Gunnislake Health Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

Gunnislake Health Centre was inspected on Wednesday 29 January 2015. This was a comprehensive inspection.

The practice is one of two health centres under the management of Tamar Valley Health. Both practices provided primary medical services to approximately 16,230 patients of which 6,200 attend the health centre at Gunnislake. The practice was located in a rural area of Cornwall and was a dispensing practice. A dispensing practice is where GPs are able to prescribe and dispense medicines directly to patients who live in a rural setting which is a set distance from a pharmacy. Approximately 5,500 patients at the practice were able to use the dispensary at the health centre. The practice provided a service to a diverse age group.

There was a team of nine GP partners, six associate GPs and a strategic management partner within the organisation. Partners hold managerial and financial responsibility for running the business. There were three GP partners based at Gunnislake Health Centre and two associate GPs. There were two female and three male GPs. The team were supported by a nurse prescriber, five practice nurses and five health care assistants who worked across both practices. The practice employed two pharmacists who were both able to prescribe and review medicines. There were also additional administrative, reception and dispensing staff.

Patients using the practice also had access to community staff including district nurses, community psychiatric nurses, health visitors, physiotherapists, speech therapists, counsellors, podiatrists and midwives.

We rated this practice as good.

Our key findings were as follows:

There were systems in place to address incidents, deal with complaints and protect adults, children and other vulnerable people who use the service. Significant events were recorded and shared with multi professional agencies. There was a proven track record and a culture of promptly responding to incidents and near misses and using these events to learn and change systems changed so that patient care could be improved.

There were systems in place to support the GPs and other clinical staff to improve clinical outcomes for patients.

Summary of findings

According to data from the Quality and Outcomes Framework (the annual reward and incentive programme detailing GP practice achievement results) outcomes for patients registered with this practice were equal to or above average for the locality. Patient care and treatment was considered in line with best practice national guidelines and staff are proactive in promoting good health. There were sufficiently skilled and trained staff working at the practice.

The practice was pro-active in obtaining as much information as possible about their patients which does or could affect their health and wellbeing. Staff knew the practice patients well, are able to identify people in crisis and are professional and respectful when providing care and treatment.

The practice planned its services to meet the diversity of its patients. There were good facilities available, adjustments were made to meet the needs of the patients and there was an effective appointment system in place which enabled a good access to the service.

The practice had a vision and informal set of values which were understood by staff. There were clear clinical governance systems and a clear leadership structure in place.

We saw two areas of outstanding practice including:

The practice employed two pharmacists who were able to treat and prescribe minor illnesses, perform medicine reviews, answer medicine queries and perform basic health reviews. The pharmacists were independent prescribers and were involved with clinical activities in the practice as well as overseeing the dispensary procedures. They had systems in place to ensure any medicines alerts and recalls were assessed and actioned. The role had led to improvements in meeting patient needs during 'on the day' appointments and ensured GPs followed the most up to date guidance. The practice provided a service called TIC TAC to the local community college. The TIC TAC service provided a drop in confidential advice and healthcare service to students during their college day. Although this was a funded enhanced service the practice had worked over and beyond the contract and reviewed the service changing it where necessary. For example initially the main services were for sexual health screening and contraception advice but more mental health issues had arisen resulting in the introduction of a counsellor and increased referrals to the community mental health teams. The practice provided a full time coordinator, daily GP and/or practice nurse and counsellor. They also had access to a school nurse. The service mainly provided health education, sexual health advice, contraception, smoking cessation advice and emotional support.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

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

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

Staff turnover was low. Recruitment procedures and checks were completed on permanent staff as required to help ensure that staff were suitable and competent. Induction procedures for staff, including locum GPs were detailed.

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

Staff were aware of their responsibilities in regard to safeguarding and the Mental Capacity Act 2005 (MCA). MCA training had been provided for GPs and was in the process of being arranged for nursing staff. There were safeguarding policies and procedures in place that helped identify and protect children and adults who used the practice from the risk of abuse.

There were arrangements for the efficient management, storage and administration of medicines within the practice and within the dispensary. Prescription stationary was stored and used effectively and in an appropriate way. The practice employed two prescribing pharmacists to assist with medicine reviews, treat and prescribe for minor illnesses and answer medicine queries.

There were clear processes to follow when dealing with emergencies. Staff had received basic life support training and emergency medicines were available in the practice or within GP bags. Checks on these medicines were performed by dispensing staff.

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

Are services effective?

Good

The practice is rated as good for providing effective services.

Summary of findings

Systems were in place to help ensure that all GPs and nursing staff were up-to-date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines.

GPs, nursing staff and dispensary staff used clear evidence based guidelines and directives when treating patients. Evidence confirmed that these guidelines were influencing and improving practice and outcomes for patients.

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

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

Effective multidisciplinary working was evidenced.

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

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

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

Are services caring?

Good

The practice is rated as good for providing caring services.

The practice had a small staff group. Both staff and patients said this helped with communication and provide a personal service. Feedback from patients about their care and treatment was consistently positive. The comment cards we received, a friends and family survey and survey data from March 2014 reflected this feedback. Patients described the practice as caring and said they trusted the GPs and knew them well.

Summary of findings

We observed a person centred culture and found strong evidence that staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. We found many positive examples to demonstrate how people's choices and preferences were valued and acted on.

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

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

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

We found the practice had a proven track record of learning from and responding in a timely way well to patient feedback, complaints, incidents and informal comments.

Patients said they could get an appointment easily in advance or with a GP on the same day but sometimes had to wait a little longer to see the GP of their choice.

The practice reviewed secure service improvements where these were identified. For example, a scheme to prevent unnecessary hospital admissions.

The practice were also involved in a TIC TAC service to the local community college and had responded to an increased need for emotional and mental health support. The drop in service provided confidential healthcare and advice to students during their college day. Although this was a funded enhanced service, the practice had worked over and beyond the contract and provided a full time coordinator, daily GP and/or practice nurse and counsellor with additional support from a school nurse. The service mainly provided health education, sexual health advice, contraception, smoking cessation advice and emotional support.

There was an accessible complaints system with evidence that the practice responded quickly to issues raised even if they were verbal informal complaints. There was evidence of shared learning, by staff and other stakeholders, from complaints.

Are services well-led?

Good

The practice is rated as good for well led.

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

Summary of findings

Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management.

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

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

Summary of findings

The six population groups and what we found

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

Older people

Good

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

Information from Public Health England showed that the practice's patient population had a higher than average number of older people compared to the county and the England average.

All patients aged 75 and over had a named GP but were able to choose an alternative if they wished or if this was more convenient for the patient.

Pneumococcal vaccinations and shingles vaccinations were provided for older people. Housebound older patients received immunisations at home where necessary. Specific flu clinics are organised in village halls in the area to enable older patients to access a more local service.

The practice did not provide specific older person clinics. Treatment was organised around the individual patient and any specific condition or need they had. A computer pop up alert system prompted clinicians to offer any tests or routine monitoring.

The practice worked with the community multidisciplinary team to identify patients at greater risk of admission. Practice nurses work with the community nursing team to provide a streamlined service.

The practice identified older patients with life-limiting conditions and co-ordinated a multi-disciplinary team (MDT) for the planning and delivery of palliative care for people approaching the end of life.

Family and Carers were included in patient care where patients requested. The practice communicated with family members (with consent) to clarify information or inviting them to come along with the patient.

The GPs worked to avoid unnecessary admissions to hospital and used care plans which were reviewed every three months to avoid patients being admitted to hospital unnecessarily.

The premises and services were purpose built and had been adapted to meet the needs of people with disabilities. There was level access and a designated accessible toilet.

People with long term conditions

Good

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

The practice had a system to identify patients with long term conditions and arrange treatment, reviews and follow up care at a

time suitable to the patient. Patients with long term conditions described the practice as efficient and organised when arranging care and treatment and said the practice reminded them of upcoming health care and medicine reviews.

Patients with diabetes were reviewed by the practice staff and community nurse specialist where required. These reviews included a medicines check, health and lifestyle advice, blood tests and foot care. There were clear guidelines and care templates for GPs and practice nurses to follow.

Patients with long term conditions had personal care plans in place. Respiratory and diabetic clinics were run by practice nurses with specialist qualifications. The nurses attended educational updates to make sure their lead role knowledge and skills were kept up to date.

The practice provided clinics for asthma and chronic lung disorders (COPD) including using spirometry, a lung capacity test, as part of its service to assess the evolving needs of this group of patients.

The practice promoted independence and self-care for patients with long term conditions. For example, some patients monitored their own health remotely and contacted the practice should their symptoms change and there was a blood pressure machine in the practice for patients to use.

The computer system contained health promotion prompts so opportunistic screening could take place regardless of for the reason for the patient's attendance.

All patients with complex needs who were in receipt of a care plan were contacted by the practice following any admission or attendance at A&E and home visits were undertaken if required to ensure medicine reviews were performed.

The practice sent 'special messages' to the out of hour's providers about patients with complex needs so the out of hours service was aware of their care and treatment. For patients at the end of their life the practice used a computerised clinical patient management system to provide continuity of care by automatically sending full consultation details to the out of hours provider.

The practice used the Quality and Outcomes Framework (QOF) which is a national performance measurement tool. The practice used the QOF to identify and support patients with long term conditions to ensure their needs were monitored and gave assurances that they were providing care to set practice standards and working within NICE Guidelines.

Summary of findings

Families, children and young people

Good

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

The practice held weekly baby and child immunisation appointments and sent letters of invitation to all parents and carers.

Patients who did not attend for immunisations were reviewed by the practice nurse and GP and contacted by the practice if appropriate. If there were any concerns regarding the reasons for non-attendance these are raised with the health visitor who visited the practice on a daily basis.

Ante-natal care was provided at a community centre next to the practice. Midwives communicated with the GPs and practice team on a daily basis should this be necessary. The practice staff also worked with health visitors, dieticians, school nurses and podiatrists.

Patients had access to contraception advice and had access to a full range of contraception services including the insertion of coils and implants. Patients could also access chlamydia testing and cervical screening. There were private areas for women to use when breastfeeding.

Appropriate systems were in place to help safeguard children or young people who may be vulnerable or at risk of abuse. All staff had received training on safeguarding children and young people.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working age people

The practice offered telephone consultations, four week advanced booking for appointments. Weekend and once weekly evening appointments were also available with a GP.

NHS Health checks, weight checks, healthy living advice, blood pressure checks, new patient checks and smoking cessation appointments were offered at a time convenient to the patient.

There was an online appointment booking system and online prescription request via the practice website which patients said was easy and convenient to use. Patients who received repeat medicines were able to collect their prescriptions at a pharmacy of their choice or at the practice dispensary if appropriate.

The practice offered travel advice and vaccinations. The practice was a nominated yellow fever vaccine centre. Nurses who provided this service had received specialist training.

Summary of findings

The practice offered services including joint injections, monitoring of patients on blood thinning medicines and electronic cardiograms (ECG-heart tracing).

People whose circumstances may make them vulnerable

Good

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

Patients with learning disabilities were offered a health check every year during which their long term care plans were discussed with the patient and their carer if appropriate. Patients who found it stressful to come to the practice were visited in their own home.

Practice staff encouraged patients with alcohol addictions to self-refer to an alcohol service for support and treatment.

The practice had access to language interpretation services but stated that patients usually chose to attend the practice with a family member.

The practice had identified that some patients were vulnerable because of the rural location and reduced public transport network. As a result the practice had enabled patients to use either practice and arranged for some immunisation clinics to be held in some of the villages in the surrounding area. The practice had also established a home delivery service for patients who were unable to collect their prescriptions from the surgery.

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.

The practice had a register at the practice which identified patients who had mental illness or mental health problems and were assigned a GP of the patient's choice for continuity of care.

The practice used QOF and recall systems to ensure mental health checks and medicine reviews were conducted to ensure patients received appropriate doses and care plans were in place. Blood tests were regularly performed on patients receiving certain mental health medicines.

Patients were offered appointments at a memory clinic and were then referred or monitored if the result showed an impairment in memory.

Summary of findings

The practice worked with the community mental health team and referred patients for urgent intervention when required. The GPs liaised with community psychiatric nurses to discuss vulnerable patients and referred patients to the community mental health team if necessary.

The practice staff had an understanding of the Mental Capacity Act 2005.

Summary of findings

What people who use the service say

We spoke with nine patients during our inspection.

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

Comment cards were detailed and stated that patients appreciated the service provided, the caring attitude of the staff and the staff who took time to listen effectively. There were comments praising GPs, nurses and the reception team. Comments also highlighted a confidence in the advice and medical knowledge and a feeling of not being rushed.

These findings were reflected during our conversations with the nine patients we spoke, on the day of inspection, with and from looking at the survey from March 2014. The feedback from patients was overwhelmingly positive. Patients told us about their experiences of care and praised the level of care and support they consistently received at the practice. Patients said they were happy, very satisfied and said they had no complaints and received good treatment. Patients told us that the GPs and nursing staff were excellent.

Patients were happy with the appointment system although said they sometimes had to wait for their appointment or it took longer to see the GP of their choice. We were told patients could either book routine appointments four weeks in advance or make an appointment on the day. We spoke with one patient who had made their emergency appointment that morning. We saw receptionists helped patients to choose an appointment that was suitable for them.

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

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

Patients found it easy to get repeat prescriptions and appreciated having the dispensary on site.

Outstanding practice

We saw two areas of outstanding practice including:

- The practice employed two pharmacists who were able to treat and prescribe minor illnesses, perform medicine reviews, answer medicine queries and perform basic health reviews. The pharmacists were independent prescribers and were involved with clinical activities in the practice as well as overseeing the dispensary procedures. They had systems in place to ensure any medicines alerts and recalls were assessed and actioned. The role had led to improvements in meeting patient needs during 'on the day' appointments and ensured GPs followed the most up to date guidance.
- The practice provided a service called TIC TAC to the local community college. The TIC TAC service provided a drop in confidential advice and healthcare service to students during their college day. Although this was a funded enhanced service the practice had worked over and beyond the contract and reviewed the service changing it where necessary. For example initially the main services were for sexual health screening and contraception advice but more mental health issues had arisen resulting in the introduction of a counsellor and increased referrals to the community mental health teams. The practice provided a full time coordinator, daily GP and/or practice nurse and

counsellor. They also had access to a school nurse. The service mainly provided health education, sexual health advice, contraception, smoking cessation advice and emotional support.

Gunnislake Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Gunnislake Health Centre

The practice is one of two health centres under the management of Tamar Valley Health. Both practices provided primary medical services to approximately 16,230 patients of which 6,200 attend the health centre at Gunnislake. The practice was located in a rural area of Cornwall and was a dispensing practice. A dispensing practice is where GPs are able to prescribe and dispense medicines directly to patients who live in a rural setting which is a set distance from a pharmacy. The practice provided a service to a diverse age group.

There was a team of nine GP partners, six associate GPs and a strategic management partner within the organisation. Partners hold managerial and financial responsibility for running the business. There were three GP partners based at Gunnislake Health Centre and two associate GPs. There were two female and three male GPs. The team were supported by a nurse prescriber, five practice nurses and five health care assistants who worked across both practices. The practice employed two pharmacists who were both able to prescribe and review medicines. There were also additional administrative, reception and dispensary staff.

Patients using the practice also had access to community staff including district nurses, community psychiatric nurses, health visitors, physiotherapists, speech therapists, counsellors, podiatrists and midwives.

The practice is open from Monday to Friday, between the hours of 8.30am and 6pm. Evening appointments were available with a GP one day a week and each Saturday morning at either of the two health centres to help those patients who worked during routine office hours.

The practice had opted out of providing out-of-hours services to their own patients and refer them to the Cornish out of hours service.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?

Detailed findings

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

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

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

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

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

We carried out our announced visit on Wednesday 29 January 2015. We spoke with nine patients, three GPs, three of the nursing team and four of the management and administration team. We collected four patient responses from our comments box which had been displayed in the waiting room. We observed how the practice was run and looked at the facilities and the information available to patients.

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

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

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety, for example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. These alerts were circulated and discussed at partner and management meetings and if necessary resulted in new policies being devised.

Staff 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 incidents and significant events were discussed. Records showed the practice had managed these consistently over time and so could show evidence of a safe track record.

Learning and improvement from safety incidents

There was an embedded culture of using any incident, accident or event as an opportunity to learn from and improve the service. The practice had a clear systematic process in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during over the last five years. Significant events were discussed within 24 hours of occurrence and formally at the three times a year significant event meetings to make sure action had been taken and the event re-reviewed. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. For example, an unexpected delivery of a baby had occurred at the practice. The staff had reviewed their actions and decided that a delivery pack was not necessary because of the unlikeliness of the event occurring again.

Staff explained the system they used to manage and monitor incidents. We tracked examples of incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example, a patient had reported that they had been automatically cut off after waiting six minutes on the telephone. The practice decided this could have been a serious issue if the patient had been unwell and decided to use the significant event process. The practice immediately looked at the telephone log and recognised a fault in the telephone software. This was rectified and was logged to be reviewed at the next significant event meeting.

National patient safety alerts were disseminated verbally and by email to practice staff. Staff were able to give examples of recent alerts. The pharmacists employed by the practice looked at all safety alerts involving patient medicines and communicated to the staff.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received safeguarding training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details displayed on a flow chart were easily accessible.

The practice had appointed two GPs at the practice as leads in safeguarding vulnerable adults and children so that there was always a lead present at the practice. They had been trained and could demonstrate they had the necessary advanced training to enable them to fulfil this role.

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

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 patients with mental health issues.

The formal chaperone policy was under review. Posters offering patients this service were displayed in the practice. A chaperone is a member of staff or person who acts as a witness for a patient and a medical practitioner during a

medical examination or treatment. Selected staff had been trained to be a chaperone and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

Medicines management

The practice was a dispensing practice. A dispensing practice is where GPs are able to prescribe and dispense medicines to patients who live in a rural setting which is a set distance from a pharmacy. Approximately 5,500 patients at the practice were able to use the dispensary at the practice.

We checked medicines stored in the dispensary and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that these medicines were kept at the required temperatures. The temperature in the room and refrigerator at the time of our inspection were within the recommended ranges for storing these medicines. New systems were being introduced for recording and monitoring storage temperatures since our inspection of another medical centre in the group, which would enable clearer records to be maintained showing that medicines were being stored at the recommended temperatures.

Systems were in place to check that medicines were within their expiry date and suitable for use, and a new system for recording was being introduced. Expired and unwanted medicines were disposed of in line with waste regulations.

There were clear operating procedures in place for dispensary processes. Systems were in place to ensure all prescriptions were signed before being dispensed. The practice had a system in place to assess the quality of the dispensing process and had signed up to the Dispensing Services Quality Scheme, which rewards practices for providing high quality services to patients of their dispensary.

Any errors or 'near misses' were recorded, monitored and actions put in place to reduce the risks of any recurrence. The practice held stocks 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 and access to them was restricted and the keys held securely. There were arrangements in place for the destruction of controlled drugs. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

Blank prescription pads and printer forms were held securely in the practice. A new system was being introduced for recording and monitoring FP10 prescription pads (pre-printed with the surgery details) to enable an audit trail of the whereabouts of these forms.

The practice employed two pharmacists who were independent prescribers and were involved with clinical activities in the practice as well as overseeing the dispensary procedures. They had systems in place to ensure any medicines alerts and recalls were actioned.

We saw records showing that dispensary staff had received appropriate training and had regular checks and appraisals of their competence.

The practice had established a home delivery service for patients who were unable to collect their prescriptions from the surgery. They also had arrangements in place to ensure people were given all the relevant information they required with their medicines.

We checked medicines stored elsewhere in the practice. Medicines stored in the treatment rooms and medicine refrigerators were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which included inaccessible plug sockets for the vaccine fridge to reduce the risk of unplugging the fridge.

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

We saw evidence that medicines and prescribing patterns were kept under review as a way of improving patient safety but also as part of the local clinical commissioning group incentive scheme.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of directions and

evidence that nurses had received appropriate training to administer vaccines. The nurses had also received appropriate training to administer travel vaccinations and give travel advice.

Patients were pleased with the process of obtaining repeat prescriptions and appreciated having the dispensary.

Cleanliness and infection control

We observed the premises to be clean and tidy. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead nurse for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy. An infection control audit had been completed within the last six months and had highlighted the need to introduce specialist waste bins to dispose of specialist clinical waste.

An infection control policy and supporting procedures were available for staff to refer to. There were also flowcharts and a policy for dealing safely with a needle stick injury. Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice employed their own cleaning staff who were considered part of the team. There were cleaning schedules in place for all areas of the practice. Cleaning staff signed to say when each area had been cleaned. The practice manager monitored this process.

Equipment

Staff told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and was due to be retested in April 2015.

Staffing and recruitment

Many members of staff had been in post for a number of years and said Gunnislake Health Centre was a good place to work because they felt supported and liked the patients and people they worked with. The practice had a recruitment policy that set out the standards it followed when recruiting staff. Recruitment records contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, health assessment, and registration with the appropriate professional body.

Criminal records bureau (CRB) checks through the Disclosure and Barring Service (DBS) had been performed for the GPs and nursing staff working alone with young people. The practice were in the process of applying for these checks for existing nursing staff who had been employed for many years and had a risk assessment in place to explain why administration staff had not had a CRB check performed.

Staff told us about the arrangement in place to cover each other's annual leave. For example, blood tests were checked by other GPs in the absence of an individual GP.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. There was a member of staff allocated each day to monitor staffing levels or areas where additional resources may be required.

Monitoring safety and responding to risk

The practice had their own risk assessment and policy which focused on all areas of the building and the practice used an external company to maintain all servicing contracts. These included water safety, electrical equipment, gas safety, legionella, boiler safety and fire systems. The last fire drill had been performed in January 2015 and legionella checks had been carried out in November 2014 as part of routine maintenance checks.

Nurses knew about how to safely dispose of clinical waste and all staff knew how to respond in the event of a fire.

Maintenance records were kept to demonstrate that there was clear system in place to report and treat any defects or physical issues with the premises. Staff said the system worked well.

There was a detailed business continuity plan in place which explained what action was necessary in the event of incidents including major incidents, a loss of power or an epidemic or pandemic.

Arrangements to deal with emergencies and major incidents

Good

Are services safe?

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that the emergency equipment was checked regularly by a nominated member of staff.

Emergency medicines were available at the practice and were stored centrally for easy access. The medicines included those for the treatment of cardiac arrest, anaphylaxis (allergic reaction to medicines) and severe low blood sugar.

Processes were in place to check whether emergency medicines and equipment were within their expiry date and suitable for use. All the medicines and equipment we checked were in date and fit for use.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. The GPs had written many templates to use for guidance when treating patients with long term conditions. These were based on NICE guidelines and were kept under review.

Patients were pleased with the care, treatment and advice they received. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. The GPs and nurses completed assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate. We saw examples where care for vulnerable patients or those with long term conditions had been reviewed.

The practice nurse and GPs led in specialist clinical areas such as diabetes, heart disease and asthma. Nursing staff were open about asking for advice and support from nurse practitioners, GPs and pharmacists when needed. The nursing team had experience in managing long term conditions and supported the GPs well. The practice provided evidence to show patients with long term conditions were offered reviews annually or more frequently as required.

The practice completed audits to ensure patients were receiving appropriate care and treatment. For example, an audit of patients who had received minor surgery at the practice had been performed to confirm infection rates and complications were low.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients who had been discharged from hospital.

National data and practice computer systems showed that the practice was in line with referral rates to hospital and other community care services for all conditions. The GPs used national standards for the referral of suspected cancers within two weeks. We saw systems used by administration staff to show how routine and urgent referrals were made.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

The GPs showed us examples clinical audits that had been undertaken in the last year. All of these were completed audits where the practice was able to demonstrate that care and treatment was effective or show the changes which were made to improve care since the initial audit.

Learning from significant events, clinical supervision and staff meetings were used to review patient outcomes achieved and areas where patient outcomes could be improved. Staff spoke positively about the culture in the practice and said there was not a name and shame environment but events were used positively to improve services. An example included changes being introduced following the inspection at the other practice earlier in the month. The changes had been communicated to staff the following day and new policies and practices being introduced within a week.

There was a protocol for repeat prescribing which was in line with national guidance. In accordance with the protocol, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. Patients said they were sent reminders on the prescription or by letter regarding these checks and thought the system worked well. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines.

Effective staffing

Practice staffing included medical, pharmaceutical, nursing, managerial, dispensary and administrative staff. We reviewed staff training records and saw that all staff

Good

Are services effective?

(for example, treatment is effective)

were up to date with annual basic life support and safeguarding training. There was a culture of staff development at the practice and all staff said they had access to the training they needed to fulfil their roles.

GPs were up to date with their yearly continuing professional development requirements and had been revalidated or had a date for revalidation. (Every GP is appraised, and undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practise and remain on the performers list with the General Medical Council).

All staff received annual appraisals that identified learning needs from which action plans were developed. Staff confirmed that the practice was proactive in providing training and funding for relevant courses.

The nurse practitioner, practice nurses and health care assistants were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, they showed evidence of their training in administration of vaccines, cervical cytology and travel advice. Those with extended roles such as diabetes and asthma management were also able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. It received blood test results, X ray results, and letters from the local hospitals including discharge summaries, out-of-hours GP services and the out of hours service both electronically and by post. The practice manager provided a clear policy on managing these results. All staff we spoke with understood their roles and felt the system in place to communicate blood test results and hospital discharges worked well. There were no instances within the last year of any results or discharge summaries that were not followed up.

The multidisciplinary team could speak with the GPs when required. The district nurses, health visitors and midwives were based at the community centre next to the practice and could discuss patients with the GP. Practice staff said communication between healthcare professionals and the practice was good.

Information sharing

The practice used 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 managing cervical smear appointments (Open Exeter). The practice used the choose and book system to access appointments for patients. (The choose and book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use and showed us the back-up system to ensure the appointments had been arranged.

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

We found that staff were aware of the Mental Capacity Act 2005 and children's legislation relating to consent and were aware of their duties in fulfilling it.

There was a practice policy for documenting consent for specific interventions. For example, for all immunisations, contraceptive procedures, minor surgery and cervical smears. Staff used the computer system to document conversations held with patients. Patients said they always consented to any treatment given to them.

Staff were aware of consent regarding young people and were aware of Gillick competence and Fraser guidelines (consent for children) and had explained these clearly in information given to young people who attended the TIC TAC service.

Health promotion and prevention

The practice offered patients a health check when they were registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture between the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients

Good

Are services effective?

(for example, treatment is effective)

aged 18-25 and offering lifestyle and smoking cessation advice to smokers. The data provided by the practice showed that 85% of preschool children had attended for immunisation against rotavirus.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and made sure they had an annual health check. For example 100% of patients with a learning disability had received an annual health check so far this year.

The practice's performance for cervical smear uptake was comparable to other practices in the CCG area. For example the practice were comparable to other practices nationally for cervical screening. There was a policy to offer written reminders for patients who did not attend for cervical smears and the practice monitored the number of patients who did not attend annually.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. For example, practice data showed that 99% of children under two years of age had received the first course of their childhood immunisations. Other immunisation and vaccine rates were similar to this.

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

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the most recent improving practice questionnaire performed by the practice in March 2014. This showed that 80% of respondents considered that their health concerns had been fully dealt with by the practice. The practice shared the initial findings from the recent friends and family test. These results showed that nine of the eleven initial respondents would be extremely likely or likely to recommend the practice to their friends and family.

Patients completed CQC comment cards to tell us what they thought about the practice. We received four completed cards and all but two of which were positive about the service experienced. The comment cards included comments from patients stating that they thought the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect.

We spoke with nine patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice staff worked hard to prevent potentially private conversations between patients and reception staff being overheard. The practice had tried the use of booths but these were removed at the request of patients.

Care planning and involvement in decisions about care and treatment

Patients we spoke to on the day of our inspection told us that GPs discussed health issues with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards and friends and family questionnaire were also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the office areas informing patients this service was available. We spoke with one patient whose first language was not English. They said the practice staff had been patient and had taken their time to listen and explain any treatments.

Patient/carer support to cope emotionally with care and treatment

Patients were positive about the emotional support provided by the practice staff. They said they had received help to access support services to help them manage their treatment and care when it had been needed. The patient comment cards we received were also consistent with this feedback. One patient said they had returned to the practice after moving back into the area and said they felt more supported at Gunnislake.

Notices in the patient waiting room 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 which resulted in support being offered to these patients.

Staff told us that if families had suffered bereavement, their usual GP provided support. Two dedicated receptionists also deal with bereavement. With GP approval, they send a bereavement letter and leaflet. There were posters and leaflets offering advice on how to find a support service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had a proven track record of responding to patient feedback. The practice used complaints, significant events, surveys, comment cards and face to face meetings with patients and the patient participation group to improve the service.

The practice had an active patient participation group (PPG) who told us they felt the practice responded well to questions, feedback and suggestions.

Patients said they had been asked for feedback from surveys and knew they could give feedback to the reception staff. The most recent survey had showed that a response to on the day appointments had been made following negative feedback from patients.

Tackling inequity and promoting equality

The premises and services were purpose built and had been adapted to meet the needs of people with disabilities. There was level access and a designated accessible toilet.

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

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

Access to the service

Patients were generally pleased with the appointment service at the practice and said they could get a same day appointment if necessary. For example, on the day of our visit, we observed one patient was attending the practice who had made an appointment that morning. Patients told us that when they got to see the GP or nurse they never felt rushed. Patients also said it took longer to make an appointment with a GP of their choice but knew they could get an appointment with any GP on the same day.

Opening hours were planned around the needs of the population. The practice was open between the hours of 8.30am and 6pm. Appointments could be booked four weeks in advance. Evening appointments were available at either practice one day a week to promote access to services to patients who worked during normal office hours. There were also Saturday morning appointments available at either of the practices.

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

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns and used this process as a part of its quality monitoring system. The practice's complaints policy and procedures were displayed in the practice and were in line with recognised guidance and contractual obligations for GPs in England. The practice manager was a designated responsible person who handled all complaints in the practice.

There had been six formal complaints received in the last year. We looked at the six complaints received in the last 12 months. . We saw that all complaints had been satisfactorily handled and dealt with in a timely way. We saw evidence of learning and changes in systems, policies and processes as a result of complaints. Practice staff were keen to use comments and verbal feedback as a way of improving services. The practice used the complaint summary to look at trends

We saw that information was available to help patients understand the complaints system. Patients were aware of the process to follow if they wished to make a complaint, but patients said they had not needed to complain.

Are services well-led?

Good

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

Our findings

Vision and strategy

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

Governance arrangements

There were structured meetings to discuss incidents, events, complaints, and clinical matters, but daily discussions also took place which meant any issues were dealt with and communicated promptly. We saw examples where the practice responded immediately to events, incidents and complaints, often finding solutions and actions before they were formally addressed at the management and clinical governance meetings. The management partner and practice manager played a central role in coordinating this process and communicating any actions. There were clinical meetings four times a year to discuss business issues and also any current complaints or significant events.

The practice had a number of written and electronic policies and procedures in place to govern activity and these were available to staff. We looked at the safeguarding adult and child policies and whistleblowing policies and saw these had been reviewed within the last year.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. QOF data for this practice showed it was performing in line with national standards.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. We looked at three examples of clinical audit. For example, the practice looked at the management of patients who had received contraception implants or coils. The practice monitored infection rates and complications to make sure the process was being conducted appropriately. The process was re audited to make sure care and treatment was still appropriate.

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

Staff at the practice discussed complaints, significant events and incidents daily with day to day events. The records for these events showed the action and learning that took place. This included a review of whether the practice should hold specialist equipment should the practice have an unplanned delivery of a baby at the practice.

Leadership, openness and transparency

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

Staff said there was an open culture within the practice and they had the opportunity and were happy to raise issues at any time.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example, recruitment procedures and induction process which were in place to support staff. Staff knew where they could find these. This support was provided for locums who visited the practice as well as permanent staff.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through a patient survey in March 2014. The survey found that most patients felt that both GPs and nurses gave them enough time, asked about symptoms, listened well and explained tests and treatments. Patients also said the GPs involved them in their care, treated them with care and concern and took their problems seriously. The survey highlighted dissatisfaction with the appointment system and had resulted in the introduction of a GP ring back service for patients requesting an appointment on the same day.

The practice had an active patient participation group (PPG). The PPG committee met every two months and held an additional open meeting every two months.They

Are services well-led?

Good

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

produced an informative newsletter for patients. PPG said they felt they could influence changes by speaking to the business partner, practice manager, GPs or receptionists. Examples of changes had included reviewing the additional services offered at the practice, suggesting using emails to contact patients for reviews, and monitoring the suggestion boxes. The PPG newsletter was aimed at informing patients of recent activities and communicating changes such as the friends and family test and reasons behind issues such as response times to telephone calls.

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

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at staff files and training records and saw that regular appraisals took place which included a personal development plan.

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