# Mullion Health Centre

## Quality Report

Mullion
Helston
Cornwall
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Date of inspection visit: 18 February 2015
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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? | Outstanding |
| Are services well-led? | Good |

# Summary of findings

## Contents



## Overall summary

**Letter from the Chief Inspector of General Practice**

Mullion Health Centre was inspected on Wednesday 18 February 2015. This was a comprehensive inspection.

The practice provided primary medical services to approximately 7,750 patients. The practice consisted of four sites. Mullion Health centre and Constantine were the main sites, with two smaller branches which opened part time during the week. We visited Mullion and Constantine for this inspection. The branch surgeries were located in the villages of Ruan Minor and Lizard. Ruan Minor, Constantine and Lizard were dispensing practices and provided a service to approximately half of the whole practice population. 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.

There was a team of five male GP partners and two female GP partners. Partners hold managerial and financial responsibility for running the business. Some of the GPs work part time. The team were supported by a nurse practitioner, four registered nurses, and four health care assistants. There were a team of six dispensing staff who cover three dispensing practices. The practice also employed a practice manager, additional administrative staff and team of cleaning staff. The GPs, nursing staff and dispensary staff worked across all of the sites. The practice had opted out of providing out-of-hours services to their own patients and refers them to another out of hour's service.

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 the practice as good.**

Specifically, we found the practice to be outstanding for providing responsive services.

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

# Summary of findings

- 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.
- The dispensary and medicines were generally managed well at the practice and responded well to incidents that occurred with medicines management.
- There were systems in place to support the GPs and other clinical staff to improve clinical outcomes for patients.
- Data 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 were proactive in promoting good health.
- There were sufficiently skilled and trained staff working at the practice.
- 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 and had worked over and above contractual obligations. 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 was a clear leadership structure in place and effective governance systems in place.

We saw areas of outstanding practice including:

The practice were responsive in the care they provided to patients.

- The practice had increased the flexibility of access to appointments and could demonstrate the impact of this by reduced use of the out of hours service and very positive patient survey results. The practice worked with three other practices to provide Saturday and Sunday morning clinics specifically to see patients identified as being vulnerable. This prevented some patients being admitted to hospital and improved continuity of care for the patients.
- The GPs worked with the emergency services and first responders by attendeding emergency call-outs to patients in the area. This was done because the nearest ambulance often took 20 minutes to attend to patients. The practice were able to give examples of successful resuscitation.
- An additional service was provided by staff at the practice for patients with indwelling intravenous lines used for prolonged treatments, for example, chemotherapy. Patients were normally required to go to hospital for management of this intravenous line, which is a 50 mile round trip. However, staff at the practice had completed extended training to enable patients to receive care locally, at the practice.
- One of the branches at the practice had a very active carers support and Friends of Constantine group. The group offered services to carers of patients with long term conditions. The group offered services such as Christmas meals, theatre trips, pamper days for carers, a support group and educational sessions. One GP had responded to a need in the community to offer patients a local specialised dermatology service to remove suspected skin cancers. The GP had completed extensive training and audited this service for patient satisfaction, complications and effectiveness. This service had reduced the dermatology referral rate to the local hospital and had reduced the distance patients had to travel for this service.

Other areas of outstanding practice included:

The practice had been EEFO approved. EEFO is a word that has been designed by young people, owned by young people. EEFO works with other community services to make sure they are young people friendly. Once a service has been EEFO approved it means that service has met certain quality standards in, for example, confidentiality and consent, easy to access services, welcoming environment and staff trained on issues young people face. Part of this scheme is the use of a green card. This is a local collaboration between the practice and the local secondary school whereby a young person can request a green card from the school office allowing them to access medical services without the need to be asked lots of questions by teaching staff. The young person is then seen without the requirement to be given an appointment.

# Summary of findings

There were areas of practice where the provider should make improvements.

**Action the provider SHOULD take to improve:**

- Introduce systems that ensure vaccines are always stored at a safe temperature. .
- All clinical staff should receive training in the Mental Capacity Act (2005) The MCA is a legal framework which supports patients who need assistance to make choices and important decisions about their care and treatment

**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 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.

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). However, not all had received training in the MCA. 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 and storage of medicines within the practice and within the dispensary. Prescription stationary was stored and used effectively and in an appropriate way and clear audit trails were in place to show who held the prescription pads.

There were clear processes to follow when dealing with emergencies. Staff had received basic life support training. emergency medicines were available at each of the four sites and had been standardised so staff were familiar with where medicines and equipment could be located in an emergency.

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.

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.

# Summary of findings

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 or slightly higher 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.

Feedback from patients about their care and treatment was consistently positive. The 18 comment cards we received, a friends and family survey and survey data from January 2014 reflected this feedback. Patients described the practice as caring and said they trusted the GPs and knew them well.

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. The practice were accredited and recognised as providing a supportive and caring environment for young patients.

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.

# Summary of findings

**Are services responsive to people's needs?**

**Outstanding** 

The practice is rated as outstanding for providing responsive services.

The practice had initiated positive service improvements for its patients that were over and above their contractual obligations. The practice acted on suggestions for improvements and changed the way they delivered services in response to feedback from the patient participation group (PPG). The practice reviewed the needs of its local population and engaged with external health care professionals and agencies to secure service improvements where these had been identified. For example, The GPs worked with the emergency services and first responders by attending emergency call outs to patients in the area, had introduced an extended minor surgery service by treating patients to remove suspected skin cancers, and managed patients' medical treatmentwhilst in the local community hospital. These services had been introduced to improve the quality of service for patients.

The GPs had responded to the needs of individual patients to improve the service provided, for example by offering extended services locally, to remove the need for patients to travel 50 miles for procedures to take place at the Acute Hospital .

Patients told us it was easy to get an appointment on the same day and appreciated the extended appointment times. The practice had increased the flexibility of access to appointments which included weekend clinics specifically to see patients identified as being vulnerable.

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 the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.

**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 local service which considered the challenges of a rural community.

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

# Summary of findings

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.

Practice data showed that almost 30% of the patient numbers were over the age of 65 and 10% were over the age of 75. The practice GPs and nurse practitioner also care for 58 patients who live in a nearby nursing home.

All registered patients aged 75 and over had an allocated GP but also had the choice of seeing whichever GP they prefer. Patients were invited to attend for Influenza, pneumococcal and shingles vaccinations which were provided at the practice and in community settings. For example, flu clinics had been held in a local village hall for older people with transportation difficulties.

The practice provided and funded regular nurse practitioner sessions at a large local nursing home, in addition to ad-hoc GP visits. The practice recognised the high proportion of elderly patients in the area and provided a higher than average number of home visits (median 10 per day) compared to the national average.

Older patients with complex needs were managed jointly with the community matron. The GPs requested home visits and coordination of both medical and social care by the community matron, in an aim to support frail elderly patients to maintain independence and good health. The practice liaised with a local patient car service and the South Western Ambulance Service to assist booking transport for elderly patients attending hospital appointments.

For patients who were registered for the dispensingservice, the practice dispensary provided medicines in blister packs for older patients with memory problems or had other difficulties. The practice also liaised with local pharmacies to provide this service for the non-dispensing patients. The practice worked alongside the local Acute Care at Home team (LCAH) and ambulatory oxygen supplier to provide same day interventions such as oxygen concentrators, intravenous fluids and antibiotics to appropriate elderly patients who would otherwise require admission to hospital.

The practice identified patients with cognitive impairment. In addition to referral to secondary care dementia services, the practice liaised with and referred to the community dementia practitioner who provided practical support to patients and their families.

# Summary of findings

The practice held monthly multidisciplinary team meetings where patients with complex needs, including end of life care, were discussed. Attendees of these meetings included GP's, the nurse practitioner, district nurses, health visitors, Macmillan nurses and the community dementia practitioner. The team strived to provide good quality palliative care in the community.

The practice provided medical care to one of the larger local nursing homes. The advanced nurse practitioner held a weekly ward round at the beginning of the week to deal with patients' non-urgent problems. This time was also used to proactively identify and manage issues which may be developing. Patients with urgent problems were addressed by one of the practice's GPs with a home visit.

Patients had local support from all four of the organisations sites across the Lizard peninsula throughout the working week. Patients had an option of booking longer appointments if necessary to enable them to cover more than one issue per visit. This cut down on the number of times patients needed to visit the practice. The practice had an open request policy for home visits due to the large proportion of elderly and frail patients and the lack of local public transport. All four sites were provided on the ground floor level and have level access throughout the buildings. There was disabled access in all four buildings with appropriate facilities.

**People with long term conditions**

Good

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

Systems were in place to identify patients with long term conditions. Patients with complex or multiple conditions had a named GP who was responsible for their overall care. The named GPs were responsible for reviewing these patients health and care needs. The practice identified that 100% of the 132 patients who were having their needs pro-actively managed had undergone a review of their care plan in the past three months to ensure that their current care and health needs are being met.

Patients were offered regular diabetes, chronic obstructive airways disease (COPD), and asthma checks with the practice nurses at both the Mullion Health Centre and Constantine Surgery sites. The individual nurses have specialist skills and transferred these between the sites to ensure patients receive the most up to date care and advice. The Advanced Nurse Practitioner (ANP) performed comprehensive reviews of patients with coronary heart disease, cerebrovascular disease and peripheral vascular disease on a yearly basis.

# Summary of findings

Patients with particularly complex long-term conditions were discussed at the monthly multi-disciplinary (MDT) meetings to allow sharing of information between health care professionals both within the practice and the allied teams. These included the district nursing team, community specialist palliative care nurse, community matron, dementia liaison nurse and health visitor. Details of these meetings were minuted and then distributed to all members of staff including those not present at the meeting.

Communication between health care professionals and the practice was enhanced by the use of the clinical system used at the practice. The system was used by the district nursing team and palliative care team. Staff said this improved continuity of care and provided additional safety measures when dealing with complex patients and their chronic needs.

The practice takes part in the local unplanned admissions enhanced service which identified patients who were at risk of emergency admission to hospital. These patients were then invited to attend the practice, or visited in their own homes. The GP and community team then discuss the patient's wishes for future care, preferred place of death and care at end of life.

The GPs and health care professionals also discuss patients with complex health care needs at the monthly MDT meetings. Any trends were then communicated to the Clinical Commissioning Group (CCG) to avoid unnecessary/inappropriate admissions.

Patients with multiple long term conditions received contact from their named GP within three days of discharge from hospital and have a review of their care plan.

The practice ensured that any patients identified as being at their end of life received multidisciplinary care from the district nursing team, community matron and community specialist palliative care nurse where appropriate. Their health issues, social issues, provision of emergency medicines, wishes for care and at time of death were shared with the local out of hour's provider.

The practice worked with the local secondary care renal unit in identifying patients at risk of acute kidney injury and giving them information leaflets advising of medicine side effects.

The practice had achieved higher than average uptake for the Influenza vaccination programme for 2014 -15. The annual national target for patients aged over 65 is 75 %. Mullion Health centre was currently at 73% with three months to go. The NHS Kernow CCG average is 68%.

# Summary of findings

Patients with long-term conditions had the support of the practice nurses in weight loss clinics and ongoing practical and emotional encouragement. Patients with neck and back problems had local access to a physiotherapy provider within one of the practice sites.

Patients with carers had the support of a carer advisor who visits two of the sites weekly to provide practical and financial advice to patient's relatives in a position of caring for a loved one.

The practice had the use of 12 beds at the local community hospital in Helston where patients could be admitted if their medical needs were appropriate. Patients were also discharged here from the local acute hospital for rehabilitation. One of the GPs oversees their care with the support of the practice registrars attached to both Constantine Surgery and Mullion Health Centre. This meant that patients received hospital based care from their own GP enhancing their discharge back into the community. Patients were also admitted to the community hospital for palliative care at the end of life and received multi-disciplinary team input from both a GP at the practice, the nursing team and a community specialist palliative care nurse.

The practice staff offered a service to flush long-line intravenous cannulas in patients who had difficulties in attending the local acute hospital. This avoided the need for patients to travel long distances and wait in busy out-patient clinics for the procedure.

The practice worked with three other local surgeries to provide additional weekend clinics in addition to the current out of hour's provider. Patients who would benefit from being proactively reviewed by a local GP were identified before the weekend in the hope that an unnecessary hospital admission was avoided or to optimise their care.

**Families, children and young people**

Good

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

Parents told us the service their children received was excellent and that the GPs and nurses were responsive in the needs of these children.

Systems were in place to identify children at risk from physical, emotional abuse, or neglect. All members of the family have the same identification within the records to ensure that the risk to other siblings is reduced. This was in line with the recommendations from the Royal College of General practitioners (RCGP) Safeguarding Children and Young People Toolkit.

All staff at the practice had received safeguarding training. The practice also had a children and young person safeguarding lead.

# Summary of findings

The practice was accredited with Level 2 EEFO status. The term EEFO is a word that has been designed by young people, to be owned by young people. EEFO works with other community services to make sure they are young people friendly. Once a service has been EEFO approved it means that service has met the quality standards. For example, confidentiality and consent, easy to access services, welcoming environment and staff trained on issues young people face. Part of this scheme is the use of a green card. This is a local collaboration between the practice and the local secondary school whereby a young person can request a green card from the school office allowing them to access medical services without the need to be asked lots of questions by teaching staff. The young person is then seen without the requirement to be given an appointment.

The practice had also worked with some of the more rural primary schools and local cub scout groups to provide health promotion and also improve links between the schools and the practice. Appointments were available outside of normal school hours to accommodate school-age children.

The practice achieved the higher tier rate (97%) for child immunisation rates for aged 2 (Immunisations) & aged 5 (Pre School Boosters).

Monthly multi-disciplinary meetings were held involving the health visitor among other health care professionals. A health visitor and midwife attended the two main sites on a regular basis to ensure that local young families had access to their support. The GPs were available to provide advice to both health care professional and parents if any concerns arise.

The practice had baby changing facilities and also a room available for women wishing to breast feed in private.

There were a wide variety of contraception services available at the practice including insertion of coils, implants and contraceptive injections.

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

Good

The practice is rated as good for working age people (including those recently retired and students)

The practice provided online services for both appointment requests and repeat prescription requests. This allowed those people whom are working to order these items during times when the practice is closed. Patients told us this system worked well.

# Summary of findings

Telephone consultations were offered for those patients who were unable to make it to the practice with queries which can be dealt with over the telephone. A text message service was available to remind patients of their appointment details.

The practice offered the national "choose and book" service for patients referred on to secondary care for further investigation and treatment. This gave patients the choice of location and time over where they will receive their treatment.

Constantine Surgery provided weekly Wednesday late night appointments with a GP. Mullion Health Centre provided weekly late night appointments using a rolling rota of days of the week. These clinics were advertised on the website, in the practice handbook and on the waiting room monitors.

Health promotion was provided both during consultations, on the website and on the waiting room monitors. The practice provided national NHS Health Checks to patients aged between 40 and 74 years of age to identify risks of ill health later on in life. This was run by the practice nurse team and GPs.

Three of the four sites had a dispensary, but patients also had an option to nominate a pharmacy with longer opening times and availability over the weekend or nearby a place of work.

The practice provided a smoking cessation service with specialist counsellor. There was a wide range of appointment times to make access for this service as easy as possible.

**People whose circumstances may make them vulnerable**

Good

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

The practice had a register to identify patients with a learning disability. The Advanced Nurse Practitioner (ADP) provided learning disability health reviews to ensure health needs were met in a more relaxed and appropriate environment. A carer usually attended these reviews for support and to ensure the patient's views and concerns are taken into consideration. If necessary, these patients were visited at home if they chose.

The practice had a protocol for safeguarding of vulnerable people and had an appointed adult safeguarding lead. All members of staff had received training in safeguarding and were aware of how to identify abuse and knew what action to take if abuse was suspected. There was easy access to guidance when information was required. Adults being identified as vulnerable had an appropriate easily identifiable note on their electronic records to make this easily recognisable to any health care professional meeting with that person.

# Summary of findings

The GPs referred any vulnerable patients to the community matron and dementia liaison member of staff for support. One of the branch surgeries facilitated support groups to carers and their families.

A bed used for patients needing alcohol detoxification was situated at the local community hospital. This service was managed by one of the GP partners at the practice. This meant patients could access inpatient care in their community and receive the support from their friends and family. The practice also held a weekly outpatient clinic with a specialist drug and alcohol treatment charity to provide ongoing support to these vulnerable patients in the community.

Patients with vulnerability due to a number of physical and psychological reasons who were unable to attend the practice were visited at home by the GPs. If these patients felt able to attend the practice, but not wait in the waiting room, they had an option of using a quieter entrance and exit.

**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).

The practice had systems in place to identify patients with mental illnesses. Patients with an enduring mental illness were offered an annual review with the lead GPs in mental health issues. These reviews were an opportunity to ensure the patients mental and physical health needs were being addressed and managed. The GPs used these appointments to develop care plans for use in times of crisis.

Patients with dementia were also offered annual health reviews. These patients were either visited in their own homes or alternative place of residence for this review.

The practice had taken part in a locally enhanced service to improve the identification of and subsequent diagnosis of dementia in patients “at risk”. Staff used a validated tool on identified patients who were assessed as being at risk.

The practice worked with the local community mental health team, with a representative attending the monthly multi-disciplinary meetings. GPs referred patients to a third sector organisation who provided in-house psychological therapies at the practice. This meant that patients did not need to travel significant distances for this treatment.

A dementia liaison nurse worked closely with the GPs and community matron to diagnose cases of dementia, provide support and advice to the practice team and to the patients and their carers. The nurse attended the monthly multi-disciplinary meetings.

# Summary of findings

## What people who use the service say

We spoke with seven 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 18 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 many 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 with, from the friends and family test results from the last two months and from looking at the survey from January 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. 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 10.30am appointment at 9am that morning. They told us the receptionists tried to fit them in where possible. Parents said emergency appointments for children were treated with priority.

Patients knew how to contact services out of hours 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.

## Areas for improvement

**Action the service SHOULD take to improve**

- Introduce systems to minimise risks of all vaccine fridges becoming unplugged.
- All clinical staff should receive training in the Mental Capacity Act (2005) The MCA is a legal framework which supports patients who needs assistance to make important decisions.

## Outstanding practice

The practice were responsive in the care they provided to patients. This can be demonstrated by:

- The practice had increased the flexibility of access to appointments and could demonstrate the impact of this by reduced use of the out of hours service and very positive patient survey results. The practice worked with three other practices to provide Saturday and Sunday morning clinics specifically to see patients identified as being vulnerable. This prevented patients being admitted to hospital and improved continuity of care for the patients.
- The GPs worked with the emergency services and first responders by attended emergency call outs to

patients in the area. This was done because the nearest ambulance often took 20 minutes to attend to patients. The practice were able to give examples of successful resuscitation.

- An additional service was provided by staff at the practice for patients with indwelling intravenous lines used for prolonged treatments. For example, chemotherapy. Patients were normally required to go to hospital for management of this intravenous line, which is a 50 mile round trip. However, staff at the practice had completed extended training to enable patients to receive care locally, at the practice.
- One of the branches at the practice had a very active carers support and Friends of Constantine group. The group of volunteers performed fundraising to by additional equipment including additional automated external defibrillators (used to attempt to restart a person's heart in an emergency). The group also offered services to carers of patients with long term conditions. The group offered services such as Christmas meals, theatre trips, pamper days for carers, a support group and educational sessions.
- The practice had 12 beds at the local community hospital in Helston where practice patients could be admitted for rehabilitation, palliative care and alcohol detoxification. GPs at the practice manages the care with the support of the practice registrars attached to both Constantine Surgery and Mullion Health Centre. This meant that patients received hospital based care from their own GP whilst remaining in their community.
- One GP had responded to a need in the community to offer a local specialised dermatology service to remove suspected skin cancers. This GP had completed extensive training and audited this service for patient satisfaction, complications and effectiveness. This service had reduced the dermatology referral rate to the local hospital and had reduced the distance patients had to travel for this service.

Other areas of outstanding practice included:

- The practice had been EEFO approved. EEFO is a word that has been designed by young people, to be owned by young people. EEFO works with other community services to make sure they are young people friendly. Once a service has been EEFO approved it means that service has met the quality standards. For example, confidentiality and consent, easy to access services, welcoming environment and staff trained on issues young people face. Part of this scheme is the use of a green card. This is a local collaboration between the practice and the local secondary school whereby a young person can request a green card from the school office allowing them to access medical services without the need to be asked lots of questions by teaching staff. The young person is then seen without the requirement to be given an appointment.

# Mullion 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 Mullion Health Centre

Mullion Health Centre was inspected on Wednesday 18 February 2015. This was a comprehensive inspection.

The CQC intelligent monitoring placed the practice in band 5. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP activity and patient experience. This includes the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being give by the GP practice. This only comes after a CQC inspection has taken place.

The practice provided primary medical services to approximately 7,750 patients. The practice consisted of four sites. Mullion Health centre and Constantine were the main sites, with two smaller branches which opened part time during the week. These were located in the villages of Ruan Minor and Lizard. Ruan Minor, Constantine and Lizard were dispensing practices and dispensed medicines to approximately half of the practice population. 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 five male GP partners and two female GP partners. Partners hold managerial and financial responsibility for running the business. Some of the GPs work part time. Collectively their working hours are the equivalent of employing 5.6 staff. The team were supported by a nurse practitioner, four registered nurses, and four health care assistants. There were a team of six dispensing staff who cover three dispensing practices. The practice also employed a practice manager, additional administrative staff and team of cleaning staff. The GPs, nursing staff and dispensary staff worked across all of the sites.

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 had opted out of providing out-of-hours services to their own patients and refers them to another out of hour's service. However, the practice were working with three other practices to provide Saturday and Sunday morning clinics specifically to see patients identified as being vulnerable. This prevented patients being admitted to hospital and improved continuity of care for the patients.

## 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?
- 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 Mullion 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 18 February 2015. We spoke with 9 patients, five GPs, a GP registrar (GP in training) four of the nursing team and four of the management and administration team. We spoke with a representative of the patient participation group (PPG) and collected 18 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. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example staff used the practice computer system to access relevant documentation and said all events and complaints were discussed at the monthly management meetings. For example, GPs had identified a medicine meant for short term use had been given for an extended length of time. This was responded to immediately by reviewing the patient and then being discussed at the weekly partners meetings and re-reviewed at the management meetings to ensure the chance of reoccurrence had been reduced.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last two years. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

**Learning and improvement from safety incidents**

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last two years and we were able to review these. Significant events were discussed as they arose and coordinated by the practice manager. They were also a standing item on the monthly practice management meeting agenda to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so. Staff said there was a no blame culture operated at the practice.

There were systems in place to make sure any medicines alerts or recalls were actioned by staff. The practice kept a record of all its dispensing errors and stated that they reviewed these for trends so that lessons could be learnt and procedures changed if necessary to reduce the risks in future. These errors were recorded and managed using the significant error system.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. We saw the system used to manage and monitor incidents. We tracked three incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example theft of prescription pads had resulted in improved security and processes for auditing where these were distributed. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated using email and the computer message system. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at clinical meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

**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 relevant role specific training on safeguarding. We asked GPs, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible using the practice policies located on the computer system.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary higher level training to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

Good

# Are services safe?

There was a system to highlight vulnerable patients and their families, where appropriate, 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.

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 nursing staff, including health care assistants, had been trained to be a chaperone.

**Medicines management**

There were dispensaries at three of the four branches. There were refrigerators in the dispensaries and in the treatment rooms for any items requiring cold-storage and there was monitoring of temperatures. The electrical plugs to those at Constantine surgery were not easily accessible. 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. Staff explained they had a significant event the day before when a plug had been removed from the socket despite a label warning against this. Staff had followed the policy, managed and reported this event appropriately and disposed of many vaccines.

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

Records of practice meetings showed that actions had been taken in response to review prescribing data. Audits had taken place of the prescribing of antibiotics and high cost medicines. Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance. Up to date patient group directions giving staff authority to administer vaccines had been adopted by the practice. Copies of these were located at the branch surgeries. Nurses had received appropriate training to administer vaccines.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. For example, how staff who generate prescriptions were trained and how changes to patients' repeat medicines were managed safely and effectively. At the time of the inspection repeat prescriptions, including those for controlled drugs, were not reviewed or signed by a GP before they were dispensed or given to the patient. By the end of the inspection day this practice had stopped and processes put in place to prevent reoccurrence. Risk assessments for repeat prescriptions were written and produced within 48hours of the inspection and standard operating procedures amended to instruct staff on the safe dispensing of medicines.

Manufacturer's patient information leaflets were supplied with all dispensed medicines. Patients said they had received enough information about their medications which included side effects and how to take the medicine.

There was a system for the management of high risk medicines which included regular monitoring in line with national guidance. Appropriate action was taken based on results.

Prescription pads and blank prescription forms for printing were stored securely, and were handled in accordance with national guidance as they were tracked through the practice. The practice held 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 always followed by the dispensary staff. There were arrangements in place for the destruction of controlled drugs.

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.

The practice used liquid nitrogen at the practice. We were supplied with risk assessments, evidence of staff training and saw the storage and protective equipment used were appropriate.

**Cleanliness and infection control**

We observed the premises to be clean and tidy. The practice employed their own cleaning staff who followed

the cleaning schedules in place and maintained cleaning records. Patients told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy. Staff received induction training about infection control specific to their role and received annual updates. Infection control audits had been conducted every three months. Any improvements identified for action had been completed on time. These actions had included introduction of more foot operated pedal bins and replacement of chairs which would be cleaned and disinfected easily.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an 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 and toilets.

The practice had a policy for the management, testing and investigation of legionella. Records confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

**Equipment**

Staff told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly, equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date of July 2014. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometers.

**Staffing and recruitment**

Records contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Nursing staff said they tried to cover for each other where possible but also had a small team of nurses to use where needed.

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.

**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. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Any identified risks were discussed at GP partners' meetings and within team meetings. For example, the practice manager had shared the recent findings from an infection control audit with the team.

Staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example, during the inspection GPs and nursing staff responded calmly and promptly to an unwell child and organised ambulance transfer to the local acute hospital.

The GPs were also able to provide examples of responding to emergencies of other patients including those with long term conditions and mental health crisis.

**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 in all four sites. The content of these bags were reviewed by the basic life support trainer each year. This included 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 it was checked regularly. Staff had explained that all four sets of equipment was set up in the same way so staff working across all four sites could easily locate equipment and medicines in the bag.

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

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised fire drills.

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. Staff said new guidelines were discussed at clinical and management meetings where the implications for the practice's performance and patients were discussed and required actions agreed. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines and discussions with specialist health care professionals when appropriate.

The GPs and practice nurses told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and said they received support and advice from each other. GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of respiratory disorders. Our review of the clinical meeting minutes confirmed that this happened.

Data from the local CCG showed that practice's performance for antibiotic prescribing was comparable to similar practices. Other data also showed that the practice had not been noted to be outliers in any other prescribing data.

Patients with specific conditions were reviewed to ensure they were receiving appropriate treatment and regular review. For example, blood pressure monitoring. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of suspected cancers. Systems were in place to make sure these patients were seen within two weeks. One GP performed minor surgery to remove suspected skin cancers. This service had reduced the dermatology referral rate to the local hospital and had reduced the distance patients had to travel for this service.

Interviews with GPs and practice nurses 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.

**Management, monitoring and improving outcomes for people**

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

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures).

The practice showed us examples of the clinical audits that had been undertaken in the last two years. The majority of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example a recent audit was conducted after a significant event involving a patient taking a medicine for longer than the recommended time. The GPs looked at the other patients taking this medicine which has variable treatment length. The audit identified 12 patients who had exceeded the recommended time limit. The audit recognised that in some cases the hospital consultant had not specified a stop date. Action from the audit and significant event including improved documentation of treatment length on the prescription and in the patient's records. The GPs had booked a date to re-audit this to make sure the learning points were still being effective. Other examples included audits to confirm that the GP who undertook minor surgical procedures was doing so in line with their registration and National Institute for Health and Care Excellence guidance. For example there had been 40 excisions performed at the practice. All but one, (97.5%) had been completely excised. The one incomplete excision had been on a patient who had refused hospital treatment.

Good

# Are services effective?

## (for example, treatment is effective)

Other examples of clinical audit showed that the practice had a system in place for completing and repeating clinical audit cycles. Following each clinical audit, changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national) clinical targets.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, 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. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary. The evidence confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. The practice also used beds in a local community hospital to provide end of life care with community health care professionals. This meant that patients who could not or chose not to die at home could be cared for in a hospital closer to home.

**Effective staffing**

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the GPs. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. The practice was a training practice. Doctors who were training to be qualified GPs told us they were offered support, extended appointments and had access to a senior GP throughout the day for support. We received positive feedback from the trainee we spoke with.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines and cervical cytology. The nurses with extended roles who managed patients with long-term conditions such as asthma, Chronic Obstructive Pulmonary Disease (COPD), diabetes and coronary heart disease 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 patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. All staff we spoke with understood their roles and felt the system in place worked well even during staff absences.

The practice held multidisciplinary team meetings monthly to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information. The community matron was based at the practice. Staff said this helped with communication.

Good

# Are services effective?

## (for example, treatment is effective)

We spoke with two health care professionals. Both said they thought the care and treatment provided at the practice was very good and that practice staff worked well and communicated effectively with them.

**Information sharing**

The practice used several electronic systems to communicate with other providers. For example, the computer system used by the practice could be accessed by other health care professionals and out of hours providers to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals. The practice made referrals through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that this system was easy to use.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record (SystmOne) 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. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

**Consent to care and treatment**

We found that staff were aware of the Mental Capacity Act (MCA) 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. Not all staff had accessed MCA training, although this was available on the eLearning system used. GPs were able to share specific scenarios where capacity to make decisions was an issue for a patient and what action had been taken. For example, supporting a patient in a mental health crisis with decision making.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually or more frequently if changes in clinical circumstances dictated it. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies and Fraser guidelines. 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.

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's written consent was documented and stored in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure. We were shown an audit that confirmed the consent process for minor surgery had being followed in 100% of cases. Consent for other procedures, including immunisations and cervical screening were recorded using set templates within the patient records.

**Health promotion and prevention**

New patients were offered a health check and any health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic blood pressure checks, and offering smoking cessation advice to smokers.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Patients appreciated that the GPs offered this service.

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 100% had been offered an annual physical health check in the last 12 months.

There was a good uptake of physical assessments for those with serious mental illness. For example, the practice were currently at 75% of target this QOF year. GPs did these checks at the patients home or at short notice on a patients better day. Support included developing crisis plans so that at the time of need those involved can provide an appropriately tailored response. The GPs explained that these patients were given opportunistic checks when they came to the practice. For example, an electrocardiogram (ECG).

Good

# Are services effective?

## (for example, treatment is effective)

The practice's performance for cervical smear uptake was comparable to others in the CCG area. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend. There was also a named member of staff responsible for following up patients who did not attend screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was above average for the CCG, and again there was a clear policy for following up non-attenders by the named practice nurse.

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 a national survey performed in January 2013, and a survey undertaken by the practice's patient participation group (PPG) in January 2014. We were also provided with patient feedback from the friends and family test between December 2014 and March 2015. The evidence from these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the patient survey showed the practice was rated higher than the national average for all outcomes including consideration, reassurance, confidence in ability and respect. The friends and family test had resulted in 34 responses. All comments were very complimentary and showed that the patients were extremely likely or likely to recommend their friends and family.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 18 completed cards all of which contained detailed positive feedback about the service provided. 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.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable 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 / 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 switchboard was located away from the reception desk which helped keep patient information private.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager.

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

Patients we spoke with on the day of our inspection told us that health issues were discussed 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 we received was 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. There were notices in the reception areas informing patents this service was available.

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

The patients we spoke with on the day of our inspection and the comment cards we received showed that they were given enough emotional support. These views were sported by the national survey which showed that 87% of respondents stated their views were considered and that they felt supported. The national average was 80%.

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

One of the branches at the practice had a very active carers support and 'Friends' group. The group of volunteers performed but also offered services to carers of patients with long term conditions. The group offered services such as Christmas meals, theatre trips, pamper days for carers, a support group and educational sessions.

Staff told us that if families had suffered bereavement, their usual GP contacted them. 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. Patients we spoke with who had had a bereavement confirmed they had received this type of support and said they had found it helpful.

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 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.

The practice welcomed feedback from patients and external bodies and used significant events, complaints and near misses to improve the services provided. Response to these events was prompt.

The practice implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). This had included improving communication about the extended appointments at the branches and when the GPs and nurses were running late with their clinic times.

**Tackling inequity and promoting equality**

The practice had recognised the needs of different groups in the planning of services. For example, the practices were located in a rural area of Cornwall, 20 miles from the nearest city and 25 miles from the nearest acute NHS trust. Some patients did not have easy access to public transport links.

The GPs worked with the emergency services and first responders and attended emergency call outs to patients in the area. This was done because the nearest ambulance could often take 20 minutes to attend to patients. The practice were able to give examples of successful resuscitation.

An additional service was provided by staff at the practice for patients with indwelling intravenous lines used for prolonged treatments, for example, chemotherapy. Patients were normally required to go to hospital for management of this intravenous line, which involved a 50 mile round trip. However, staff at the practice had completed extended training to enable patients to receive care locally, at the practice.

One of the branches at the practice had a very active carers support and Friends of Constantine group. The group of volunteers performed fundraising to buy additional equipment including additional automated external defibrillators (used to attempt to restart a person's heart in an emergency). The group also offered support to carers of patients with long term conditions with services such as Christmas meals, theatre trips, pamper days for carers, a support group and educational sessions to help prevent social isolation.

The practice had 12 beds at the local community hospital in Helston where practice patients could be admitted for rehabilitation, palliative care and alcohol detoxification. GPs at the practice managed the medical care with the support of the practice registrars attached to both Constantine Surgery and Mullion Health Centres. This meant that patients were able to receive hospital based care from their own GP whilst remaining in their community.

One GP had responded to a need in the community to offer a local specialised dermatology service to remove suspected skin cancers. This GP had completed extensive training and audited this service for patient satisfaction, complications and effectiveness. This service had reduced the dermatology referral rate to the local hospital and had reduced the distance patients had to travel for this service.

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 patents this service was available.

The practice had been EEFO approved. EEFO is a word that has been designed by young people, to be owned by young people. EEFO works with community services to make sure they are young people friendly. The practice had been awarded a higher level for being approachable and showed the practice had met the quality standards. For example, confidentiality, consent, easy to access services, welcoming environment and staff trained on issues young people face. Part of this scheme was the use of a green card. This is a local collaboration between the practice and the local secondary school whereby a young person can request a green card from the school office allowing them to access medical services without the need to be asked lots of questions by teaching staff.

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 which had been fitted with grab rails.

Outstanding ☆

# Are services responsive to people's needs?

## (for example, to feedback?)

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.

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 and baby changing facilities available.

**Access to the service**

Appointments were available from 08:30 am to 6pm on weekdays and both main branches and half days on four days a week at the two small branch surgeries. Patients could see a GP at Constantine surgery until 8pm once a week. The practice also worked with three other practices in the area to provide Saturday and Sunday morning clinics specifically to see patients identified as being vulnerable.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent 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.

The practice had responded to the rural location of the practices and to the needs of patients by increasing the flexibility of access to appointments. The practice had extended some appointment times for patients who required longer sessions. This also included appointments with a named GP or nurse. The practice also worked with three other practices to provide Saturday and Sunday morning clinics specifically to see patients identified as being vulnerable. This prevented patients being admitted to hospital and improved continuity of care for the patients. The response made by the practice had reduced patient use of the out of hours service and resulted in very positive patient survey results.

Home visits were made to a large local nursing home on a weekly basis but also at any other time if required, by a named GP the nurse practitioner.

Patients were pleased with the appointments system. They confirmed that they could see a GP on the same day if they needed to. Two patients had made their mid-morning appointments that morning and said that they had never been turned away.

Patient feedback about access to appointments was reflected in the national survey. For example 99% of respondents said the last appointment they made was convenient and 88% of respondents were satisfied with the practice opening times. This survey had resulted in practice staff improving ways of informing patients about the extended appointment times.

**Listening and learning from concerns and complaints**

The practice viewed complaints as part of the quality improvement process. There was a system in place for handling complaints and concerns. The complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice manager was the designated responsible person who handled all complaints in the practice.

Posters and website information was available to help patients understand the complaints system. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at the nine complaints received in the last 12 months and found and saw they were satisfactorily handled. The complaints were dealt with in a timely way with openness and transparency.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on. For example, prescription administration error complaints had resulted in a review of the patient's prescriptions, an apology to the patient and action by dispensary staff and GPs.

# 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**

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at a sample of these policies and procedures. All policies and procedures we looked at had been reviewed annually and were up to date.

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. We spoke with eight members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. Audits were performed in response to significant events, complaints, prescribing data and clinical data results. The GPs also conducted audits in response to the service they provided and for areas of interest to them. For example, the GP responsible for minor surgery produced detailed audit findings for patient satisfaction, complications and effectiveness.

The practice held monthly management meetings where governance issues were discussed as standing agenda items. We looked at minutes from previous meetings and found that performance, quality and risks had been discussed.

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.

**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 that team meetings were held regularly but issues were discussed and sorted as they happened too. For example, nurses said there had been a significant event with the temperature control of the vaccines in one of the fridges. All staff were immediately informed and the situation was managed, Staff said this would then be discussed informally during the working day but more formally reviewed at the clinical meetings and management meetings. Staff told us that there was an open culture within the practice and said they had the opportunity and were happy to raise issues at team meetings.

The practice manager was responsible for human resource policies and procedures. We reviewed the recruitment policy and induction programme which were in place to support staff. We were shown the electronic information that was available to all staff, which included sections on employment and whistleblowing. Staff we spoke with knew where to find these policies if required.

**Seeking and acting on feedback from patients, public and staff**

The practice had gathered feedback from patients through patient surveys, suggestions, friends and family test and any complaints received. We looked at the results of the annual patient survey and saw that patients from the patient participation group (PPG) agreed that more communication about extended appointments would be useful. As a result of this the practice had put this information on the screen and clearly on the web site.

# 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 active patient participation group (PPG). The PPG included representatives from some but not all of the population groups. A representative said they were going to try changing the meeting time to attract younger members. The PPG had influenced the questions in the recent survey and the on line appointment system. Representatives said communication was good with the practice and they appreciated being kept up to date by the practice manager.

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.