organisations included the local Healthwatch, NHS England, the local clinical commissioning group and local voluntary organisations.

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

We carried out our announced visit on St Blazey Surgery on 3 March 2015. We spoke with 10 patients and eight staff at the practice during our inspection and collected one patient response from our comments box which had been displayed in the waiting room. We obtained information from and spoke with the practice manager, four GPs, receptionists/clerical staff, practice nurses and health care assistants. We observed how the practice was run and looked at the facilities and the information available to patients. We also spoke with three representatives from the patient participation group (PPG).

We looked at documentation that related to the management of the practice and anonymised patient records in order to see the processes followed by the staff.

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

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

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

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

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

# Are services safe?

## Our findings

### Safe Track Record

We looked at the national GP patient survey results for 2014-15. There had been 113 respondents. 100% of respondents had confidence and trust in the last nurse or GP they saw or spoke to.

The practice had a system in place for reporting, recording and monitoring significant events.

The practice kept records of significant events that had occurred and these were made available to us. The practice followed national guidelines by reporting significant events to NHS England.

There was evidence that appropriate learning had taken place where necessary and that the findings were communicated to relevant staff. Significant event meetings had been held, the minutes agreed and signed by all staff attending. These minutes showed review dates and outcomes.

Staff were aware of the significant event reporting process and how they would verbally escalate concerns within the practice. All staff we spoke with felt very able to raise any concern however small. Staff knew that following a significant event, the GPs undertook an analysis to establish the details of the incident and the full circumstances surrounding it. Staff explained that these monthly meetings were well structured, well attended and not hierarchical. Records from meetings held in January and February 2015 confirmed these findings.

There were systems in place to make sure any medicines alerts or recalls were actioned by staff.

The practice manager ensured these alerts were shared with relevant staff and the information stored in a shared folder. These alerts had also been discussed at meetings.

### Learning and improvement from safety incidents

At St Blazey Surgery the process following a significant event or complaint was both informal and formalised. GPs discussed incidents daily and also monthly at clinical meetings. GPs, nurses and practice staff were able to explain the learning from these events. For example, a patient at the practice had their NHS number incorrectly confused with another person elsewhere in England. A

member of staff at St Blazey Surgery had spotted the error and corrected it. This had been fed back to NHS England who planned to publish the incident in a future NHS newsletter, in order to share learning across the country.

### Reliable safety systems and processes including safeguarding

Patients told us they felt safe at the practice and staff knew how to raise any concerns. A named GP had a lead role for safeguarding older patients, young patients and children. Staff knew which GPs held lead roles at the practice and where to go for advice and support.

The safeguarding lead GP had been trained to the appropriate advanced level three, which met best practice. There were appropriate policies in place to direct staff on when and how to make a safeguarding referral. The policies included information on external agency contacts, for example the local authority safeguarding team. These details were displayed where staff could easily find them.

There were monthly multidisciplinary team meetings with relevant attached health professionals including social workers, district nurses, palliative care nurses, physiotherapists and occupational therapists. At these meetings vulnerable patients or those with more complex health care needs were discussed, and their care needs reviewed. Health care professionals were aware they could raise safeguarding concerns about vulnerable adults at these meetings.

Practice staff said communication between health visitors and the practice was good and any concerns were followed up. For example, if a child failed to attend routine appointments, looked unkempt or was losing weight the GP could raise a concern for the health visitor to follow up.

The computer based patient record system allowed safeguarding information to be alerted to staff in a discreet way. When a vulnerable adult or 'at risk' child had been seen by different health professionals, staff were aware of their circumstances. Staff had received safeguarding training in February 2015 and were aware of who the safeguarding leads were. Staff also demonstrated knowledge of how to make a patient referral or escalate a safeguarding concern internally using the whistleblowing policy or the safeguarding policy. These policies had been reviewed and updated in July 2014. There was an easy to follow guide to whistleblowing on the practice computer system.

## Are services safe?

We discussed the use of chaperones to accompany patients when consultation, examination or treatment were carried out. A chaperone is a member of staff or person who acts as a witness for a patient and a medical practitioner during a medical examination or treatment. Patients were aware they were entitled to have a chaperone present for any consultation, examination or procedure where they feel one is required.

Trained nursing staff acted as chaperones at the practice. They had received chaperone training. Chaperone signs were displayed in patient areas. The practice had a written policy and guidance for providing a chaperone dated April 2014 for patients which included expectations of how staff were to provide assistance. Staff understood their role was to reassure and observe that interactions between patients and doctors were appropriate and record any issues in the patient records.

### Medicines Management

St Blazey Surgery was not a dispensing practice. There was an independent pharmacist adjacent to the practice and other independent pharmacists nearby in St Blazey.

The practice policy on medicines management was updated annually. It had last been reviewed in August 2014. GPs were responsible for prescribing medicines at the practice. The control of repeat prescriptions was managed well. Patients were not issued any medicines until the prescription had been authorised by a GP. Patients were satisfied with the repeat prescription processes. They were notified of health checks needed before medicines were issued. Patients explained they could use the box in the surgery, send an e-mail, or use the on-line request facility for repeat prescriptions.

Medicines stored on site were managed well. There were effective systems in place for obtaining, using, safekeeping, storing and supplying medicines. Clear checks and temperature records were kept to strengthen the audit of medicines issued.

All of the medicines we saw were in date. Storage areas were clean and well ordered. Deliveries of refrigerated medicines were immediately checked and placed in the refrigerator. This meant the cold chain and effective storage was well maintained. We looked at the storage facilities for refrigerated medicines and immunisations, the refrigerator plug was not easily accessible therefore was very unlikely to be switched off.

Patients were informed of the reason for any medicines prescribed and the dosage. Where appropriate patients were warned of any side effects, for example, the likelihood of drowsiness. All patients said they were provided with information leaflets supplied with the medicine to check for side effects.

The computer system highlighted high risk medicines, and those requiring more detailed monitoring. We discussed the way patients' records were updated following a hospital discharge and saw that systems were in place to make sure any changes that were made to patient's medicines were authorised by the prescriber. Medicine alerts were received and co-ordinated by the practice manager who cascaded the information to staff. Alerts had also been discussed at team meetings.

There were suitably secure storage arrangements for controlled drugs (CD) at the practice. These met nationally recognised standards. There was a CD audit conducted every month. In addition, a CD self-assessment audit had been completed in August 2014 and submitted to the CD appointed officer for the Kernow Clinical Commissioning Group (KCCG). This met best practice.

### Cleanliness & Infection Control

The practice had policies and procedures on infection control. These were updated regularly and had been reviewed within the last 12 months. An infection control audit had been completed in August 2014. The findings of this audit had been shared at team meetings, actions agreed and implemented. For example, a signed and dated daily cleaning schedule had been put in place.

We spoke with the infection control lead nurse who demonstrated good knowledge of infection control procedures. An annual hand washing audit had been completed in March 2015. Staff had access to supplies of protective equipment such as gloves and aprons, disposable bed roll and surface wipes. The nursing team were aware of the steps they took to reduce risks of cross infection and had received updated training in infection control.

We left comment cards at the practice for patients to tell us about the care and treatment they receive. We received 1 completed card. This specifically commented on the building being clean, tidy and hygienic. Patients told us staff used gloves and aprons and washed their hands.



## Are services safe?

Treatment rooms, public waiting areas, toilets and treatment rooms were visibly clean. There were hand washing posters on display to show effective hand washing techniques. Patient and staff toilets all had hand washing gel and paper towels.

Clinical waste and sharps were being disposed of in safely. There were sharps bins and clinical waste bins in the treatment rooms. The practice had a contract with an approved contractor for disposal of waste. Clinical waste was stored securely in a dedicated secure area whilst awaiting its collection from a registered waste disposal company.

### Equipment

Emergency equipment and emergency medicines at the practice were within the expiry dates. The practice had a system using checklists to monitor the dates of emergency medicines and equipment so they were discarded and replaced as required.

Equipment such as the weighing scales, blood pressure monitors and other medical equipment were serviced and calibrated where required. For example, a portable blood pressure monitor which could be taken home by patients had been checked on each occasion by staff and serviced regularly.

Portable appliance testing (PAT) where electrical appliances were routinely checked for safety had been carried out by an external contractor within the last 12 months.

During our inspection emergency equipment was deployed at the practice to assist a patient who had unexpectedly become unwell. We observed that staff had sufficient equipment at the practice to support patients in an emergency.

### Staffing & Recruitment

There were suitable numbers of staff on duty and staff rotas were managed well to cover day to day duties, sickness, courses or annual leave.

The practice had a relatively low turnover of staff. The practice used two part time locums to cover one health care assistant position during a period when they were recruiting a new health care assistant. One partner GP was

absent on a 12 month sabbatical and was due to return in July 2015. The practice used three part time locum GPs to cover this absence. GPs told us they covered for each other during shorter staff absences.

The practice used a team approach where the workload for part time staff was shared equally. Each team had appointed clerical support. Staff explained this worked well but there remained a general team work approach where all staff helped one another when one particular member of staff was busy. The practice had recruited a medical note summariser to reduce the administrative burden on staff.

Recruitment procedures were safe and staff employed at the practice had undergone the appropriate checks prior to commencing employment. Clinical competence was assessed at interview. Once in post staff completed an induction which consisted of ensuring staff met competencies and were aware of emergency procedures.

Criminal record checks via the disclosure barring service (DBS) had been performed for all staff. This met best practice.

The practice had up to date disciplinary procedures to follow should the need arise. The practice manager had carried out back to work interviews to support all staff who had experienced absences due to sickness. All staff had been issued with a staff handbook which was also available on the practice computer system.

Each registered nurse Nursing and Midwifery Council (NMC) status was completed and checked annually to ensure they were on the professional register to enable them to practice as a registered nurse.

### Monitoring Safety & Responding to Risk

The practice had a suitable business continuity plan that documented the practice's response to any prolonged events that may compromise patient safety. This included events such as burglary, power failures and adverse weather conditions. Flood boards were available at the practice and the practice was registered to a system which issued flood alert warnings.

Nursing staff received any medical alert warnings or notifications about safety by email or verbally from the practice manager. Actions in relation to these had been recorded. Such notifications were also discussed at meetings.



## Are services safe?

There was a system in operation to ensure one of the nominated GPs covered for their colleagues when necessary, for example home visits, telephone consultations and checking blood test results.

### **Arrangements to deal with emergencies and major incidents**

During our inspection, emergency procedures were demonstrated when an emergency occurred with a patient.

The GP, nurse and reception staff professionally and calmly dealt with the patient and situation, ensuring patient comfort, reassurance and privacy until safe transfer to hospital by helicopter.

Appropriate equipment was available and maintained to deal with emergencies, including if a patient collapsed. Administration staff appreciated that they had also been included on the basic life support training sessions in March 2015.

# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment, care & treatment in line with standards

One of the GPs at the practice regularly attended Kernow Clinical Commissioning Group (KCCG) meetings in order to ensure the practice kept up to date with the latest guidance on standards of care and treatment. GPs at the practice attended regular health care forums to remain up to date on delivering effective care.

There were examples where care and treatment followed national best practice and guidelines. For example, emergency medicines and equipment held within the practice followed the guidance produced by the Resuscitation Council (UK). The practice followed the National Institute for Health and Care Excellence (NICE) guidance and had formal meetings to discuss latest guidance. Where required, guidance from the Mental Capacity Act 2005 had been followed. Guidance from NICE had been discussed at weekly meetings.

The practice used the quality and outcome framework (QOF) to measure their performance. The QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice in their surgeries. The QOF data for this practice showed they generally achieved higher than national average scores in areas that reflected the effectiveness of care provided.

Prior to our inspection, the CQC had information which indicated that the practice had scored below the KCCG average in four areas. These included the percentage of patients with diabetes with a record of foot examination and risk classification 1-4 within the last 12 months, the percentage of patients with diabetes in whom the last blood pressure reading is 140/80 mmHg within the last 12 months, the percentage of patients with physical or mental health conditions whose notes recorded their smoking status in the last 12 months and finally the percentage of patients with schizophrenia, bipolar affective disorder or other psychoses whose notes recorded their alcohol consumption in the last 12 months.

During our inspection, we found evidence that demonstrated that the practice had improved significantly in each of these areas as detailed below.

The practice had identified that their practice nurse was referring new diabetic patients to podiatry for initial assessment, rather than doing this in-house. This caused a delay in the practice receiving the information back from podiatry and so the records were not updated in a timely manner. The practice contacted podiatry for a list of patients and their results and updated the records. The practice nurse carried out foot checks on all diabetics, including new diabetics, and now recorded these correctly to meet the QOF read coding requirements. The practice current QOF score was 79.1% which was above average. The practice was actively contacting patients who did attend.

The practice had employed a locum health care assistant to run specific blood pressure clinics for diabetic patients and had currently achieved a total of 62.1% which was above average.

The practice had written to patients with a mental health issue asking them about their smoking and alcohol status and offering advice. The practice now had smoking status recorded for all of these patients. The practice had now recorded alcohol consumption for 80.5% of these patients. This enabled the practice to ensure effective needs assessments were updated and in place.

### Management, monitoring and improving outcomes for people

The practice told us they were keen to ensure that staff had the skills to meet patient needs and so nurses had received training including immunisation, diabetes care, cervical screening and travel vaccinations.

The GPs referred patients to the community matron team, who provided support in the patient's home for short term treatment and rehabilitation. This enabled patients to remain at home and to be treated for a short period of time, avoiding an unplanned hospital admission where appropriate.

GPs in the practice undertook minor surgical procedures and joint injections in line with their registration and NICE guidance. The staff were appropriately trained and kept up to date. There was evidence of regular clinical audit in this area which was used by GPs for revalidation and personal learning purposes. For example, clinical audits had been undertaken on aspirations, injections, excisions and all minor surgery operations. The results of each audit were available to staff on their computer system.

# Are services effective?

## (for example, treatment is effective)

The practice used QOF to monitor, manage and improve outcomes for patients. For example, QOF data from the practice showed that 100% of patients with hypertension had been seen and reviewed within the last 12 months. This was above KCCG average.

### Effective Staffing

GPs in the practice participated in the appraisal system leading to revalidation of their practice over a five-year cycle. The GPs we spoke with told us and demonstrated that these appraisals had been appropriately completed. Each GP had a team buddy which enabled effective peer review of each other's work and shared best practice.

All of the GPs at the practice had attended an annual update on primary medical services. The GPs supported medical students at the practice to assist their professional development. Nursing staff had received an annual formal appraisal and kept up to date with their continuous professional development programme, documented evidence confirmed this. A process was also in place which showed clerical and administration staff received regular formal appraisal. Staff told us that the GPs and other staff were always open to honest feedback.

There was a comprehensive induction process for new staff which was adapted for each staff role. The staff training programme was monitored to make sure staff were up to date with training the practice had decided was mandatory. This included basic life support, safeguarding, fire safety and infection control within the last 12 months. Staff said that they could ask to attend any relevant external training to further their development. Training programmes had been tailored to suit individual staff roles.

There was a set of policies and procedures for staff to use and additional guidance or policies located on the computer system.

### Working with colleagues and other services

The practice worked effectively with other services. Multi-disciplinary team meetings took place every month. These meetings included GPs, clinical staff, mental health services, health visitors, specialist nurses, hospital consultants and community nursing teams.

Practice staff met with the stop smoking consultant once a week to discuss patient progress. Practice GPs worked with community psychiatric nursing teams to support patients with mental illness.

### Information Sharing

Staff had received training on the Data Protection Act 1998 (DPA) and there was a nominated Caldicott Guardian at the practice. Staff understood the importance of patient confidentiality when sharing information with other healthcare providers.

The GPs had prepared detailed patient notes for palliative care patients and drug dependent patients at the practice. These notes enabled facilitated effective communication with the out of hours service was good as the out of hours GPs were able to access these notes with the patient's consent. A new system was being implemented in April 2015 to share more information with appropriate healthcare professionals.

If a patient had been seen overnight by an out of hours provider, an email was sent to the practice. This email was printed by administrative staff and scanned onto patient notes. Staff then alerted the patient's GP who was then kept up to date with any developments in their patient's care.

### Consent to care and treatment

Patients told us they were able to express their views and said they felt involved in the decision making process about their care and treatment. They told us they had sufficient time to discuss their concerns with their GP and said they never felt rushed. Feedback given to us during our inspection showed that patients had different treatment options discussed with them, together with the positive or possible negative effects that treatment can have.

Staff had access to different ways of recording that patients had given consent to treatment. There was evidence of patient consent for procedures including immunisations, injections, and minor surgery. Patients told us that nothing was undertaken without their agreement or consent at the practice. GPs had conducted full reviews of patient's treatment escalation plans and care plans on annual basis or more frequently if appropriate.

Where patients did not have the mental capacity to consent to a specific course of care or treatment, the practice had acted in accordance with the Mental Capacity Act (2005) to make decisions in the patient's best interest. Staff were knowledgeable and sensitive to this subject. All staff had received training in the MCA in November 2014.

# Are services effective?

(for example, treatment is effective)

## Health Promotion and Prevention

There were regular appointments offered to patients with complex illnesses and diseases. The practice manager explained that this was so that patients could access care at a time convenient to them. A full range of screening tests were offered such as smear tests, chlamydia tests and bowel cancer tests.

Vaccination clinics were organised on a regular basis which were monitored to ensure those that needed vaccinations were offered them. Patients were encouraged to adopt healthy lifestyles and were supported by services such as smoking cessation clinics. Patients with diabetes were invited to a diabetes clinic where staff discussed how changes to lifestyle, diet and weight could influence their diabetes.

All patients with learning disability were offered a physical health check each year.

Staff explained that when patients were seen for routine appointments, prompts appeared on the computer system to remind staff to carry out regular screening, recommend lifestyle changes, and promote health improvements which might reduce dependency on healthcare services.

The practice recognised the need to maintain fitness and healthy weight management. GPs had referred patients to a weight management support service in the local community centre.

There was a range of leaflets and information documents available for patients within the practice and on the website. These included information on family health, travel advice, long term conditions and minor illnesses. Website links were easy to locate.

Family planning, contraception and sexual health screening was provided by the practice. The practice offered a travel vaccination service. The nearest nominated yellow fever centre was in St Austell.

# Are services caring?

## Our findings

### **Respect, Dignity, Compassion & Empathy**

Patients told us they felt well cared for at the practice. Patients we spoke with on the day of the inspection told us they were communicated with in a caring and respectful manner by all staff. Patients spoke highly of the staff and GPs. We did not receive any negative comments about the care patients received or about the staff.

We left comment cards at the practice for patients to tell us about the care and treatment they received. We collected one completed card. This contained positive comments. All written feedback stated that the staff took time to listen and were caring.

We saw that patient confidentiality was respected within the practice. The waiting area had sufficient seating and was located away from the main reception desk which reduced the opportunity for conversations between reception staff and patients to be overheard. There were additional areas available should patients want to speak confidentially away from the reception area. We heard, throughout the day, the reception staff communicating pleasantly and respectfully with patients.

We looked at the national GP patient survey results for 2014-15. There had been 113 respondents. 91% found the receptionists at this surgery helpful. This was higher than the national average.

Conversations between patients and clinical staff were confidential and conducted behind a closed door. Window blinds, sheets and curtains were used to ensure patient's privacy. The GP partners' consultation rooms were also fitted with dignity curtains to maintain privacy.

We discussed the use of chaperones to accompany patients when consultation, examination or treatment were carried out. A chaperone is a member of staff or person who is present with a patient during consultation, examination or treatment. Posters displayed informed patients they were able to have a chaperone should they wish. Chaperone trained staff understood their role was to reassure and observe that interactions between patients and doctors were appropriate.

### **Care planning and involvement in decisions about care and treatment**

Patients told us that they were involved in their care and treatment and referred to an ongoing dialogue of choices and options. Feedback we obtained related patients' confidence in the involvement, advice and care from staff and their medical knowledge, the continuity of care, not being rushed at appointments and being pleased with the referrals and ongoing care arranged by practice staff. We were given specific examples where the GPs and nurses had taken extra time and care to diagnose complex conditions. Patients told us they did not feel rushed during appointments and that they understood they could ask for a double appointment if they had more than one issue to discuss.

### **Patient/carer support to cope emotionally with care and treatment**

We looked at the results of the national GP patient survey 2014-15 for this practice. There had been 113 respondents. The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 93% said that the last nurse they saw or spoke to was good at listening to their concerns. This was higher than the KCCG average. The patients we spoke to and the written feedback we examined was consistent with this information.

Notices in the patient waiting room and patient website signposted people to a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Staff told us families who had suffered bereavement were contacted by their usual GP. GPs said the personal list they held helped with this communication. There was a counselling service available for patients to access. All staff at the practice were informed of a bereavement in order to avoid inappropriate verbal or written communication being made. Markers were placed on the computer system and patient records were archived appropriately.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

Each patient at the practice had a named GP. Patients told us they felt the staff at the practice were responsive to their individual needs. They told us that they felt confident the practice would meet their needs. GPs told us that when home visits were needed, they were normally made by the GP who was most familiar with the patient.

The 2014-15 GP Patient survey had received 113 responses from patients who used the practice. 97% of respondents said the last nurse they saw or spoke to was good at explaining tests and treatments and responding to their needs. This was higher than the KCCG average of 92%.

Systems were in place to ensure any referrals, including urgent referrals for hospital care and routine health screening including cervical screening, were made in a timely way. Patients told us that any referral to secondary care had always been discussed with them.

An effective process was in place for managing blood and test results from investigations. When GPs were on holiday the other GPs covered for each other and results were reviewed within 24 hours. Patients said they had not experienced delays receiving test results.

A patient participation group (PPG) had been set up. The PPG had 15 members aged from 18 to 80 years. Four members of this group attended the practice during our inspection and were very keen to inform us about the strong links and support they enjoyed with the practice. The PPG members said they were encouraged to contribute suggestions and the practice listened to and acted upon their views.

For example, the practice had responded to feedback from the PPG about patients who failed to attend their booked appointments. All instances of non-attendance were recorded. Letters were sent to patients who did not attend. After receiving four such letters, a patient would be invited to register elsewhere.

### Tackle inequity and promote equality

The practice had recognised the needs of different groups in the planning of its services. All staff had completed equality and diversity training within the last 12 months.

Of the 6,350 patients registered at the service, 99% had described their ethnicity as White British. The number of

patients with a first language other than English was very low and staff said they knew these patients well and were able to communicate well with them. The practice staff knew how to access language translation services if information was not understood by the patient, to enable them to make an informed decision or to give consent to treatment.

The patient participation group (PPG) were working to recruit patients from different backgrounds to reflect each of the six population groups identified in this report.

The practice had carried out risk assessments which ensured that the premises was compliant with the Disability Discrimination Act 1995 (DDA). The practice had a ramp at the front entrance with an automatic door. The Practice was based entirely on the ground floor. The staff entrance was level with the car-park with a double door which could be used for patients who had difficulty with the main door.

There was no evidence of discrimination when making care and treatment decisions.

### Access to the service

Patients were able to access the service in a way that was convenient for them and said they were happy with the system. Two patients told us they sometimes had to wait to get through to the practice on the telephone during busy Monday morning periods. The majority of patients told us they were satisfied with access to the service.

The GPs provided a personal patient list system. These lists were covered by colleagues when GPs were absent. Patients appreciated this continuity and GPs stated it helped with communication.

The GP national patient survey showed that 93% of 113 patient respondents said that the last appointment they got was at a time and on a day convenient to them. This was higher than the KCCG average.

The same survey showed that 71% of 113 respondents with a preferred GP usually got to see or speak to that GP. This was higher than the KCCG average of 66%.

These findings were reflected during our conversations. Patients were happy with the appointment system and said they could get a same day appointment if necessary.

# Are services responsive to people's needs?

(for example, to feedback?)

Information about the appointment times were found on the practice website and on notices at the practice. Patients were informed about the out of hours arrangements by a poster displayed in the practice, on the website and on the telephone answering message.

## **Listening and learning from concerns & complaints**

The posters displayed in the waiting room and patient information leaflet explained how patients could make a complaint. The practice website also stated that the surgery welcomed patient opinion by sharing ideas, suggestions, views, and concerns. Patients told us they had no complaints but knew how to complain should they wish to do so.

The complaints procedure stated that complaints were handled and investigated by the practice manager and would initially be responded to within three days. Evidence showed that GPs had responded to clinical complaints appropriately. Records were kept of complaints which showed that patients had been offered the chance to take any complaints further, for example to the parliamentary ombudsman.

Staff were able to describe what learning had taken place following a complaint. Complaints were also discussed as a standing agenda item at monthly meetings.



# 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 vision was to provide high quality patient care in good surroundings. The practice management engaged staff in this strategy through team building days with staff, regular feedback and annual appraisals.

Staff knew and understood the practice values and knew what their responsibilities were in relation to these. Staff spoke positively about communication, team work and their employment at the practice. They told us they were actively supported in their employment and described the practice as having an open, supportive culture and being a good place to work. Many staff had worked at the practice for a number of years and were positive about the open culture.

We were told there was mutual respect shared between staff of all grades and skills and that they appreciated the non-hierarchical approach and team work at the practice.

### Governance Arrangements

A staff away day had been held in September 2014. At this event staff had collaborated to produce an analysis of the strengths, weaknesses, opportunities and threats to the practice. Action points had been agreed and embedded in the governance arrangements at the practice. Staff told us that they felt truly involved in the governance of the practice.

The practice held a range of different meetings to ensure well led governance of the practice.

GPs met daily and discussed any complex issues, workload or significant events or complaints. These were often addressed immediately and communicated through a process of face to face discussions or email. Monthly clinical meetings included standing agenda items on significant events, near misses, complaints and health and safety. Staff explained these meetings were well structured, well attended and a safe place to share what had gone wrong.

The practice used the quality and outcomes framework (QOF) to assess quality of care as part of the clinical governance programme. The QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice in their surgeries. The QOF scores for St Blazey Surgery were consistently above the national average.

The clinical auditing system used by the GPs assisted in driving improvement. All GPs were able to share examples of audits they had performed. In addition to the incentive led audits the GPs told us they wanted to perform audits to improve the service for patients and not just for their revalidation or QOF scores. Examples included audits on prescribing, admissions, dementia prevalence, significant events and safety alerts. A full audit cycle was in place. When new data was received it was reviewed against any pre-existing data so that trends could be observed and any necessary remedial actions taken.

Each year the practice audited all smear tests, noting the smear taker and the results. This enabled the practice to assess how many smears each GP had performed to maintain competency and to ascertain whether there were a high number of inadequate results that would indicate retraining needed. The audit results for the last two years showed that there were no concerns.

### Leadership, openness and transparency

Staff were familiar with the leadership structure, which had named members of staff in lead roles. For example, there was a lead nurse for infection control, a lead GP for safeguarding and a lead for staff training. Staff spoke about effective team working, clear roles and responsibilities and talked about a supportive non-hierarchical organisation. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns. Staff described an open culture within the practice and opportunities to raise issues at team meetings.

The practice manager was responsible for updating human resource policies and procedures. These were held on a practice computer system. Staff were aware of where to find these policies if required.

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

The practice had a patient participation group (PPG). We spoke with four members of this group. It was an active group with 15 members in total. Ages ranged from 18-80 years which covered a broad spectrum. The PPG held bi-monthly meetings. The four PPG members who came to the inspection said the practice manager and GP representative were keen to encourage patient feedback and involvement. The PPG said they were always consulted about any important changes at the practice.



# Are services well-led?

Good 

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

The PPG members said they had been able to provide open and honest feedback to the practice and that this had been acted upon. These included jargon buster leaflets and changes to the website which now set out specialisations of different clinical staff at the practice, so that patients could request a particular GP or nurse depending on their issues.

An annual patient survey had been completed by practice and their PPG in March 2014. Of the 104 respondents, 90% stated their telephone consultation was very satisfactory. The other 10% had expressed their preference to book a face to face appointment. This had been acted upon and face to face consultations had been offered.

## Management lead through learning & improvement

The practice management led through learning and improvement. For example, the practice had sought feedback from patients via a friends and family feedback survey. Results from December 2014 and January 2015 had been collated. Both sets of results had been discussed at the weekly meetings and the December results had been discussed with the Patient Participation Group (PPG). The results were generally favourable; however two action points had been identified. Firstly, concerns were raised about waiting times to obtain an appointment with the healthcare assistant for routine blood tests. Secondly, a concern was raised with regards to the waiting room not being very welcoming.

As a result of these findings the practice agreed with the PPG that additional healthcare assistant hours were required to help ease the workload. In addition, the practice had begun to recruit new staff.

The practice had also taken action with regard to the waiting room. It was agreed with the PPG that having a radio playing in the background may help with the atmosphere and aid confidentiality at reception. The PPG agreed to conduct a survey to find out if this was something that would be welcomed by patients. The results were due to be evaluated at the next PPG meeting in March 2015.

The practice had systems in place to identify and manage risks to the patients, staff and visitors that attended the practice. The practice had a suitable business continuity plan to manage the risks associated with a significant disruption to the service. This included, for example, if the practice experienced a power failure or if a flood alert was received.

There were environmental risk assessments for the building. For example annual fire assessments, electrical equipment checks, control of substances hazardous to health (COSHH) assessments had been carried out in June 2014. Visual checks of the building had been carried out. Health and safety items were a standing agenda item for the monthly clinical meetings. There was a nominated health and safety officer at the practice.