Petroc Group Practice

Quality Report

St Columb Major Surgery
Trekenning Road
St Columb
Cornwall
TR9 6RR
Tel: 01637 880359
Website: https://www.petrocgroupppractice.co.uk

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

Ratings

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

Summary of findings

Contents

Summary of this inspection

Page

Overall summary 2
The five questions we ask and what we found 4
The six population groups and what we found 6
What people who use the service say 10
Areas for improvement 10
Outstanding practice 10

Detailed findings from this inspection

Our inspection team 11
Background to Petroc Group Practice 11
Why we carried out this inspection 11
How we carried out this inspection 11
Detailed findings 13
Action we have told the provider to take 24

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at St Columb Major practice on 17 February 2015. Overall the practice is rated as good.

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

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

- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- There was a commitment to providing well co-ordinated, responsive and compassionate care for patients.
- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following current practice guidance.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care. Urgent appointments were available the same day and staff were flexible and found same day gaps for patients needing routine appointments.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

Summary of findings

- Audits were used by the practice to identify where improvements were required. Action plans were put into place and audits repeated to ensure that improvements had been made.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The practice had a vision and a strategy. However, there was a lack of governance cohesiveness which we highlighted at the inspection. We found specific gaps in communication and systems, which would if improved enhance governance arrangements at the practice.

We saw areas of outstanding practice including:

- The continuing development of practice staff and those of other agencies are recognised as integral to ensuring high quality, responsive emergency care. With no land based ambulance station in an area of 200 square miles, the practice has a highly qualified and skilled team who provide rapid emergency assessment and treatment for patients en-route to the main hospital from all areas of North Cornwall. One of the GP partners is an Advanced Life Support instructor working with the Resuscitation Council UK and is also a Royal College of Surgeons Pre Hospital Life Support Instructor. This GP provides training for all paramedics in Cornwall as well staff at the practice and other organisations including the Lifeboat service. The practice is well equipped with the same level of emergency equipment seen at the local Accident & Emergency Unit.

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

Importantly the provider must:

Ensure that there is proper and safe management of medicines by:

- Ensuring that nurses always work from the most up-to-date guidelines about vaccinations.
- Blank prescription forms and prescription pads are handled in accordance with national guidance, providing an audit trail through the practice to demonstrate that they are kept secure at all times.

The provider should:

- Ensure that records are kept of recruitment checks carried out for locum staff, including checks of the performers list.
- Have a mechanism which provides oversight of skills and training needs across the whole team utilising information from the appraisal system. This should ensure that there is proactive management of training to provide triggers for when updates are due and identifies if staff have any gaps in training or skills.
- Staff responsible for managing Health & Safety should have the appropriate skills and training to manage COSHH risks associated with identified hazards and carry out actions to reduce these.
- Create greater cross communication across staff groups to ensure that audit and governance systems remain effective. For example, there was limited collaboration and involvement of nurses in clinical and strategy at the practice. Practice nurses should be actively invited to attend multidisciplinary meetings about vulnerable patients, and involved at strategic level in analysis of all significant events and complaints.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services.

Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff and the practice demonstrated they reviewed resources in line with patient needs. Recruitment practices mostly ensured that staff were fit to work at the practice or safe to carry out chaperone duties. The management of medicines required improvement regarding the security of prescription stationary and authorisation of staff in relation to vaccinations. Staff responsible for managing Health and Safety needed additional training and support to ensure that hazardous substances were adequately controlled and risks reduced to staff and patients.

Are services effective?

Good

The practice is rated as good for providing effective services.

Data showed patient outcomes were at or slightly above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Petroc Group Practice is a training practice and the quality of training and support provided for trainee GPs and doctors was positive. Staff had received training appropriate to their roles. GPs worked with multidisciplinary teams, which included strong links with other health and social care professionals supporting patients at the end of their lives.

Are services caring?

Good

The practice is rated as good for providing caring services.

Data showed patients rated the practice higher than others for some aspects of care. All of the 38 patients involved in the inspection gave positive feedback. A common theme was that the staff were supportive and patients were always treated with respect and compassion. Staff promoted patient privacy and dignity. Information was available to help patients understand the care available to them.

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice recognised the needs of specific occupational groups and tailored health monitoring and extended appointments around these. 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. The practice had responded quickly to issues raised. Learning from complaints with staff and other stakeholders was reviewed and acted upon by GPs.

Are services well-led?

Good

The practice is rated as good for providing well-led services.

The practice had a vision and a strategy. There was a documented leadership structure and staff felt supported by management. There were some governance systems in place to monitor, review and mitigate risk within the practice. We highlighted that communication and systems could be improved to further strengthen quality assurance. Patient safety systems were effective. Staff had received inductions and attended staff group team meetings. The practice proactively sought feedback from patients, which it acted on. The patient participation group (PPG) was active. The practice had strong links with the Peninsular Medical School Deanery providing GP education.

Summary of findings

The six population groups and what we found

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

Older people

Good

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

All older patients at the practice had a named GP. Vulnerable older people were identified, closely monitored and supported to reduce the risk of unplanned hospital admissions. For those people who did require hospital care, newly discharged patients were contacted within three days of leaving hospital to ensure their needs were met.

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

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

The practice signposted people to carers clinics run by a community support worker to provide additional help for carers.

People with long term conditions

Good

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

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

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

Summary of findings

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

The practice recognised the needs of patients and their difficulty with transport to the hospital for appointments. The hospital based diabetes and heart failure nurse specialists held clinics to see patients across three of the four practices, including the St Columb Major one. This was appreciated by patients we spoke with who were in this position as it avoided them having to travel to the main hospital approximately 17 miles away

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

Families, children and young people

Good

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

All patients had a named GP. Emergency processes were in place for acutely ill children, young people and acute pregnancy complications. The practice recognised the isolation of the coastal location and distance to the nearest main hospital from other villages North of the practice. GPs held advanced life saving qualifications and had specialist equipment on site to deal with paediatric emergencies and supported ambulance personnel with these.

The practice worked collaboratively with midwives, health visitors and school nurses to deliver antenatal care, child immunisation and health surveillance. Parents were signposted to services where parenting support was available. Safeguarding was taken seriously at the practice, with all staff trained to recognise and report any suspected abuse.

Young children were seen quickly at routine appointments and those of school age were able to attend outside of school hours.

The practice was designated as a young person friendly practice having achieved quality standards for information and support available. For example, information about contraception and promotion of health was targeted for young people. Young people had access to information and could request chlamydia screening.

Summary of findings

Practice staff understood issues around consent and demonstrated how they assessed whether a child had the maturity to make their own decisions and to understand the implications of those decisions.

Working age people (including those recently retired and students)

Good

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

All working age patients at the practice had a named GP. The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, tailored monitoring of patients working in the sea fishing and agriculture industries was flexible, risk based and person centred. Extended hours, telephone consultations and tailored medication regimes were available.

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

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

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

People whose circumstances may make them vulnerable

Good

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

All patients had a named GP. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks for people with a learning disability. It offered longer appointments for up to an hour for people with a learning disability and their carers for reviews.

Health education, screening and immunisation programmes were offered as appropriate. This included alcohol and drug screening. Patients with alcohol addictions were referred to an alcohol service for support and treatment and to the local drug addiction service. Onsite counselling services provided by the local mental health partnership trust were available for patients and this included a self-referral service.

Summary of findings

The practice worked closely with the community nursing staff to arrange visits to vulnerable patients to assess and arrange any equipment or other assistance needed by the patient and their carers. Systems were in place to help safeguard vulnerable adults.

The practice welcomed all patients to the practice and had systems in place to temporarily register people if needed. Homeless patients needing specialised care were signposted to a service in Truro.

People experiencing poor mental health (including people with dementia)

Good

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

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

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

Patients with depression or addictions, needing time limited, low key counselling services were able to refer themselves or be referred to counselling services in the community. The practice had a system in place to follow up patients diagnosed with depression if they did not attend appointments.

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

Summary of findings

What people who use the service say

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

We received 31 comment cards and spoke with six patients and one member of the Patient Participation Group (PPG). All comments received verified that patients found the staff helpful, caring and polite and described their care as very good.

Our findings were in line with results received from the National GP Patient Survey. For example, the national GP patient survey results for 2013/14 showed that 91.81% of patients described their overall

experience of this surgery as fairly good or very good, which is above the national average of 85.75%.

Areas for improvement

Action the service MUST take to improve

Ensure that there is proper and safe management of medicines by:

- Having patient group directions in date so that nurses are working from the most up-to-date guidelines about vaccinations.
- Blank prescription forms and prescription pads were not handled in accordance with national guidance as these was not an audit trail through the practice and they were not kept securely at all times.

Action the service SHOULD take to improve

- Ensure that records are kept of recruitment checks carried out for locum staff, including checks of the performers list.
- Have a mechanism allowing oversight of skills and training needs across the whole team through the appraisal system, so that there is proactive management of training needs and provides triggers when updates are due.
- Staff responsible for managing Health & Safety should have the appropriate skills and training to manage COSHH risks associated with identified hazards and carry out actions to reduce these.
- Create greater cross communication across staff groups to ensure that audit and governance systems remain effective. For example, there was limited collaboration and involvement of nurses in clinical and strategy at the practice. Practice nurses should be actively invited to attend multidisciplinary meetings about vulnerable patients, and involved at strategic level in analysis of all significant events and complaints.

Outstanding practice

- The continuing development of practice staff and those of other agencies are recognised as integral to ensuring high quality, responsive emergency care. With no land based ambulance station in an area of 200 square miles, the practice has a highly qualified and skilled team who provide rapid emergency assessment and treatment for patients en-route to the main hospital from all areas of North Cornwall. One of the GP partners is an Advanced Life Support instructor working with the Resuscitation Council UK and is also a Royal College of Surgeons Pre Hospital Life Support Instructor. This GP provides training for all paramedics in Cornwall as well staff at the practice and other organisations including the Lifeboat service. The practice is well equipped with the same level of emergency equipment seen at the local Accident & Emergency Unit.

Petroc Group Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP, CQC pharmacist inspector, practice nurse and quality assurance specialist advisors.

Background to Petroc Group Practice

The GP partnership runs the Petroc Group Practice comprising of four registered locations. The main one is at St Columb Major with three other practices at St Columb Road, Padstow and St Merryn Surgery. This inspection focussed on services provided at the St Columb Major practice, which has a dispensary.

At the time of our inspection there were 15,927 patients registered at the Petroc Group Practice, with 7300 receiving services at the St Columb Major practice. There is a higher percentage of patients over 45 years and slightly fewer children when compared to national averages. The practice looks after patients from specific occupations which requires a tailored approach to care and appointments and includes workers from the fishing industry, lifeboat personnel and farming industry. There are no secondary schools in close proximity to the practice and young people attend these at Wadebridge and Newquay.

Petroc Group Practice is contracted with NHS England, Devon and Cornwall Area Team to provide general medical services to people living in St Columb Major and the surrounding rural and coastal villages, where the level of social deprivation is in the mid range. The practice provides some enhanced services under contract with Kernow CCG which are above what is normally required covering the childhood vaccination and immunisation scheme, extended hours access, facilitating timely diagnosis and support for people with dementia, influenza and pneumococcal immunisations as well as monitoring the health needs of people with learning disabilities. The practice also provides direct enhanced services including remote care monitoring for vulnerable patients and shingles and rotavirus vaccination.

There are 14 GPs at Petroc Group practice who cover a rota seeing patients at the four practices in the group. Of these, there are eight GP partners holding managerial and financial responsibility for running the business. The GPs are supported by five female and one male registered nurses, one of whom is a nurse practitioner with prescribing qualifications. Three female healthcare assistants provide additional support. The practice has a dispensary manager and dispensing assistants, a practice manager, additional administrative and reception staff. Petroc Group Practice is a training practice, with three GP partners approved to provide vocational training for GPs, second year post qualification doctors and medical students. There was one GP registrar on placement when we inspected the practice.

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

St Columb Major practice is open from 8 am – 6.30 pm Monday to Friday with appointments available between 9am - 5 pm. Extended opening hours are held from 6.30 – 8.30 pm on Tuesday and Thursday providing appointments for working patients. The practice also provides appointments before and after clinics by agreement for working patients. The dispensary at St Columb Major is open from 9am - 12.45pm and from 2.30pm - 5pm.

Detailed findings

During evenings and from Saturday afternoon onwards for the rest of the weekend, when the practice is closed, patients are directed to an Out of Hours service delivered by another provider. This is in line with other GP practices in the Kernow clinical commissioning group.

Why we carried out this inspection

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

How we carried out this inspection

Before visiting the practice, we reviewed a range of information we held about the service and asked other organisations, such as the local clinical commissioning group, local Health watch and NHS England to share what they knew about the practice. We carried out an announced inspection of the St Columb Major practice and dispensary on 17 February 2015.

During our visit we spoke with 14 staff; 6 GPs, the practice manager, 2 registered nurses, 1 healthcare assistant, a phlebotomist, administrative and reception staff. We also spoke with 5 patients who used the practice and met a representative of the patient participation group. We observed how patients were being cared for and reviewed 31 comment cards where patients shared their views about the practice, and their experiences. We also looked at documents such as policies and meeting minutes as evidence to support what staff and patients told us.

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

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

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

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

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

We reviewed safety records, incident reports and minutes of meetings for 2014 where these were discussed. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term. For example, the practice ran a regular report about significant events which minutes showed was discussed, actions agreed and monitored. Staff were readily able to locate this information and describe learning and changes made.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. All of the staff were familiar with this system and gave examples of shared learning. There was a formal review process for reviewing significant events, which ensured these were discussed by GPs at the practice meeting every month. Nursing staff verified that they did not attend these meetings. Minutes recorded actions from past significant events and complaints. The practice had an educational meeting programme at which safety incidents were discussed. Learning from significant was shared verbally and electronically across the entire practice team and changes made where necessary.

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

Reliable safety systems and processes including safeguarding

Systems were in place to manage and review risks to vulnerable children, young people and adults. The practice had a named GP lead for safeguarding vulnerable adults and children. The policy for safeguarding children referred to 2010 national documents and had not been updated to include guidance from the document 'Working Together 2013 and Intercollegiate Guidelines 2014' and the Royal College of GPs Safeguarding Toolkit 2014. Discussions with staff demonstrated that they were following these principles in practice.

Training records showed that all staff had received relevant role specific training on safeguarding. For example, of the GPs had completed training at level 3 for safeguarding vulnerable children and had completed awareness and alerter training for safeguarding adults.

The practice had a computer system for patients' notes and there were alerts on a patient's record if they were at risk or subject to protection. However, templates used to assess patients with mental health issues did not identify whether they had parental responsibilities or what support their children might need at times of crisis. A chaperone policy was available on the practice's computer system. The practice nurses and health care assistants acted as chaperones if required and a notice was in the waiting room to advise patients the service was available should they need it. Staff had received training to carry out this role and all staff had received a Disclosure and Barring Service (DBS) check.

Medicines management

St Columb Major practice had dispensary on site. Medicines stored in the treatment rooms and medicine refrigerators were stored securely and only accessible to authorised staff. There was a refrigerator for medicines held for the dispensary and in the treatment room for any items requiring cold-storage. There was a clear policy for ensuring medicines were kept at the required temperatures. This was being followed by the practice staff, and the action to take in the event of a potential failure was described.

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. We saw records of practice meetings that noted actions taken in response to review prescribing data. Audits had taken place of the prescribing of antibiotics and high cost medicines

Vaccines were not administered by nurses using directions that had been produced in line with legal requirements and national guidance. We saw that only four of the patient group directions were in date and therefore the nurses

were not working from the most up-to-date guidelines for all vaccines given. After the inspection, the practice confirmed that 32 patient group directions had been reviewed, dated correctly and signed off by a senior GP partner. 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. This helped to ensure that patient's repeat prescriptions were still appropriate and necessary. All the repeat prescriptions were reviewed and signed by a GP before they were dispensed or given to the patient. Manufacturer's patient information leaflets were supplied with all dispensed medicines.

Blank prescription forms and prescription pads were not handled in accordance with national guidance as these was not an audit trail through the practice and they were not kept securely at all times.

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. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. These procedures were always followed by the dispensary staff. There were arrangements in place for the destruction of controlled drugs.

All dispensed medicines were scanned using a barcode system to help reduce any dispensing errors. 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.

Cleanliness and infection control

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

Treatment rooms were equipped with hand washing facilities and personal protective equipment (such as gloves). Hand gels for patients were available throughout the building. Clinical waste disposal contracts were in place and spillage kits were available. The senior practice nurse was the designated clinical lead for infection control. There was an infection control policy in place. Staff verified they had completed infection control training. There were cleaning schedules in place and an audit system to enable them to monitor the cleanliness of the building and most equipment. However, we highlighted that there was no audit trail showing the cleaning process of some equipment, for example nebulisers loaned out for use at home to patients with respiratory problems.

Other related policies such as the control of substances hazardous to health (COSHH), management of legionella risk, cleaning procedures and risk assessments were in place. The expertise of the local NHS Trust estates department was used to carry out assessments for the practice. However, the practice did ensure that records were kept demonstrating that the COSHH requirements were actually met. The practice also had a contract with the local NHS Trust to carry out legionella testing. Records also showed the practice was following suitable procedures to reduce the risk of legionella. This is a bacterium that can grow in contaminated water and can potentially be fatal.

Equipment

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

Staffing and recruitment

Information provided by the practice showed that staff retention at Petroc Group Practice was high. All of the staff told us they enjoyed working at the practice and new staff had been recruited. GP meeting minutes demonstrated that staff resources and duty rotas were regularly reviewed to meet the changing needs of patient demands across the four practices in the group.

Requires improvement

Are services safe?

Recruitment procedures were in place and had been followed. Professional registers, including the performers list for GPs and nurses had been checked prior to employment. There was a system in place to monitor the on-going validity of professional registration, which would reduce the potential risk of a nurse or GP working outside of this. The practice had obtained a Disclosure and Barring Service (DBS) check for all permanent staff. There was a named locum GP was used occasionally when sessions could not be covered by the permanent GP team. Staff confirmed that checks had been undertaken but could not produce any records to support this. The practice had an induction pack for locum GPs. .

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. An oxygen cylinder was not stored securely in an appropriate carrier with chain to prevent it falling and being a fire risk. We asked whether this had been picked up in the fire risk assessment and it had not been. A trolley with chain to hold the oxygen cylinder was ordered during the inspection to rectify this.

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

Staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. There were emergency processes in place for patients with long-term conditions. For example, emergency appointments/telephone consultations were always available each day and patients referred onto specialists such as midwifery services for acute pregnancy emergencies. All young children were offered an appointment, immediate if necessary, without the need to be triaged. Rescue medications and emergency equipment was easily accessible and the location known by clinical staff.

Arrangements to deal with emergencies and major incidents

There is no land based ambulance station where the practice is situated within an area of 200 miles. The practice had developed a highly qualified and skilled team who provide rapid emergency assessment and treatment for patients en-route to the main hospital from all areas of North Cornwall. One of the GP partners is an Advanced Life Support instructor working with the Resuscitation Council UK and is also a Royal College of Surgeons Pre Hospital Life Support Instructor. All of the staff verified they had completed life support training for children and adults, which for GPs was at the advanced level. However, staff files did not contain training certificates of this. The practice training register had gaps so did not provide an accurate overview of when all staff, including GPs and salaried GPs might need an update. The practice was well equipped with the same level of emergency equipment seen at the local Accident & Emergency Unit.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis, suspected meningitis, hypoglycaemia, severe asthma, overdose, nausea and vomiting and epileptic fit. Processes were in place to check whether emergency medicines were within their expiry date and suitable for use. All of the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. Staff explained that the practice worked collaboratively with three other practices in the area. They told us they would liaise with these practices in the event of an emergency that meant St Columb Major could not operate.

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

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

At the point of registration the practice nurse or healthcare assistant carried out a full health check which included information about the patient's individual lifestyle as well as their medical conditions. Patients were booked for a longer appointment to discuss their needs and to also be introduced to what services were available in order for patients to make best use of the practice. Patients were then referred to a GP where necessary.

GPs and nursing staff were able to give clear rationale for their approaches to treatment. They were familiar with current practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. Educational meetings were held every month and minutes showed that the latest guidelines and research was discussed at these.

Practice nurses had additional qualifications which allowed the practice to focus on specific conditions. For example, some of the practice nurses held diplomas in diabetes, asthma and chronic respiratory disease had joint responsibility with GPs for managing the care of patients with these long term conditions. Data for the local CCG showed that the practice performance for monitoring patients with long term conditions for the year 2014-15 was comparable or better than other practices in the area. For example, 84% patients with diabetes had their blood sugar levels checked compared with the national average of 78%.

The practice used a risk stratification tool to identify patients at risk of unplanned admission and there were 300 patients being monitored at the time of the inspection. National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. Data showed that the practice was performing well in preventing unplanned admissions for vulnerable patients with Petroc Group Practice at 12.8 % compared with national average of 13.6%. Data seen also showed that 100% patients with suspected cancers were referred and seen within two weeks. For example, one of the GPs specialised in dermatology and the practice had a digital microscope to take close up images and video of skin lesions which could be skin cancer. A patient told us that they had seen this GP and was referred to the main hospital for an urgent appointment within four hours of being assessed and diagnosed with skin cancer.

Designated staff dealt with results from investigations and demonstrated that these were seen on the same day by the GP who referred the patient for the investigation or duty doctor.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate. Staff showed us information which was in easy read and picture formats, which they used to enable patients with learning disabilities to be fully involved in making decisions about their care and treatment. Patients in written and verbal feedback gave us examples of this. Six patients we met told us they were treated as individuals and their views respected.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework system (QOF). This is a system for the performance management of GPs intended to improve the quality of general practice and reward good practice. No major risk areas were identified for the practice regarding QOF data. GPs had key roles in monitoring and improving outcomes for patients and discussed the outcomes of these at GP partner meetings. The information was collated by the practice manager to support the practice to carry out clinical audits.

GPs showed us clinical audits that had been undertaken in the last three years. Following each clinical audit, changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved. For example, an emergency care audit was carried out each year for 2013, 2014 and 2015. This highlighted areas for action, including extending staff skills through advanced life support training (Adult and Paediatric), upgrading equipment and guidance across the whole practice. These audits demonstrated that the emergency care services improved year on year so that the practice provided effective urgent treatment for patients enroute to the main hospital. In 2013, for example, two patients were treated at the practice for cardiac arrest and had survived with no significant long term effects.

Audits seen also confirmed that the GPs who undertook minor surgical procedures were doing so in line with their

Good

Are services effective?

(for example, treatment is effective)

registration and National Institute for Health and Care Excellence guidance. One GP was mid way through an audit cycle, which included analysis of the associated risks and benefits for patients receiving minor surgery.

There was a protocol for repeat prescribing which was in line with current national guidance. Repeat prescription requests were reviewed daily and signed off by a GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being followed. The IT system had recently been updated so that relevant medicines alerts were flagged up when the GP was prescribing medicines. This enabled the GPs to prescribe according to current guidelines with the most cost effective medicines.

The practice worked to the gold standards framework for end of life care. The nearest hospice to the practice was in Truro, so the team of GPs worked closely with the palliative care team to support patients to be at home and receive services there. A palliative care register was held and reviewed regularly. This included monthly multidisciplinary meetings to discuss the care and support needs of patients and their families. Practice nurses were not routinely invited to attend these meetings.

Effective staffing

Staffing at the practice included medical, nursing, managerial and administrative staff. Training records sent prior to the inspection provided minimal information about qualifications obtained and mandatory courses completed such as annual advanced/basic life support, safeguarding and fire safety. Eight staff records were reviewed and none had any evidence of the training provided for these staff. However, staff verified that they had completed mandatory and role specific training where appropriate. Nursing staff held their own portfolios with certification of training and qualifications completed.

Petroc Group Practice is a training practice providing placements for GPs and trainee doctors. The practice had attracted previous trainee GPs to join as salaried and then partners. There was a good skill mix across the team, with the GPs each having their own specialist interests areas such as teaching/training, emergency care, child care, dermatology. Three GP partners were qualified trainers. Each GP also had specific interests in developing their skills and disseminating this to the team. All the GPs we met confirmed they were up to date with their yearly continuing professional development requirements and had revalidated or had a date for revalidation. However, the practice did not have an overview of when these dates were to mitigate risks. Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practice and remain on the performers list with the NHS England.

Working with colleagues and other services

The practice worked effectively with other services. GPs held meetings with the health visitor and school nurse to discuss vulnerable children every month. Every month there was a multidisciplinary team meeting to discuss high risk patients and patients receiving end of life care. This included the multidisciplinary team such as physiotherapists, occupational therapists, health visitors, community nurses and the mental health team. However, practice nurses told us they did not usually attend these meetings. The practice had a list of vulnerable adults and worked closely with community professionals to monitor risks and provide early intervention to avoid hospital admission where ever possible.

Information sharing

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

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

Staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in promoting

Good

Are services effective?

(for example, treatment is effective)

patient rights. Staff shared recent incidents that had required further assessment of a patient's ability to weigh up and understand information to give informed consent. Consent was recorded on patient notes seen.

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

Health promotion and prevention

Information about numerous health conditions and self-care was available in the waiting area of the practice. The practice offered new patients a health check with a nurse or with a GP if a patient was on specific medicines when they joined the practice.

There was information on how patients could access external services for sexual health advice. The practice had met the Young Friendly quality standards and was listed as a service which young people could use for sexual health advice, including chlamydia screening and contraception. The practice did not have a specific young person's clinic, however patients attending for appointments told us that staff were sensitive and discreet in meeting the needs of the young person they were accompanying.

Child immunisation rates for standard vaccinations given at 12 and 24 months and 5 years were comparable with national levels. For example, 193 children were eligible for the measles, mumps and rubella vaccination and the practice 94.3% compared with the national rate of 93.9%. GPs told us that if any parents raised concerns or were unsure about whether to proceed they were automatically offered an appointment with them for further discussion. A parent told us that the practice was prompt with sending reminders to make appointments for the child's immunisations.

The practice had systems in place to monitor and improve outcomes for vulnerable patients. For example, a register of patients with learning disability was held. Information for the previous 12 months submitted to the showed that 100% patients had a physical health check.

An annual flu vaccination programme was underway. For patients within the relevant age range a vaccination against shingles was also available and information about this highlighted in the practice newsletter and website. The practice held additional clinics for vaccination as well as when patients attended for other appointments so they did not have to make unnecessary trips to the practice. Patients were contacted via text, phone or email. Data showed that the practice had performed well in the last year with 99.84 % diabetic patients had been vaccinated against flu compared with the national average of 93.5%. Data showed that the practice performed highly in vaccinating patients at risk under 65 (84.01%) when compared with the national average of 52.29%.

Data showed 90.37% of patients who were current smokers with physical and/or mental health conditions whose notes contained an offer of smoking cessation support and treatment within the preceding 12 months. The national average was 96%. The practice had added a prompt on the patient record system to increase the level of patients being assessed and offered support.

Data showed that the percentage of women aged between 25 and 65 years old whose notes recorded that a cervical screening test had been performed in the preceding 5 years was 89.73% which was slightly higher than the national average of 82%.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed that members of staff were courteous, caring and very helpful to patients both attending at the reception desk and on the telephone.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 31 completed cards and all were positive about the care and treatment experienced. All of patients (6) we spoke with said they felt the practice offered exceptional services and staff were caring, helpful and professional. Results from the national GP patient survey showed that approximately 92% of patients said the last GP they saw or spoke to was good at treating them with care and concern this was slightly above the national average of 86%. The patient survey also showed that approximately 94% of patients said that the last time they saw or spoke to a GP; the GP was good or very good at involving them in decisions about their care this was above the national average of 82%.

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

The practice had a confidentiality policy in place and all staff were required to sign to verify they would follow this as part of their contract of employment.

Care planning and involvement in decisions about care and treatment

The national GP patient survey results showed that approximately 85% said the last nurse they saw or spoke to was good or very good at involving them about their care which was which was comparable with the national average. The survey also showed that approximately 95% said the last nurse they saw or spoke to was good at treating them with care and concern which was higher than the national average of 90%.

The practice participated in the avoidance of unplanned admissions scheme. Informal meetings took place to discuss patients on the scheme to ensure care plans and those held by the community nursing team were regularly reviewed. GPs told us that previously there had been a good working relationship with the community matron, however the position was vacant at the time when we inspected.

The practice had access to a language service to support those patients where English was not their first language. Staff we spoke with told us they did not need to use this service often but knew how if needed. Information leaflets about services were in different languages and on the practice website and in the waiting room.

Patient/carer support to cope emotionally with care and treatment

The practice held a carers list, however this did not include parents who had a caring role. For example, we looked at records relating to a young person with a long term condition and saw there was no record of who cared for them.

The practice signposted patients to a carers clinic run by a community support worker, to provide practical and emotional support for patients who were carers. Members of the Patient Participation Group (PPG) told us that the practice also had good links with the voluntary sector and was working to increase these further so patients could get additional support and advice. Notices in the patient waiting room and practice website also told patients how to access a number of support groups and organisations.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. Operational meetings were held at the practice every month. For example the practice was working with other providers to develop meaningful shared care plans for patients identified as at risk of unplanned admission. The practice was in the process of being part of a cohort of services seeking to make greater use of the voluntary sector for providing people needing non medical support in the community.

The practice had an established patient participation group (PPG). Adverts encouraging patients to join the PPG were available on the practice's website. The PPG met quarterly and patient surveys were sent out annually. We spoke with one member of the group who told us the practice had been responsive to their concerns. For example, the practice continued to listen and raise issues with the local CCG regarding the increasing population in the village and impact this would have on the services provided by the practice.

Tackling inequity and promoting equality

The practice had had access to translation services. However, staff told us there had been no patients attending the practice who needed this service. The building had access for disabled people.

The practice had an equal opportunities and anti-discrimination policy which was available to all staff

on the practice's computer system. Staff understood these principles when we spoke with them and they explained that they completed on line training about this. Information sent to us prior to the inspection did not demonstrate that the practice had an overview of how many staff had completed this training.

Access to the service

The St Columb Major practice is open from 8 am – 6.30 pm Monday to Friday with appointments available between 9am - 5 pm. Extended opening hours are held from 6.30 – 8.30 pm on Tuesday and Thursday providing appointments for working patients. The practice also provides appointments before and after clinics by agreement for working patients. The dispensary at St Columb Major is open from 9am - 12.45pm and from 2.30pm - 5pm.

During evenings and from Saturday afternoon onwards for the rest of the weekend, when the practice is closed, patients are directed to an Out of Hours service delivered by another provider. This is in line with other GP practices in the Kernow clinical commissioning group.

GPs told us that a significant number of working age patients registered with the practice were in high risk occupations, for example deep sea fishing and agricultural industries. They explained that the extended hours services and health screening services had been specifically tailored to these patients needs. They highlighted that patients in the fishing industry were often away from home at sea for up to two weeks at a time and more than 150 miles off shore, which placed them at greater risk should their health deteriorate. Air/sea rescue services only covered the UK shores up to 175 miles out to sea, therefore GPs said they monitored the health of these patients closely and were overly cautious when screening them because of the risks posed by the industry they worked in. Administrative staff showed us the prompts and follow up systems which demonstrated that the practice was accessible and flexible in providing appointments for patients.

New patients were given an information pack and introductory letter. This explained that patients registered at the practice had a named GP but could choose to see any GP they wished to.

Information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits. The website stated that patients were able to book appointments in advance via the practice website, however when we visited this service was not yet available but due to be in place shortly afterwards.

Feedback cards completed by 31 patients had a recurring theme highlighting that they were able to get an appointment when they needed it. Five patients confirmed that the appointment system was accessible, by telephone or bookable in person. Administrative staff told us that there was a combination of bookable and same day appointments available. Routine appointments were usually for 10 minutes, however the timings were flexible

Good

Are services responsive to people's needs?

(for example, to feedback?)

and arranged according to patient needs. Patients confirmed urgent appointments were available on the same day. Reception staff answered the telephone to patients in a friendly way and were accommodating in getting them appointments to see the GPs or nurses.

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

The practice provided several specialist services onsite; a GP with post graduate dermatology qualifications provided consultations using digital microscope to take close up images and video to diagnose skin conditions; 24 hour electro cardiogram and doplar services on site so patients were able to avoid having to travel to the main hospital in Truro some distance away; and the practice had purchased specialist equipment so that blood screening was carried out at the practice for patients. Instead of receiving results the next day, results were available immediately and discussed with patients.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. The policy was in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints at the practice. Information about making a complaint was clearly displayed in several areas around the practice. We looked at an audit covering 11 complaints received from patients between April 2014 and February 2015, all of which had been investigated. The practice manager verified that resolution meetings were held with patients, however no record of this was kept.

The practice demonstrated evidence of learning from patient complaints and GPs held a regular meeting to discuss these. Staff responsible for managing complaints demonstrated that changes had been made as a result of learning. However, the practice had not had a whole staff meeting for more than two years, so opportunities to share and discuss the learning across the team was limited.

All 37 patients who contributed to the inspection, verified they had never made a complaint. Patients we spoke with said they would either speak to the receptionists, the GP or practice manager and were confident that should they have any concerns they would be dealt with.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's strategy and five year business plan. The practice aspired to high standards of care, responsibility and accountability, and continuous improvement.

We spoke with 14 members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. All 37 patients we received comments from in person or in writing described the practice as "excellent" and the staff "kind and very caring".

Staff were motivated and there was a low turnover of staff. As a training practice, Petroc Medical Group had attracted interest from trainee GPs in becoming salaried staff. Staff said they felt valued and were able to deliver safe and effective care and treatment for patients.

Governance arrangements

There was a documented leadership structure and staff felt supported by management. Some governance systems were in place which monitored, reviewed and mitigated risk within the practice. Patient safety systems were effective and followed. Staff had received inductions and attended their own team meetings. GP partners had oversight of business objectives and clinical outcomes for patients, which were in line or above national averages. We found communication and some systems could be improved, which would enhance governance arrangements at the practice and highlighted these during the inspection:

The practice did not proactively identify gaps in skills and address training needs across the whole team. There were opportunities to further develop the nursing team in leading the management of long term conditions for patients, which were not being fully utilised. This would enable the practice to be better prepared in managing the challenges currently associated with GP and nurse recruitment as part of succession planning. There was no oversight of GP and salaried training to provide triggers to identify expired training.

The employee handbook highlighted that employment records would be reviewed to monitor adherence to the recruitment and selection procedure. However, we found that practice had not identified that when checks had been carried out for a locum GP these were not recorded. The practice did not have any formal written performance management processes.

Health and safety risks were not fully understood by staff responsible for managing these. The health and safety policy was last reviewed in 2012. The policy stated that there was a health and safety committee as part of the governance arrangements, however the practice did not have one. The practice did not have oversight of control of substances hazardous to health (COSHH) requirements being adhered to. For example, the local NHS Trust provided expertise in this area but records of checks and controls were not produced at the inspection.

Communication was not embedded across the practice as a whole. For example, there was limited collaboration and involvement of nurses in clinical and strategy at the practice. Practice nurses were not actively invited to attend multidisciplinary meetings about vulnerable patients, or involved at strategic level in analysis of all significant events and complaints.

Leadership, openness and transparency

Staff had specific lead roles within the practice for example safeguarding and infection control. There was a practice manager who oversaw the administrative support staff and worked closely with GP partners to manage the business.

Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues with their line manager. We were told that there had been no whole practice meetings for two years and team away days had not been held. Instead each team held meetings regularly and minutes were kept. We saw this limited opportunities to ensure cross communication of innovation was embedded across the whole practice team. Each staff group worked collaboratively together and supported the common focus of improving quality of care and people's experiences. For example, GPs were actively involved in setting up comprehensive care planning for the most vulnerable patients with support provided by the voluntary sector for non medical issues. However, other members of the practice team were not aware of this. Administrative staff had suggested staff role rotation, which had been implemented and meant that Petroc Group practice had a flexible administrative team able to respond quickly to cover absences.

Are services well-led?

Good

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

Seeking and acting on feedback from patients, public and staff

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

There was an active patient participation group (PPG) consisting of 10 members at Petroc Group Practice. Minutes showed that the group met with the practice manager every month. We met one patient representative told us that the GPs listened and acted upon suggestions made to improve the practice. In November 2013 the patient participation group determined that it would be appropriate for the group to designate itself the patient reference group and commission and respond to practice surveys carried out. For example, the PPG had four key areas to work towards; improving the waiting areas; improvement of telecommunications and public address systems for patients; reviewing the appointments system to improve availability of GP of choice; and reviewing how test results were communicated to patients. The patient representative told us that the PPG was raising patient awareness about the constraints faced by GPs. In particular, they were promoting the positive approach Petroc Group Practice took to ensure all patients had a named GP which was not a typical experience of patients across the country.

Management lead through learning and improvement

Staff in interviews confirmed that training needs were identified, present conduct discussed and future plans agreed upon with their line manager. Written records held on files did not always record this information, which we highlighted during feedback. Nursing staff confirmed they held their own evidence of professional training and reflection on specific issues to maintain registration with the Nurses, Midwives Council (NMC). Clinicians were appraised by clinicians and administration staff appraised by administration staff.

The practice undertook a range of audits and professional groups had specific objectives to achieve. GPs and nurses are subject to revalidation of their qualifications with their professional bodies. For example, nurses held records of anonymised cervical screening results, which were peer reviewed. All 'inadequate result' cervical smears carried out for patients were repeated and reviewed. Mentoring and support was provided where needed to improve skills and accuracy with such testing. The data showed performance was within the national expected range.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines We found that the registered person had not protected people against the risk of safe care and treatment. This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Care and treatment must be provided in a safe way for service users and must include- The proper and safe management of medicines: How the regulation was not being met: · Only four of the patient group directions were in date and therefore the nurses were not working from the most up-to-date guidelines about vaccinations. · Blank prescription forms and prescription pads were not handled in accordance with national guidance as these was not an audit trail through the practice and they were not kept securely at all times.