Morrab Surgery

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Morrab Surgery on 11 March 2015. The practice has a small branch surgery at Mousehole, where patients with minor concerns are seen. This inspection focussed on the Morrab Surgery. Overall the practice is rated as GOOD.

Specifically, we found the practice to be outstanding for caring and responsive services. The practice was good for providing effective and well led services, but required improvement to safety. It was good for providing services for older people, working age people and people with mental health needs including dementia and people with long term conditions. It was outstanding for and families, babies children and young people and vulnerable people.

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

- Patient contentment at Morrab Surgery was significantly higher with 100% expressing overall satisfaction with the practice. Patients they were treated with “exceptional” compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- There was a strong commitment to providing person centred, 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.

Summary of findings

- 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.
- 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.
- The practice had clear policies and procedure providing guidance for staff. However, we found that the recruitment policy had not been adhered to and needed improvement.

We saw areas of outstanding practice including:

- The practice understood the needs of the patient list and the challenges of the coastal location and had developed a responsive service accordingly. There were many examples of this seen at the inspection. For example, Morrab Surgery is strongly committed to breaking down barriers for vulnerable people, including homeless people who are valued, made welcome and very well supported. Extended appointments were made available immediately so thorough health assessments of homeless people could be done and treatment provided where appropriate.
- Staff are consistent in supporting people live healthier lives through a targeted and proactive approach. For example, the practice is focussed on working with young people to reduce the number of unplanned pregnancies. The practice is an approved Young people friendly service and able to provide friendly, confidential support that is focussed on the needs of young people. Statistics for the practice showed that the number of unplanned births to women under 18 years had fallen slightly from 5 in 2010 to 2 in 2014 and 1 in 2015. A dedicated young person clinic is run once a week after school hours and information at the practice and website is aimed at young people providing contraception and sexual health advice, support and treatment.

However there were areas of practice where the provider needs to make improvements.

Importantly the provider must:

Establish and operate effective recruitment procedures to ensure that information regarding pre-employment checks is kept.

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?

Requires improvement

The practice is rated as requires improvement 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 procedures were in place, but had not been consistently adhered to.

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. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Morrab Surgery provides placements for medical students and has a research focus. The clinical team was involved in research that would influence the way patients with high cholesterol levels are treated in the future. 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 and focussed development of staff who were supported to extend their skills through additional qualifications. 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?

Outstanding

The practice is rated as outstanding for providing caring services.

Data showed patients rated the practice higher than others for their care. For example, in the national survey 100% patients expressed overall satisfaction with the service. Sixty six patients involved in the inspection gave high levels of praise and positive feedback. A common theme was that the staff were exceptionally supportive and patients were always treated with respect and compassion. This

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was borne out in the way staff engaged with patients with complex communication needs and homeless people in particular. Patients we met who were in this position told us they felt valued and cared for in a surgery that welcomed them.

Staff we spoke with were aware of the importance of providing patients with privacy. Information was available to help patients understand the care available to them.

Are services responsive to people's needs?

Outstanding ☆

The practice is rated as outstanding for providing responsive services.

Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. 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 reviewed and acted upon.

There were high levels of practice was designated as a young person friendly practice having achieved quality standards for information and support available. Services for young people were aimed at reducing the number of unplanned pregnancies seen in Penzance by providing early intervention with sexual health advice and contraception.

Penzance has a high number of homeless and vulnerable people who are socially deprived. Staff actively encouraged homeless people they met on the streets of Penzance to attend the surgery for support and healthcare. They were made welcome and the team were responsive providing immediate extended appointments for people to carry out thorough assessments of their health and provide treatment where necessary.

Morrab Surgery also had developed onsite services in conjunction with private providers so that alternative therapies clinics were available to provide support and counselling for patients. These included therapies commonly used in supporting people in recovery from addictions such as acupuncture and herbal remedies, gentle yoga, psychotherapy, counselling was also available to support patients dealing with stress and anxiety.

Are services well-led?

Good

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

The practice had a clear vision and strategy. There was a strong collaboration and support across all the staff and a common focus

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on improving quality of care and people's experiences. The practice had strong links with universities within the Peninsular and provided placements for medical students. There was clear proactive approach to seeking out and embedding new ways of providing care and treatment, for example by developing care and treatment pathways overseen by the nursing team and involvement in research. 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. 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.

All older patients at the practice had a named GP and all of the staff knew the patients needs well. Vulnerable older people were identified, closely monitored and supported to reduce the risk of unplanned hospital admissions. For those people who did require hospital care, newly discharged patients were contacted within three days of leaving hospital to ensure their needs were met and the GPs worked closely with the community matron so that there was a safety net to avoid any patient not being monitored.

Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. Pneumococcal and flu vaccination was provided at the practice for older people. Shingles vaccinations were also provided to patients who fit the age criteria. Patients were contacted to offer them the opportunity to make an appointment to have the vaccination.

There was a strong commitment to providing well co-ordinated, responsive and compassionate care for patients nearing the end of their lives. Repeat and urgent medicines were delivered direct to the home of vulnerable patients on a needs basis from the onsite private pharmacy.

The practice signposted people to voluntary sector services to reduce the risk of isolation, loneliness and provide support for carers.

People with long term conditions

Good

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

All patients had a named GP. Nursing staff took the lead in chronic disease management and had dedicated appointments to review patients with diabetes, asthma and/or chronic respiratory disease. Patients at risk of hospital admission were identified as a priority. All these patients had a named GP and a structured review tailored to their needs to check that their health and medication needs were being met. The frequency of reviews was determined by patient need, for patients with unstable diabetes this could be as often as every two weeks.

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Longer appointments and home visits were available when needed. Home visits for patients newly discharged from hospital were undertaken jointly with the community nursing team to carry out an assessment and arrange additional support where needed.

The practice had invested in various specialist equipment. For example, allowing patients who were on high risk medicines to have blood tests, results and advice about any dosage changes at the same appointment.

The practice recognised the needs of patients and their difficulty with transport to the hospital for appointments. The hospital based diabetes and heart failure nurse specialists held clinics to see patients at the practice.

Health education around diet and lifestyle was promoted by the practice. The practice took an early intervention approach. Patients were enabled to change their lifestyles through the in-house weight management or smoking cessation programmes where further advice and support was provided.

Families, children and young people

Outstanding ☆

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

All patients had a named GP. Emergency processes were in place for acutely ill children, young people and acute pregnancy complications. The practice worked collaboratively with midwives, health visitors and school nurses to deliver antenatal care, child immunisation and health surveillance. Parents were signposted to services where parenting support was available. Safeguarding was taken seriously at the practice, with all staff trained to recognise and report any suspected abuse. The practice had been the sole provider of GP services for women living at Penzance refuge and were supporting the patients to improve their health and wellbeing to rebuild their lives after surviving abusive relationships.

Young children were seen quickly at routine appointments and those of school age were able to attend outside of school hours. The practice was designated as a young person friendly practice having achieved quality standards for information and support available. For example, information about contraception and promotion of health was targeted for young people. Statistics for the practice showed that the number of unplanned births to women under 18 years had fallen slightly from 5 in 2010 to 2 in 2014 and 1 in 2015. Young people had access to information and could request chlamydia screening. Practice staff understood issues around

consent and demonstrated how they assessed whether a child had the maturity to make their own decisions and to understand the implications of those decisions. A dedicated young Persons Clinic was run every Wednesday afternoon after school hours.

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).

All working age patients at the practice had a named GP. 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. For example, tailored monitoring of patients working in the sea fishing industry was flexible, risk based and person centred. Extended hours, telephone consultations and tailored medication regimes were available. The practice had set up a unique 24 hour helpline for patients, which signposted patients to services and included a request for repeat prescription service. The practice staff responded to messages left by patients at the beginning of the day.

The practice was developing online services and provided a full range of health promotion and screening that reflects the needs for this age group.

Overseas travel advice including up-to-date vaccinations and anti-malarial drugs was available from the nursing staff within the practice with additional input from the GP's as required.

Opportunistic health checks were being carried out with patients as they attended the practice. This included offering in-house smoking cessation consultations, providing health information, routine health checks including blood tests as appropriate, and reminders to have medication reviews.

People whose circumstances may make them vulnerable

Outstanding

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

All patients had a named GP. 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 had completed 100% of these with patients. Longer appointments for up to an hour were offered to patients with a learning disability and their carers for reviews.

Health education, screening and immunisation programmes were offered as appropriate. This included alcohol and drug screening,

which was targeted due to the high levels of deprivation in the area and numbers of patients presenting with addictions. Patients with alcohol addictions were referred to an alcohol service for support and treatment and to the local drug addiction service. The practice hosted clinics at the practice making these more accessible for patients, for example a specialist hepatic clinic was run at the practice by a visiting GP with extended qualifications. Onsite counselling services provided by the local mental health partnership trust and private providers were available for patients and this included a self-referral service. Alternative therapies recognised as helping patients recovering from addictions were hosted at the practice run by outside practitioners and included acupuncture, herbal remedies and gentle yoga.

The practice worked closely with the community nursing staff 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 told us that their policy was to never decline to register a homeless person. Patients in this position who we met at the inspection verified this and told us they felt valued as human beings, were welcomed and felt safe. Patients were signposted to appropriate helping agencies. A flexible approach was taken so that patients could be seen at short notice, given time and on occasions arrangements made for them to receive correspondence about test results and appointments from the practice. The practice staff occasionally gave out food and regularly offered food vouchers to vulnerable people.

People experiencing poor mental health (including people with dementia)

Good

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

All of the patients had a named GP who oversaw their care. Monthly shared care management meetings were

held at the practice with the consultant psychiatrist for patients with complex mental health needs and those with addictions. Medication reviews were conducted to ensure patients received appropriate doses. For example, patients taking lithium had regular blood tests to ensure safe prescribing. Preventative interventions were put in place quickly and staff demonstrated they were highly skilled in recognising and responding to patients at risk of or experiencing mental health crisis.

Summary of findings

Flexible services and appointments were available. Patients were able to book an appointment via an online appointment booking system, over the telephone or in person. Longer appointments of up to an hour were offered at quieter times of the day, avoiding times when people might find this stressful.

Patients with depression or addictions, needing time limited, low key counselling services were able to refer themselves or be referred to counselling services available at the practice. The practice had a system in place to follow up patients diagnosed with depression if they did not attend appointments. Morrab Surgery also had developed onsite services in conjunction with private providers so that alternative therapies clinics were available to provide support and counselling for patients. These included therapies commonly used in supporting people in recovery from addictions such as acupuncture and herbal remedies, gentle yoga, psychotherapy, child counselling was also available to support patients dealing with stress and anxiety.

Patients with suspected dementia were being screened and referred to the memory clinic for diagnostic tests. Carers were identified and signposted to a carers clinic and memory cafe run by a community worker, where additional support could be offered.

Summary of findings

What people who use the service say

As part of our inspection process we asked patients to complete comment cards.

We received 43 comment cards and spoke with 23 patients. Patients told us they were treated with "exceptional" compassion, dignity and respect and they were involved in their care and decisions about their treatment.

Our findings were in line with results received from the National GP Patient Survey. For example, the national GP patient survey results for 2013/14 showed that 100% of patients described their overall experience of this surgery as fairly good or very good, which is above the national average of 85.75%.

Areas for improvement

Action the service MUST take to improve

Establish and operate effective recruitment procedures to ensure that information regarding pre-employment checks is kept

Outstanding practice

The practice understood the needs of the patient list and the challenges of the coastal location and had developed a responsive service accordingly. There were many examples of this seen at the inspection. For example, Morrab Surgery is strongly committed to breaking down barriers for vulnerable people, including homeless people who are valued, made welcome and very well supported. Extended appointments were made available immediately so thorough health assessments of homeless people could be done and treatment provided where appropriate.

Staff are consistent in supporting people live healthier lives through a targeted and proactive approach. For example, the practice is focussed on working with young people to reduce the number of unplanned pregnancies. The practice is an approved Young people friendly service and able to provide friendly, confidential support that is focussed on the needs of young people. Statistics for the practice showed that the number of unplanned births to women under 18 years had fallen slightly from 5 in 2010 to 2 in 2014 and 1 in 2015. A dedicated young person clinic is run once a week after school hours and information at the practice and website is aimed at young people providing contraception and sexual health advice, support and treatment.

Morrab Surgery

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, another specialist advisor who was a practice manager and an expert by experience.

Background to Morrab Surgery

The GP partnership run the practice from Morrab Surgery and provide primary medical services to people living in the town of Penzance and the surrounding coastal and inland villages, where the level of social deprivation is low. There is a small branch surgery overseen by the practice in Mousehole, where patients with minor concerns can be seen. The nearest main hospital is situated some 32 miles away in Truro.

The practice is contracted to provide Personal Medical Services (PMS). Morrab Surgery provides some enhanced services which include the childhood vaccination and immunisation scheme, extended hours access, facilitating timely diagnosis and support for people with dementia, influenza and pneumococcal immunisations as well as monitoring the health needs of people with learning disabilities.

The practice hosts clinics run by substance misuse and addiction counsellors and has facilities to carry out echocardiograms and minor surgical procedures on site. Morrab Surgery also provides facilities for visiting surgeons from the main hospital to run diagnostic and surgical procedure clinics for patients using the minor surgery operating room at the practice. These include hernia repair, vasectomies for men and carpal tunnel surgery. The practice has developed close liaison with other therapy providers, who provide clinics at the practice.

At the time of our inspection there were 6302 patients registered at the practice. There is a higher percentage of patients over 45 years when compared to national statistics. The practice supports a very high percentage of patients with drug and alcohol addiction.

The practice is EEFO accredited (an organisation working with Young People in Cornwall) and is able to provide friendly, confidential support that is focussed on the needs of young people. These include emergency contraception, coils and implants, free condoms, contraceptive advice and any health / wellbeing advice needed.

There are four GP partners at Morrab Surgery, two male and two female, who hold managerial and financial responsibility for running the business. There is also a female GP associate. The GPs are supported by three female registered nurses, one of whom is an advanced nurse practitioner. There is a female healthcare assistant, a practice manager and administrative and reception staff. The practice provides placements for medical students as part of their undergraduate medical training. GPs and nurses at the practice are keen to promote evidence based practice that is effective for patients, so carry out research projects from time to time.

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

Morrab Surgery is open from 8.30 am – 5.30 pm for routine appointments Monday to Friday. GPs hold additional appointments at the end of the day for patients needing routine and urgent appointments. Extended opening hours are provided by the GPs and Advanced nurse practitioner.

Detailed findings

The GPs provide late evening appointments, one evening a week, for working patients between 6.30 – 8 pm. The Advanced Nurse Practitioner provides extended hours appointments three mornings a week from 8am to 8.30am. Around these, GPs provide a flexible and responsive service to meet the needs of homeless people and is arranged by phone or in person at the practice. Longer appointments are provided to accommodate homeless people so that they can be fully assessed and treated. The practice does not currently have an online appointment booking system. A Young Persons Clinic is run every Wednesday afternoon after school hours providing appointments for all young people living in Penzance and the surrounding villages.

The practice has a dedicated emergency helpline, which is available to patients 24 hours a day, 7 days a week. Repeat prescriptions can be ordered using this phone line and are processed within 48 working hours. During evenings and at 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.

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 11 March 2015.

During our visit we spoke with five GPs, the community matron, a visiting GP running a substance misuse clinic, the practice manager, a registered nurse, a healthcare assistant, administrative and reception staff. We also spoke with 23 patients who used the practice. We observed how patients were being cared for and reviewed 43 comment 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)

Requires improvement

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.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term. Staff were readily able to locate this information and describe learning and changes made.

Learning and improvement from safety incidents

Morrab Surgery had a system in place for reporting, recording and monitoring significant events, incidents and accidents. All of the staff were familiar with this system and gave examples of shared learning. There was a formal review process for reviewing significant events, which ensured these were discussed at the practice meeting every month. Minutes recorded actions from past significant events and complaints. For example, a young person had attempted to self-harm and the events leading to this had been scrutinised. As a result, the practice had tightened up the monitoring of non-attendance at appointments so that staff were able to identify when a person might be at risk of mental health crisis and needing greater support.

The practice had an educational meeting programme at which safety incidents were discussed. Learning from significant was shared verbally and electronically across the entire practice team and changes made where necessary.

National patient safety alerts were disseminated by email to practice staff. We were shown examples of these held on the practice intranet, which was also accessible to staff.

Reliable safety systems and processes including safeguarding

Systems were in place to manage and review risks to vulnerable children, young people and adults. Training records showed that all staff had received relevant role specific training on safeguarding. GPs, nurses and administrative staff were able to describe recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. For example, concerns about the parenting skills and poor nutrition of a child had been promptly acted upon and appropriate referrals made demonstrating that staff knew how to share information, properly record documentation of safeguarding concerns. Contact details were accessible and listed within the policies and procedures.

The practice had a named GP partner as the lead for safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. For example, they had completed awareness and alerter training for safeguarding adults and children (Level 3).

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 and linked with other siblings and family members registered at the practice. GPs were using the required codes appropriately on the electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults. Records demonstrated good liaison with partner agencies such as the police and social services. For example, a monthly audit of all children and young people who did not attend appointments was done to look for any concerning patterns. If any were identified, minutes showed these were discussed at a monthly meeting with the health visitor and agreement made about how this would be followed up.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure. All of the staff we spoke with understood the principles and verified that they offered patients the choice of having a chaperone. Nursing staff confirmed that they were often asked to chaperone for patients. All nursing staff, including the health care assistant had been trained to be a chaperone. Named reception staff, although trained to do so rarely acted as

chaperones. The recruitment policy for the practice stipulated that all non-clinical staff undertaking a chaperone role would require a Disclosure and Barring Service (DBS) check and this had been done.

Medicines management

Medicines were stored securely in the treatment rooms and medicine refrigerators and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Nursing staff were responsible for monitoring these and knew the safe temperature range for storing medicines. Records for the previous month demonstrated that refrigerators were operating within the safe range described by staff. Expired and unwanted medicines were disposed of in line with waste regulations.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Records of practice meetings demonstrated that actions had been taken in response to reviews of prescribing data. We reviewed data which showed that prescribing patterns of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice showed no evidence of risk when compared with local and national data.

The nurses and the health care assistant administered vaccines in line with legal requirements and national guidance. Patient group directions were up to date and nurses had received appropriate training to administer vaccines. Patient specific directions were also in place. For example, we saw a patient specific direction in a patient's electronic notes demonstrating that the healthcare assistant was authorised to give a flu vaccination to the named patient.

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 a high number of patients with mental health needs some of whom were homeless. A number of patients were on high risk medicines, which for example required regular blood testing. The practice nurses had a system for monitoring patients, which was risk rated and closely monitored. The practice used several methods to engage with patients for these tests, utilising the local pharmacies in reminding patients to attend and also if staff saw the patient on the streets of Penzance. Patients were recalled and the practice quickly involved the community mental health team if a patient did not attend for their blood test.

GPs had access to a well stocked grab bag to take out on home visits. The content of this bag was checked every month by a designated member of staff. We saw that all of the contents were in date.

The practice held a small stock of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard, access to them was tightly restricted and the keys held securely.

Practice staff undertook regular audits of controlled drug prescribing to look for unusual products, quantities, dose, formulations and strength. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area. The staff followed agreed guidelines for patients with known drug addiction ensuring repeat prescriptions were issued for short periods to maintain patient safety.

Cleanliness and infection control

The premises was clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept by the external contractor used. The practice held copies of cleaning audits carried out the external and was monitoring the quality of the service provided.

In the majority of the 43 comment cards, patients remarked that they were satisfied with the standard of cleanliness at the practice. All 23 patients we spoke with were also satisfied with the cleanliness and infection control at the practice.

The practice had three named staff responsible for overseeing the infection control policies and procedures. Two of these were clinical staff, a GP partner and Advanced nurse practitioner. New staff had received induction training about infection control specific to their role. Infection control audits were completed annually and we saw these for last three years. The last audit in December 2014, identified several areas for improvement which

covered the cleaning of toys in the waiting room, greater attention to hard to reach areas prone to dust collection, maintenance of the environment and outlining responsibilities for each member of staff regarding cleaning surfaces and equipment. Discussions with staff demonstrated that these areas had improved, for example regarding the standards of cleaning required at the end of each clinic session.

Personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. Staff described how they would use these to comply with the practice's infection control policy. The practice had a needle stick injury policy in place and staff knew the procedure to follow in the event of an injury. The practice used needles with an integral safety sheath, which was in line with current practice.

Equipment for examination or used to deliver medical gases to patients was single use, was checked monthly and in date.

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.

Other related policies such as the control of substances hazardous to health (COSHH), management of legionella risk, cleaning procedures and risk assessments were in place. Staff showed us records demonstrating that the practice was following suitable procedures for managing COSHH requirements. Records also showed the practice was following suitable procedures to reduce the risk of legionella. This is a bacterium that can grow in contaminated water and can potentially be fatal. The practice was carrying out regular checks in line with national guidance 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.

The practice still used equipment which contained mercury, for example for taking blood pressure. The practice sent us a risk assessment and protocol covering procedures to follow in the event of mercury spillage. This was in line with current guidelines.

Staffing and recruitment

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

There was a recruitment procedure, which highlighted that a criminal record check using the Disclosure and Barring Service (DBS) was required for all clinical staff and non-clinical staff undertaking chaperone duties. The policy supported the decisions about what level of checks should be undertaken for each role at the practice. We looked at three files for staff recruited since April 2013.

One of the three staff files we looked at was a role highlighted as needing a DBS check. We found there was insufficient information on file. The practice manager was unable to locate a DBS certificate to demonstrate that this had been obtained, copy held or a reference number to show that one had been applied for. We were told that verbal references had been obtained from previous employer however these were not recorded and there was no information about professional registration or immunisation status, photo identification or indemnity insurance to show this had been checked prior to employment. Two other files were for non-clinical staff and had limited or no information to demonstrate checks had been carried out.

Other records seen demonstrated that professional registration checks for long standing employees who were nurses and GPs 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. Professional indemnity insurance was seen and valid.

Requires improvement

Are services safe?

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 and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and

visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. 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 (AED) which is used to attempt to restart a person's heart in an emergency). GPs training also included AED.

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 in place, which were effective in checking whether emergency medicines were within their expiry date and would identify any near to expiry so that they were suitable for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. Staff explained that the practice worked collaboratively with three other practices in the area. They told us they would liaise with these practices in the event of an emergency that meant Morrab Surgery 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. A fire drill had taken place the previous 12 months for all staff.

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 nurse led 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. For example, we looked at the care pathway for respiratory disorders; this followed NICE guidelines and set out clear parameters for monitoring and treating patients. There was clear guidance about when to escalate concerns to a GP.

The GPs told us they lead in specialist clinical areas such as hospital care, family planning, gynaecology, end of life care, diabetes, heart disease and asthma. Practice nurses had additional qualifications which allowed the practice to focus on specific conditions. For example, all 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 2014-15 was comparable or better than other practices in the area. For example, at the point of inspection 92.4% patients with hypertension had been reviewed with another 3 weeks of reviews taking place in the year 2014-15. Staff told us they were targeting patients with diabetes to ensure that reviews were taking place.

Data from the local CCG of the practice's performance for antibiotic prescribing demonstrated that this was comparable to similar practices with 24% versus the national rate of 28%. GPs told us that they educated patients about antibiotic use so that they understood when it was appropriate to prescribe. GPs worked closely with the secondary care physicians and for certain patients, with chronic disease, provided "rescue" antibiotics to patients to be kept at home to be taken if they were showing any signs of ill health. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. The practice held a weekly meeting with the community matron to review all the vulnerable patients. We met with the community matron who was at the practice for this weekly meeting and were told that the practice responded promptly to changing needs of patients and involved other health and social care professionals to support patients accordingly.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. Data showed that the practice was performing well in preventing unplanned admissions for vulnerable patients with Morrab at 11.1% compared with national average of 13.6%. Data seen also showed that 100% patients with suspected cancers were referred and seen within two weeks. 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 GP covering them.

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. Sixty six patients in written and verbal feedback gave us examples of this. All of the patients we met told us they were treated as individuals and their views were respected.

Management, monitoring and improving outcomes for people

The practice met with the commissioners to discuss the implications of the Joint Strategic needs assessment for their population. The practice provided information for the commissioners showing the performance with regard to delivering health promotion. For example, health checks were offered to patients over the age of 40 years for the year 2014 to 2015 and was run by a healthcare assistant trained to deliver this. During these checks a patient was found to have an irregular heart rhythm, an electrocardiogram was done the same day and after seeing a GP the patient was referred to the hospital cardiology service for a review.

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 and deputy practice manager to support the practice to carry out clinical audits.

GPs told us the team at Morrab Surgery used an evidence based approach and utilised every opportunity to review and improve their practice through research. For example, a GP and nurse were involved in a clinical trial to compare the benefits for patients using injectable cholesterol lowering drugs as opposed to the standard oral medicines.

GPs showed us 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, an audit of patients with respiratory disease had taken place to determine whether the patients had a clear diagnosis and whether the treatment they were receiving was appropriate for prevention and management of symptoms. Five hundred patients with known respiratory disorders were reviewed at the practice and were called in where necessary for this to take place. This resulted in prescription changes being to the inhalers patients were using. The practice had also developed a risk register of all the patients, so had an overview of the people requiring closer monitoring. We saw examples of individual respiratory plans that had been agreed with the patient covering what triggers to look out for and how they should use the inhalers

prescribed as a preventative measure to lessen the risk of an exacerbation of their condition. Audits seen also confirmed that the GPs who undertook minor surgical procedures were doing so in line with their annual appraisal to maintain professional registration and National Institute for Health and Care Excellence guidance.

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 provided relevant medicines alerts when the GP was prescribing medicines. This enabled the GPs to prescribe safely 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 Hayle, which is seven miles away. 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 six weekly multidisciplinary meetings to discuss the care and support needs of patients and their families.

Patients with long term medical conditions were offered a minimum of yearly health reviews. There was an advanced nurse practitioner at the practice who provided leadership for the management of patients with long term conditions. Nurses told us that the frequency of these reviews were agreed with patients and dependent upon their health needs. Prior to the inspection, we looked at data for 2013-2014 which showed that the practice was performing within or better than national averages for monitoring patients with these conditions. For example, 100% patients with atrial fibrillation (heart disease) had been reviewed. The recall system was seen in process and demonstrated that patients were being invited in for appointments on a rolling schedule each month. Administrative staff explained that each patient received two further letters if they didn't arrange an appointment for an annual review. We looked at the letters and staff told us that if a patient failed to arrange a review the practice had an escalation policy in which a GP reviewed the situation and contacted the patient direct themselves.

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. Information for the previous 12 months showed that 100% patients had a physical health check.

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. Morrab provides placements for medical students during their undergraduate training. There was a good skill mix across the team, with the GPs each having their own specialist interests areas such as research, child care, learning disabilities and complex mental health care. Each GP also had specific interests in developing their skills and disseminating this to the team for example an associate GP worked within the sexual health unit at the main hospital.

Good

Are services effective?

(for example, treatment is effective)

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.

All staff undertook annual appraisals with the practice manager and a GP, which included identification of individual learning needs. Staff confirmed that in preparation for their appraisal they had been asked to identify their training needs and it was discussed with them at the meeting. Mandatory training was provided on-line and some staff showed us their training records and paper portfolios with certificates of completed courses. Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses. For example, a healthcare assistant had been enabled to develop their skills in health promotion and phlebotomy through funded courses at the university. This had enabled the healthcare assistant to carry out extended roles, which included delivering health screening for patients over 40 years and carrying out blood checks of patients on anti-clotting medicines.

The nursing staff received their clinical appraisal from a GP at the practice. A nurse told us that they had the opportunities to update their knowledge and skills and complete their continuing professional development in accordance with the requirements of the Nursing and Midwifery Council. 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.

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 worked effectively with other services. Meetings were held with the health visitor and school nurse to discuss vulnerable children every six weeks. 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. For example, community nursing staff told us that there was an open door policy at the practice, whereby GPs and nurses were able to communicate and respond quickly when a patient's needs changed. They told us that GPs made themselves available to the team to provide guidance and to support to them in their role as community health workers.

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

Staff were aware 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, GPs shared an example of a patient who had signs of memory impairment who they were supporting. The GP demonstrated they followed best interest principles and had shared information with other agencies about concerns they had for the person's safety and wellbeing.

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. The practice is an approved young person friendly service, and was running a clinic once a week specifically aimed at meeting the needs of young people. 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. Six parents with children attending the practice when we inspected confirmed that they were always present during consultations. They told us that all of the staff were very 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. GPs recorded that relevant risks, benefits and complications of the procedure had been discussed with the patient. Nursing staff showed us examples of recorded patient consent for procedures such as wound dressing, blood taking or cervical screening.

Health promotion and prevention

Information about numerous health conditions and self-care was available in the waiting area of the practice. This was young person friendly and 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.

There was information on how patients could access external services for sexual health advice. A GP specialised in sexual health promotion. Teenage pregnancy prevention was a high priority for the practice and made appointments available on the same day for women needing emergency contraception. Statistics for the practice showed that the number of unplanned births to women under 18 years had fallen slightly from 5 in 2010 to 2 in 2014 and 1 in 2015. A dedicated young person clinic was being run once a week after school hours and information at the practice and website was aimed at young people providing contraception and sexual health advice, support and treatment.

Health checks were provided for patients over 40 and seen by a healthcare assistant trained to do this. As part of the check, lifestyle was discussed and patients were screened to determine whether there were any risks such as alcohol dependence or smoking. These were rated giving the patient a score and advice and support was tailored to this including being referred to their named GP for further discussion. Staff told us that there was high levels of social deprivation in Penzance, which meant they were supporting a very high number of patients with alcohol and drug dependency.

The annual flu vaccination programme was still underway. Older patients, those with a long term medical condition, pregnant women, babies and young children had all received vaccinations. For patients within the relevant age range a vaccination against shingles was also available and information about this highlighted in the practice and on the website. The practice held additional clinics for vaccination as well as when patients attended for other appointments so they did not have to make unnecessary trips to the practice. Patients were contacted via text, phone or email. Data showed that 98.4% diabetic patients had been vaccinated against flu compared with the national average of 93.5%.

Childhood immunisation rates for the vaccinations given were comparable to CCG/National averages. For example, by March 2015 childhood immunisation rates for the vaccinations given to under twos was at 90% and 70% of five year olds had received a booster. GPs shared examples with us where they had visited families at home to immunise children, when parents had not responded to recall letters or attended appointments.

The practice had been working to improve the number 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

Good

Are services effective?

(for example, treatment is effective)

preceding 12 months. At the point of the inspection, data was showing that 92.70% patients had recorded support and there was another three weeks of reviews taking place. The national average was 96%.

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 96.41% which was significantly higher than the national average of 82%. This was particularly significant given that the practice supports a high number of vulnerable people who experience homelessness.

Outstanding ☆

Are services caring?

Our findings

Respect, dignity, compassion and empathy

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.

We received 43 completed cards and all were positive about the care and treatment experienced. Another 23 patients we spoke with said they felt the practice offered exceptional services and staff were caring, helpful and professional. They said staff treated them with dignity and respect. Patients were complimentary about reception staff and told us that every effort was made to give them a same day appointment even for routine issues. Our observations of reception staff responding in person with patients or over the telephone also confirmed this.

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.

Staff spoke passionately about promoting equality and showed genuine care and concern for their patients. For example, the practice staff routinely engaged with homeless people in the town to encourage them to attend for health checks. The practice had also been the sole provider of GP services to a women's refuge in the town up until just before the inspection. The team demonstrated that they provided high levels of support to women in challenging circumstances to help them regain confidence and control over their lives, which in many cases involved their children. For example, the practice worked closely with local charities like the Breadline Centre in Penzance to support women and homeless people.

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. The atmosphere in the waiting room was welcoming, calm and friendly with handcrafted seating, pictures and toys. Some of the patients we met told us that they were homeless and appreciated the way they were treated and environment within which they were seen made them feel valued and welcomed.

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 routinely 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 very high levels of patient satisfaction. For example, in the national patient survey 100% patients had expressed overall satisfaction and involvement in planning and making decisions about their care and treatment. For example, data from the national patient survey showed 97.16% of practice respondents said the GP involved them in care decisions which significantly higher than national average of 81.83%. Patient feedback in the same survey showed that 77% felt that the GP was good at explaining treatment and results, which again was comparable with national statistics.

Staff told us that translation services were available for patients who did not have English as a first language. Notices in the reception areas and information on the practice website explained the translation services available in a number of languages. Practice staff told us they recorded this information in the patient record and the most common language other than English was Polish. A GP shared an example with us of how they had used this service with a patient whose first language was Polish, which had worked well.

Outstanding ☆

Are services caring?

The practice used total communication methods such as easy read and picture information and were working closely with the community teams supporting people with learning disabilities. We saw accessible information in picture and easy read formats which was sent out when a review appointment was arranged with the patient. Other self-check information was also used with patients at these appointments, for example, which provided advice about how patients should check their breasts or testes.

Patient/carer support to cope emotionally with care and treatment

Data showed that 95.85% patients at the practice compared with 85.3% nationally felt that their GP treated them with care and concern. All of the 23 patients we spoke with told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. Staff were described as being "excellent" and "wonderful" and patients shared many examples with us about the kindness and support they received. Patient feedback in 43 comment cards we received was also positive and aligned with these views.

Patients highlighted that staff responded compassionately when they needed help and described as going beyond what was expected of them. The practice ran a monthly carers clinic in conjunction a community support worker, to provide practical and emotional support for patients who were carers. The practice staff told us about the good links they had 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. Notices in the patient waiting room 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.

Morrab Surgery also had developed onsite services in conjunction with private providers so that alternative therapies clinics were available to provide support and counselling. Acupuncture and herbal remedies, gentle yoga, psychotherapy, child counselling was also available to support patients dealing with stress and anxiety.

Outstanding ☆

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 frequency of reviews was determined by patient need, for example patients with long term conditions such as unstable diabetes were being reviewed as often as every two weeks when needed.

The practice took an early intervention approach. Patients were enabled to change their lifestyles through the in-house weight management or smoking cessation programmes where further advice and support was provided. Alcohol and drug screening was targeted due to the high levels of deprivation in the area and numbers of patients presenting with addictions. Patients with alcohol addictions were referred to an alcohol service for support and treatment and to the local drug addiction service. The practice hosted clinics at the practice making these more accessible for patients, for example a specialist hepatic clinic was run at the practice by a visiting GP with extended qualifications. Onsite counselling services provided by the local mental health partnership trust and private providers were available for patients and this included a self-referral service. Alternative therapies recognised as helping patients recovering from addictions were hosted at the practice run by outside practitioners and included acupuncture, herbal remedies and gentle yoga.

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 month.

Patients commented in person or in writing that the prescription system was good. The practice had set up a unique 24 hour helpline, which was also a prescription request service. Patients told us this worked well and we saw administration staff and a GP responding immediately to one such request at the beginning of the day demonstrating that this was efficient and effective. The practice rented premises to a private pharmacy so patients could choose whether to have their prescriptions sent through to this chemist or another one of their choice. The practice had arrangements in place for more vulnerable patients for example homeless people, which included a delivery service of the medicines direct to the patient via local pharmacies.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patients. For example, 86% patients had reported it very or fairly easy to book ahead for appointments with only 6% saying they found it not very easy. In response to the 6% who did not find it easy, the practice had added a further three consultation slots to one of the GP clinics and the receptionists had been reminded that extended hours appointments were almost always available during the week and could be offered at any time.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The practice had access to online and telephone translation services.

The practice staff were able to access equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed or were completing the equality and diversity training. All of the staff told us that equality and diversity was regularly discussed at staff appraisals and team events. We saw evidence of these principles being followed, for example in the way reasonable adjustments were made for people with learning disabilities and homeless people.

The practice was situated in an adapted 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 patients using 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 who may be living in vulnerable circumstances, with specific information in individual records about potential risks and

support that was needed. GPs told us there were no barriers for homeless patients and workarounds were in place to record contact information. Homeless people were registered as patients and there was an arrangement for all health related correspondence to be sent to the practice for them to collect. Staff told us they tried to fit patients in for appointments if they presented on the day, making appointments accessible. Homeless people we met in the waiting room confirmed this was their experience.

Access to the service

Morrab Surgery is open from 8.30 am – 6.30 pm for appointments Monday to Friday. GPs hold additional appointments at the end of the day for patients needing routine and urgent appointments. Extended opening hours are provided by the GPs and Advanced nurse practitioner. The GPs run provide late evening appointments, one evening a week, for working patients between 6.30 – 8 pm. The Advanced Nurse Practitioner provides extended hours appointments three mornings a week from 8am to 8.30am. Around these, GPs provide a flexible and responsive service to meet the needs of homeless people and is arranged by phone or in person at the practice. Longer appointments are provided to accommodate homeless people so that they can be fully assessed and treated. The practice does not currently have an online appointment booking system.

A Young Persons Clinic is run every Wednesday afternoon after school hours providing appointments for all young people living in Penzance and the surrounding villages. This was focussing on reducing the number of unplanned pregnancies amongst young people. The clinic provided a flexible, supportive and informative service for young people. As a result, statistics for the practice showed that the number of unplanned births to women under 18 years had fallen slightly from 5 in 2010 to 2 in 2014 and 1 in 2015.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits. Patients were able to book appointments in advance by phoning or visiting the practice.

New patients were given an information pack and introductory letter. All patients were allocated to a named GP and encouraged to see them for continuity of care where ever possible. Sixty six patients gave us positive feedback about their experiences of care at the practice. National patient survey data showed very high levels of satisfaction (100%) with the overall service received.

There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. The practice had a dedicated emergency helpline, which is available to patients 24 hours a day, 7 days a week. Repeat prescriptions can be ordered using this phone line and are processed within 48 working hours. Patients were directed to an Out of Hours service delivered by another provider.

Flexible arrangements were in place for working age patients, which extended the opportunities for health screening to take place at one appointment. Repeat prescribing requests could be made by patients in some circumstances for up to six months as appropriate.

Sixty six patients gave feedback as part of this inspection and confirmed that the appointment system worked well and met their needs. Routine appointments were usually for 10 minutes but extended to meet patient needs. Many patients we spoke with confirmed that urgent appointments were available on the same day, several told us that they had been fitted in and seen for routine appointments the same day also. We saw reception staff answered the telephone to patients in a friendly way and were accommodating in getting them appointments to see the GPs or nurses. Nurses explained that longer appointments were made available for homeless people so that a full health assessment could be undertaken and treatment provided where necessary.

The practice used a triage system and offered telephone appointments for patients. A duty GP was available every day. Patients told us their GP usually telephoned them quickly and found this a good alternative to attending in person for minor issues. The practice had a system for prioritising children so that they were seen by the duty GP and were not kept waiting for their appointment.

Longer appointments were also available for patients who needed them and those with long-term conditions. For example, patients with learning disabilities and/or mental health needs were offered appointments at quieter times of the day and for longer periods for up to an hour if necessary. Counselling services were available on site provided by the local mental health partnership trust. Information was displayed in waiting areas for patients and highlighted they could self-refer to the depression and anxiety counselling service if they wished to.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Listening and learning from concerns and 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 a sample of complaints received from patients between April 2014 and March 2015, all of which had received a prompt acknowledgement and outcome in writing. The practice demonstrated evidence of learning from patient complaints. Examples seen had a positive impact on patient experience of care and treatment.

Sixty six patients involved in the inspection told us they had never made a complaint. Patients said if they did, they would either speak to the receptionists, the GP or practice manager. They were confident that if they did have any concerns it would be taken seriously and investigated.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The details of the vision and practice values were evident throughout the inspection in the way patients were treated, information available and access to services and support. The practice had a strategy and five year business plan, which saw further development of the practice site and collaboration with a nearby practice. Data showed that the number of registered patients each year was increasing due to the popularity of the practice.

We spoke with 15 members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. All 66 patients we received comments from in person or in writing described the practice as "excellent" and the staff "very caring".

The practice was focussed on delivering evidence based compassionate care and saw the importance of developing medical students interest in taking a career pathway in general practice. Two GP partners and two nurses were involved in funded research with close links with the university and active input in contributing new knowledge for health care professionals that could benefit patient care. Staff told us they felt they were well supported and enjoyed working at the practice.

Staff morale was very high and there was a low turnover of staff. Staff said they felt valued and were encouraged to be innovative to deliver safe and effective care and treatment for patients. For example, the practice had agreed care and treatment pathways to facilitate this and all clinics for patients with long term conditions were nurse led. Nurses carried out research and audits aimed at improving patient care and treatment. The practice team was managed in an open and transparent way. Whole practice events took place so that there was good team building.

Governance arrangements

The GP partners took clinical governance seriously and had oversight of outcomes relating to patient care and treatment. Reports were prepared for each meeting and closely monitored by the team of GPs and nurses. The team were reviewing feedback from patients and other health and social care professionals through practice meetings. For example, an action plan was created and had been acted upon following the national patient survey results. Another example seen showed how the practice was monitoring performance of patient outcomes. Statistical data showed that the practice was performing above national average in several areas, particularly with regard to monitoring vulnerable patients and those with long term conditions. For example, 100% patients with learning disabilities had at least an annual health check and followed up according to their specific needs. For the current year the practice performance in caring for patients aged 75 or over who were at risk or had experience a bone fracture and were treated with an appropriate bone-sparing medicine had reached 100% by the time we inspected. The team knew that the practice performance for managing patients with diabetes had dropped from the previous year due to a diabetic nurse specialist retiring and were acting on this information. Whilst performance had dropped this was still comparable with the national averages.

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. Minor changes were needed to some of these covering the management of legionella, mercury spillage and recording of emergency medicines checks so that the expiry dates were clearly visible. We highlighted these at feedback at the end of the inspection and within 48 hours were sent the updated versions.

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 was the lead for safeguarding children and adults. We spoke with 15 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.

Are services well-led?

Good

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

The practice had an on-going programme of clinical and non-clinical audits which it used to monitor quality and systems to identify where action should be taken.

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. However, the practice had not identified that the recruitment procedure had not been consistently followed as highlighted under the safe section.

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 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 training days and social events were held to develop good team building.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, recruitment and induction policies and management of health and safety which were in place to support staff.

Seeking and acting on feedback from patients, 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 a newly formed patient participation group (PPG) at Morrab Surgery, which the practice place high value on. It was too early to report about activities with the PPG or outcomes of actions taken in response of their involvement in the development of the practice. The GP partners and management staff were keen to develop the PPG and find ways to engage vulnerable people whose circumstances were challenging and were looking at other examples of outstanding practice across the country.

Management lead through learning and 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 maintain registration with the Nursing and Midwifery 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 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.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers We found that the registered person had not protected people against the risk of fit and proper persons employed. This was in breach of regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 19(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Recruitment procedures must be established and operated effectively to ensure that information regarding pre-employment checks is kept regarding persons employed. How the regulation was not being met: · Checks had not been consistently kept to show that staff employed are registered with the staff were registered with the relevant professional body, including the performers list for locum staff. · Proof of identity including a recent photograph was not held on file. · A full employment history, together with a satisfactory written explanation of any gaps in employment was not provided. · Satisfactory evidence of conduct in previous employment was not recorded as having been sought. · Satisfactory information about any physical or mental health conditions which are relevant to the person's capability were not assessed for all staff. · A DBS check had not been obtained for a member of staff in a role identified in the practice recruitment policy as requiring one.