

# St Mawgan Medical Centre

## Quality report

St Mawgan  
Newquay  
TR8 4HP

Date of inspection visits:  
29 January 2019

Date of publication:  
8 March 2019

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 

# Chief Inspector's Summary

## **St Mawgan Medical Centre is rated as Good overall**

The key questions are rated as:

- Are services safe? – Requires Improvement
- Are services effective? – Good
- Are services caring? – Good
- Are services responsive? – Good
- Are services well-led? - Good

We carried out an announced comprehensive inspection of St Mawgan Medical Centre on 29 January 2019.

Defence Medical Services (DMS) are not registered with the CQC under the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014 and are not required to be. Consequently, DMS services are not subject to inspection by the CQC and the CQC has no powers of enforcement. This inspection is one of a programme of inspections that the CQC will complete at the invitation of the Surgeon General in his role as the Defence Authority for healthcare and medical operational capability.

### **The overall findings from the inspection:**

- The practice was well-led and leaders demonstrated they had the vision, skill and capability to provide a patient-focused service.
- The practice understood the needs of the patient population and made changes to ensure patient needs were met.
- There was an open and transparent approach to safety. All staff knew how to raise and report an incident. However, we saw some inconsistencies with the management of significant events with attention needed to ensure all events are learned from.
- We saw some improvement was needed to keep patients and staff fully safe. This included the need for personal safety alarms for all staff, actioning issues identified through the infection control audit and ensuring patients could be seen in the waiting room.
- Staff were aware of current evidence based guidance. They had received training so they were skilled and knowledgeable to deliver effective care and treatment.
- The practice worked collaboratively and shared best practice to promote better health outcomes for patients.
- There was clear evidence to demonstrate quality improvement was embedded in practice, including an annual programme of clinical audit used to drive improvements in patient outcomes.
- The practice proactively sought feedback from patients which it acted on. Feedback showed patients were treated with compassion, dignity and respect and were involved in care and decisions about their treatment.
- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns.

- The layout of the building did not meet the privacy and confidentiality needs of patients, although the practice did all it could to mitigate this. In addition, the building was not fully accessible to patients with mobility problems.
- Staff were aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.

**We identified the following notable practice, which had a positive impact on patient experience:**

- The practice was proactive in working with other NHS providers to ensure patients continued to provide safe and effective care following discharge.

**The Chief Inspector recommends:**

- Review the premises and facilities to establish whether improvements can be made to provide an environment that minimises risks for the patients and staff. This includes improving confidentiality, alarms for all staff, safety of patients in the waiting room and a thorough action plan and schedule for those issues identified in the infection control audit.
- Ensure all equipment is fit for use.
- The system in place for reporting significant events should be reviewed to ensure any learning is captured and shared.
- Update health promotion literature.
- Ensure privacy and dignity of patients is upheld in an environment that is fit for purpose.
- Complete an access audit as defined in the Equality Act 2010.

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

---

## **Our inspection team**

The team that inspected St Mawgan Medical Centre included a CQC lead inspector and a team of specialist advisors including a GP, a practice manager and a nurse.

---

## **Background to St Mawgan Medical Centre**

St Mawgan Medical Centre provides an integrated service of primary care, occupational health care and physical rehabilitation services to a varied patient population.

Based on the station, St Mawgan Medical Centre provides a service to a practice population of 320 patients. In addition to routine primary care services, the practice provides occupational health care to service personnel, including force preparation and aviation medicals. Family planning advice is available. Maternity and midwifery are provided by NHS practices and community teams. A Primary Care Rehabilitation Facility (PCRF) is located on the premises, with physiotherapy and rehabilitation staff integrated within the medical centre.

The practice is open from 07:30 to 16:00 Monday to Thursday and on Friday 07:30 to 13.30. Arrangements are in place on weekdays for access to medical cover when the practice closed and before NHS 111 is available.

The staff team comprises of a mix of civilian and military staff and included:

- A Civilian Medical Practitioner (CMP) (four days per week).
- One practice nurse (four days per week).
- A physiotherapist and an Exercise Rehabilitation Instructor (ERI).
- A medic from Culdrose Medical Centre provides administrative cover, (a different person every day). A medic is trained to provide medical support and in a medical centre setting, their role is like that of a health care assistant in NHS GP practices but with a broader scope of practice.
- A practice manager visits the practice once a week from Culdrose Medical Centre.
- The Principal Medical Officer from Culdrose Medical Centre assumed overall accountability for the practice.

<b>Are services safe?</b>	<b>Requires improvement</b>
---------------------------	-----------------------------

**We rated the practice as requires improvement for providing safe services.**

**Safety systems and processes**

The practice had systems to keep patients safe and safeguarded from abuse. However, some improvement was needed.

- Measures were in place to protect patients from abuse and neglect. Arrangements for safeguarding reflected relevant legislation and local requirements. The practice had safeguarding policies in place for adults and children.
- The initial registration identified new patients who were vulnerable or subject to formal safeguarding arrangements. Codes were used on the electronic patient record system (referred to as DMICP), and regular searches made to highlight these patients. Vulnerable patients were discussed, with written consent, at the weekly welfare meetings. Practice staff had developed good relationships with the welfare team. The CMP attended the monthly Station Welfare Committee meetings and the monthly Unit Health committee meeting. Concerns about all vulnerable patients were discussed at both.
- All staff had received chaperone training and notices advising patients of the chaperone service were displayed. Staff had been subject to safety checks to ensure they were suitable to work with young people and vulnerable adults. If patients requested access to a male GP or nurse this could be facilitated via Culdrose Medical Centre that was situated approximately an hour away.
- The full range of recruitment records for permanent staff was held centrally. However, the practice manager could demonstrate that relevant safety checks had taken place including a DBS check to ensure staff were suitable to work with vulnerable adults and young people. DBS checks were renewed every five years. They also monitored each clinical member of staff's registration status with their regulatory body. All staff had professional indemnity cover. Information was in place to confirm staff had received the relevant vaccinations required for their role at the practice.
- The practice maintained good standards of cleanliness and hygiene. We observed the premises were clean and tidy. There were cleaning schedules and monitoring systems in place. The lead person responsible for infection control was the practice nurse. All staff had completed infection

prevention and control (IPC) online training. The most recent audit (August 2018) identified a number of issues that needed addressing. However, an action plan was not in place to address these. We saw sharps boxes throughout the practice had been dated in line with best practice guidance

- Deep cleaning was completed. The practice had a dedicated cleaner who was trained to clinical cleaning standard. The cleaning was monitored against the current cleaning contract.
- Systems were in place to ensure facilities and equipment were safe. Electrical safety checks were undertaken in accordance with policy. Fire safety, including a fire risk assessment, fire plan, firefighting equipment tests and fire drills were all in-date. Portable appliance and clinical equipment checks were up-to-date and records maintained.
- Equipment throughout the practice as in good order except for some pieces in the Primary Care Rehabilitation Facility (PCRF). We saw some equipment was out of use because they had not been serviced, including the treadmills and the cross trainer. This had been reported but had not been resolved.

### **Risks to patients**

There were systems to assess, monitor and manage risks to patient safety. However, some improvement was needed

- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures. Staff, including reception staff, had received medical emergency training in the last 12 months, for example in sepsis management.
- The layout of the practice meant not all patients in the waiting area could be observed by reception staff. This was particularly important in the event of a medical emergency. This was on the practice risk register waiting for action from the regional team.
- There was a documented approach to the management of test results. There was a local policy in place as well as simple table top instructions, all staff were aware of this.

### **Information to deliver safe care and treatment**

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- Summarisation of records was completed on DMICP and were flagged for the nurse and/or doctor to review.
- Staff described occasional loss of connectivity with DMICP but said this did not have a significant impact on patient care. If this happened, the business resilience plan was followed and urgent appointments only were offered.

### **Safe and appropriate use of medicines**

The arrangements for managing medicines and vaccines were well managed. This included arrangements for obtaining, recording and handling of medicines.

- The CMP was the lead for medicines management within the practice. All dispensing was outsourced to the contracted community pharmacy. Repeat prescriptions were accepted in person and were reviewed regularly with the patients. Repeat medicines were processed within 48 hours.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use. All staff who administered vaccines had received the immunisation training as well as the mandatory anaphylaxis training.
- All prescription pads were stored securely at all times and entry was restricted. All forms were booked out from the bound register and signed out by individual prescribers.
- There were procedures in place for the review of high risk medicines. For example, the monitoring of disease modifying anti rheumatic medicines which were initiated by secondary care. The practice took bloods regularly, checked the results, gave short prescriptions and put alerts on the clinical system and had a system of management in place. However, we identified two patients who were prescribed high risk medicines by secondary care but did not have a shared care agreement in place. We saw a clear audit trail of correspondence (two letters) from the practice to the secondary care provider requesting the shared care agreements but there had been no response; the pursuit of this was ongoing. We were satisfied that the CMP had the appropriate knowledge and monitoring in place to manage these two patients in the meantime.
- All Medicines and Healthcare Products Regulatory Agency (MHRA) safety notices and alerts were correctly logged on a spreadsheet with hyperlinks to the relevant webpage for the alert or safety notice. Only those alerts considered to be relevant were sent to the clinical staff. There was a designated lead and deputy responsible for this role. A table top instruction was also evident to ensure all staff were aware of the process to be followed. We saw one example whereby an alert had prompted the CMP to contact seven patients, by letter, advising them that the emollient they were prescribed had been found to be highly flammable.
- PGDs (Patient Group Directions) were in use to allow non-prescribing staff to carry out vaccinations in a safe way. PGDs were appropriately managed as staff had received training and authorisation by the CMP had been recorded. All had completed their relevant vaccine administration training.

### **Track record on safety**

The practice had a good safety record. However, there was some scope for improvement.

- The practice manager from Culdrose Medical Centre was the lead for health and safety and had completed training relevant for the role. Risk assessments pertinent to the practice were in place including patient handling, needle stick injury, lifting and handling and lone working. The PCRF had a specific risk assessment for the safe use of needle acupuncture.
- There was a pull cord alarm system in each clinical room, but the positioning of the chords posed a risk due to them being out of reach for staff to use. Staff did not have individual alarms to summon assistance in the event of an emergency.

### **Lessons learned and improvements made**

The practice reported incidents and were supported to do so. Systems needed improvement to ensure learning and improvement was identified and shared.

- There was an electronic organisational-wide system (referred to as ASER) for recording and acting on significant events, incidents and near misses. All practice staff knew how to raise and report an incident. We saw some inconsistencies with the management of significant events at a

higher level with no clear indication that a full root cause analysis had been completed and actions identified to address what had occurred. We saw two ASERs that had been closed too early so learning to reduce the likelihood of re-occurrence were missed. There was a scheduled weekly meeting to review ASERs and to feed into the main healthcare governance meeting.

<b>Are services effective?</b>	<b>Good</b>
--------------------------------	-------------

We rated the practice as good for providing effective services.

### **Effective needs assessment, care and treatment**

The practice assessed needs and delivered care in accordance with relevant and current evidence based guidance and standards.

- The practice had systems to keep all clinical staff up to date. Staff had access to guidelines from National Institute for Health and Care Excellence (NICE) and used this information to deliver care and treatment that met patients' needs. We saw evidence which showed there were processes in place to review updates and discuss these with clinical colleagues to ensure evidence-based best practice was updated in line with amendments. Audits were undertaken stemming from NICE recommendations, for example, for the management of depression.

### **Monitoring care and treatment**

The practice had a good chronic disease management plan in place managed by the practice nurse. Patients were recalled appropriately and patients received effective, individually personalised care.

The practice used data collected for the Quality and Outcomes Framework (QOF) to monitor outcomes for patients. QOF is a system intended to improve the quality of general practice and reward good practice. It is used across many NHS practices. The Defence Medical Services (DMS) have a responsibility to deliver the same quality of care as patients expect in the NHS. The QOF provides a useful way of measuring this for DMS. Because the numbers of patients with long term conditions are often significantly lower at DPHC practices, we are not using NHS data as a comparator.

The practice provided the following patient outcomes data to us from their computer system on the day of the inspection:

- There was one patient on the diabetic register. DMICP records for this patient showed that cholesterol levels had been measured and were 5mmol/l or less and showed their last blood pressure reading was 150/90 or less which is an indicator of positive blood pressure control.
- There were 10 patients recorded as having high blood pressure. All had a record for their blood pressure taken in the past nine months. Eight patients had a blood pressure reading of 150/90 or less, the remaining two were prescribed medication for the condition.
- There were three patients with a diagnosis of asthma. All had an asthma review in the preceding 12 months which included an assessment of asthma control using the three Royal College of Physicians questions.
- There were 29 patients being treated with depressive symptoms. All had a review of between 10 and 56 days after diagnosis. We were assured their care was being effectively and safely managed, often in conjunction with other relevant stakeholders such as the welfare team and the Department of Community Mental Health (DCMH).

- Information from the Force Protection Dashboard, which uses statistics and data collected from military primary health care facilities, was also used to gauge performance. Service personnel may encounter damaging noise sources throughout their career. It is therefore important that service personnel undertake an audiometric hearing assessment on a regular basis (every two years). Data we were provided with for the Group Practice showed:
  - 91.5% of patients had an audiometric assessment within the last two years.
- There was evidence that clinical audit was taking place. From discussions with staff, it was clear the practice was pro-active in using a quality improvement approach to review its underlying systems of care and identify actions leading to measurable improvements in health care delivery. A comprehensive, active programme of audit was in place that focussed on the needs of the population and demonstrated a commitment to improving outcomes for patients. Audits undertaken were relevant to the needs of the patient population, including a rolling programme of audit for long term conditions. There was evidence of two cycles for some audits.
- Clinical audits undertaken for the practice included: long term condition audits, prescribing audits, and chronic disease management. We saw there had been an audit undertaken by the CMP showing two audit cycles had been completed. The aim of the audit was to assess and measure compliance against the NICE guideline 'Depression in Adults'. The audit showed a comprehensive, honest and in-depth critique of their own clinical practice. It showed how following the first cycle areas for improvement were identified and had been made. For example, in using another template as an additional tool for gathering information.

### **Effective staffing**

Evidence reviewed showed that staff had the skills and knowledge to deliver effective care and treatment.

- The practice could demonstrate how they ensured role-specific training for relevant staff. For example, the practice nurse had extended training in long term conditions such as asthma. The CMP had three years' experience in psychiatry and welcomed every opportunity to continue to learn and develop those skills.
- All staff had received updated infection prevention and control training.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The practice had an induction pack which covered mandatory and role specific induction for all clinical and administrative staff and locums. We saw that this was being updated, but that in the meantime a whole pack of table top instructions and guidance was in place for new staff to use and understand.
- Staff had access to one-to-one meetings, appraisal, coaching and mentoring, clinical supervision and support for revalidation. Clinical staff were given protected time for professional development and evaluation of their clinical work.
- Meetings were established for staff to link with their peers to share ideas and good practice. The CMP attended weekly Medical Officer meetings at Culdrose Medical Centre for professional support. Peer support for the CMP was not available but not regularly planned for.

## **Coordinating care and treatment**

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- We found that the practice shared relevant information with other services in a timely way, for example when referring patients to other services.
- The practice participated in a monthly aviation medicine dial-in; this was a telephone conference held by aviation trained GPs and the flight safety team at another local military medical centre. All the doctors (including locums who were aviation trained) had protected clinic time to dial-in. This was an opportunity for clinicians to update on air safety incidents related to aviation medicine, and any aviation medicine updates such as changes in policy.
- Clinical meetings to discuss patients were held each month between the physiotherapists and clinicians. PCRf staff referred patients to other clinics if it was deemed appropriate to their rehabilitation, such as the multi-disciplinary injury assessment clinic (MIAC) at the Regional Rehabilitation Unit (RRU), Plymouth.
- The CMP and a representative from the PCRf attended Unit Health Committee (UHC) meetings to update unit commanders on medically downgraded patients. In addition to UHC meetings, the CMP attended welfare meetings where the needs of vulnerable patients, including patients with mental health needs, were discussed.

## **Supporting patients to live healthier lives**

Staff were proactive in helping patients to live healthier lives.

- Records showed, and patient feedback confirmed, that staff encouraged and supported patients to be involved in monitoring and managing their health. Staff also discussed changes to care or treatment with patients as necessary.
- The practice supported national priorities and initiatives to improve the population's health including, stop smoking campaigns and tackling obesity. Advice on prevention of musculoskeletal (MSK) injury was available from physiotherapy staff at the practice, as well as the clinicians providing services. The practice attended unit health fairs to endorse and promote good health.
- Health displays were evident in the patient waiting area. Staff said the displays were refreshed on a regular basis and they often targeted the needs of the population and/or seasonal activities, such as influenza. However, we noted, that much of the literature was old and out of date.
- Patients had access to appropriate health assessments and checks. We saw that effective recall and reminders were sent to patients.
- All new patients were required to register with the practice and to complete an administrative arrival form (to check contact details, outstanding hospital appointments and repeat medicines etc.) and complete a health questionnaire. They were then offered a new joiner medical screen with the practice nurse. The questionnaire was summarised and health record updated. Patients who declined new joiner appointments were followed up.

It is important that military personnel have sufficient immunity against the risk of contracting certain diseases. The World Health Organisation sets a target of 95% for vaccination against diphtheria, tetanus, pertussis and polio and measles, mumps and rubella. The following illustrates the current 2018 vaccination data for the practice patient population. The practice was unable to provide comparators to regional and national statistics.

- 98% of patients were recorded as being up to date with vaccination against diphtheria.
- 98% of patients were recorded as being up to date with vaccination against hepatitis A.
- 98% of patients were recorded as being up to date with vaccination against hepatitis B.
- 99% of patients were recorded as being up to date with vaccination against typhoid.
- 100% of patients were up to date with vaccination against yellow fever.

### **Consent to care and treatment**

Staff recorded patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored through patient records audits. We reviewed patient records and saw that written consent was sought when required. We also saw that written consent was gained from the patient if they were going to be discussed at the welfare meeting.

<b>Are services caring?</b>	<b>Good</b>
-----------------------------	-------------

**We rated the practice as good for caring.**

### **Kindness, respect and compassion**

- We received 73 CQC comment cards completed prior to the inspection, this equated to approximately 25% of the patient population. All 73 were highly positive about the care they received from the practice. All feedback in relation to how patients were treated by staff was complimentary. A theme identified overall was that patients felt that the CMP and the nurse went 'over and above' to ensure they received the best care they could. We received three written reports from patients each describing the care they received when they were experiencing mental health difficulties. One described how the CMP had shown them great care and kindness not only whilst they were at a patient at St Mawgan Medical Centre but also went to great lengths to ensure the NHS GP they were referred to, when discharged, had all the necessary information to continue with the planned care.
- The patient survey showed 91% of patients would recommend the practice to friends and family.
- The practice had an information network available to all members of the service community, known as HIVE. This provided a range of information to patients who had relocated to the base and surrounding area. Information included what was available from the local unit and from civilian facilities, including healthcare facilities.

### **Involvement in decisions about care and treatment**

Staff supported patients to be involved in decisions about their care.

- An interpretation service was available for patients who did not have English as a first language and all staff we spoke with were aware of how to access it.
- The Patient Experience Survey showed 91% of patients at St Mawgan Medical Centre felt involved in decisions about their care. Feedback from the CQC patient feedback cards supported this positive outcome.
- Processes were in place to identify patients who also had a caring responsibility so that additional support or healthcare could be offered if needed. The practice identified carers either through the Chain of Command, welfare meetings or by requesting that carers make themselves known using signage in the practice reception. They also asked the question on the new joiners' paperwork/health questionnaire. A review of the carers search within DMICP showed three patients Read coded as carers, all had alerts recorded to flag to reception staff or clinicians.

### **Privacy and dignity**

The practice respected the privacy and dignity of patients.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. Clinic room doors were closed during consultations. However, the doors were old and not sound proof. Staff said they could hear consultations if they were in the corridor. Equally patients in the waiting room could hear the practice nurse having a conversation in the treatment room, a television was on to try and mask this. Every effort was made by staff to ensure patient confidentiality but the building being so old and in need of refurbishment made this very difficult.
- The layout of the reception areas had recently been improved and meant that conversations between patients and reception could not be easily overheard. Reception staff said that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

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

**Good**

**We rated the practice as good for providing responsive services.**

### **Responding to and meeting people's needs**

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences. It was evident that 50% of the practice population at St Mawgan required MSK or psychiatric consultation and care. The remaining 50% accounted for occupational matters or Force Protection. We saw that the delivery of care focussed on this. For example

- A clinician from the Department of Community Mental Health (DCMH) undertook a clinic at St Mawgan once a week.
- There were longer appointments available for patients who required more time.
- Same day appointments were available for those patients with medical problems that required same day consultation.
- Telephone consultations were available.
- Patients could receive vaccines required for occupational health at the practice.

- Multi-disciplinary clinics for managing patients with MSK injuries were held. There were two types of these that included the patient, physiotherapist, ERI and the Medical Officer (PRIMO).
- For those patients being discharged from the military support was offered with registering at local NHS practices. The handover process was detailed, which was particularly key for patients who had complex needs or caring responsibilities.
- The medical centre was old and in need of refurbishment. An access audit as defined in the Equality Act 2010 had not been completed for the premises. The practice did not have a fully accessible toilet and access to parts of the facility were difficult. For example, there were three steps in the main corridor which prevented access to the PCRf, other than over a grassed area to the rear of the building. Doors and doorways were very old, and not wide enough for easy access for wheelchairs.

### **Timely access to care and treatment**

- Patients accessed physiotherapy via the GP as a direct access physiotherapist service (DAPS) was not yet in place. On inspection day we were unable to obtain the PCRf dashboard, which reports key performance indicators including the access to physiotherapy waiting times over time. A real-time sample of the DMICP diary on the inspection day showed the next available new patient appointment was within ten working days.
- There was good access for all patients including an early morning triage for urgent care.
- Details of how patients could access the GP when the practice was closed were available through the base helpline. Details of the NHS 111 out of hours service was also displayed on the outer doors of the medical centre and in the practice leaflet.
- The patient experience survey showed that 91% of patients at the practice were satisfied with the location of their appointment.

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

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information was available and displayed to help patients understand the complaints process.
- The practice worked with the DPHC complaints policy and procedure. The business manager was the designated responsible person for handling all complaints. We saw the practice leaflet contained information about how to complain but no contact details were provided.
- The patient survey undertaken in October 2018 showed 100% of patients asked (12) felt that their concerns, compliments and suggestions were listened to.
- St Mawgan Medical Centre had received one written complaint in the past year.

<b>Are services well-led?</b>	<b>Good</b>
-------------------------------	-------------

**We rated the practice as good for providing a well-led service.**

### **Leadership capacity and capability**

- Despite being a very small practice with limited staff we saw a practice that was well led. The CMP demonstrated they had the experience and skills to deliver high-quality sustainable care. They clearly understood the practice priorities and demonstrated they had capability and tenacity to drive service change for the benefit of patients. We saw evidence from several professionals who worked remotely but liaised regularly with the CMP at the practice. All were

highly complementary of their skills and knowledge. For example, St Mawgan served a mixed population of people and because of this the occupational health provision could be demanding due to the differing needs of each service. We were told that because of the efficient communication and consultation made by the CMP this process was seamless and ensured patients remained safely employed or their sickness appropriately managed.

- There was a comprehensive meetings programme in place and the practice, although very small, held weekly whole team meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. We noted team away days were organised by Culdrose Medical Centre and the staff team at St Mawgan were always included.
- All staff were involved in discussions about how to run and develop the practice, and the CMP encouraged all members of staff to identify opportunities to improve the service delivered by the practice.
- The practice was aware of and had systems to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). This included support training for all staff on communicating with patients about notifiable safety incidents. The leaders encouraged a culture of openness and honesty.

### **Vision and strategy**

The practice had a clear vision and credible strategy to deliver high quality, sustainable care.

- The practice vision was “St Mawgan will put patient safety at the centre of all we do using best practice to improve patient care and patient employability”.
- The medical centre planned its services to meet the needs of the practice population.

### **Culture**

The practice had a culture of good quality sustainable care.

- Staff stated they felt respected, supported and valued.
- The practice focused on the needs of patients.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints.
- Staff we spoke with told us they could raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they needed. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.

### **Governance arrangements**

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures and ensured that:

- There was a clear staffing structure in place and staff were aware of their roles and responsibilities, including delegated lead roles in specific topic areas. Terms of reference were in place to support job roles.
- An understanding of the performance of the practice was maintained. The practice manager used the Common Assessment Framework (CAF) as an effective governance tool.
- A programme of clinical and internal audit was used to monitor quality and to make improvements.
- A comprehensive understanding of the performance of the practice was maintained. The practice nurse monitored achievement against clinical indicators in QOF and reported if there were areas which required focus.

### **Managing risks, issues and performance**

There were clear and effective processes for managing many risks, issues and performance.

- The CMP understood the risks to the service and kept them under scrutiny through the risk register. For example, we saw the practice had developed their own internal policies and procedures to mitigate risk due to low staffing numbers. For example, every day a different member of staff from Culdrose Medical Centre worked at St Mawgan to fill in whilst a permanent receptionist was employed (this post had been vacant since the end of 2018). St Mawgan recognised that staff from Culdrose Medical Centre would not be familiar with administration processes and the nuances of the patient population and so developed a step by step guide to common processes for them to refer to.
- Processes were in place to manage current and future performance. Performance of clinical staff was demonstrated through peer review, including review of clinical records.
- Plans were in place for major incidents and staff were familiar with how to respond to a major and/or security incident.
- Practice leaders had oversight of national and local safety alerts.

### **Appropriate and accurate information**

The practice had appropriate and accurate information, although we noted a gap in performance information for the PCRF.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- There were good arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

### **Engagement with patients, the public, staff and external partners**

The practice involved patients, staff and external partners to support high-quality sustainable services.

- A patient experience survey was undertaken throughout the year and a suggestion box was in the patient waiting room. We saw positive changes were made because of patient feedback. For example, the reception area had been improved so that patient confidentiality was better served.

- The practice, including a representative from the PCRf, attended unit welfare meetings each month.
- There were various options in place to encourage patients to provide feedback on the service and contribute to the development of the service. A patient experience survey was undertaken throughout the year.
- The practice had good and effective links with internal and external organisations including the Regional Rehabilitation Unit (RRU), the DCMH and local NHS primary care providers.

### **Continuous improvement and innovation**

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking. From minutes of meetings we reviewed, we noted that the leadership of the practice focussed on improving the speed and quality of delivery of care for all patients. Improvements implemented were evident from outcome of audits and the networking with outside agencies. It was clear to us that the practice used this to identify learning and make change. For example, caring for patients with mental health issues and depression and the transition for staff from the military to civilian life.