Bottreaux Surgery

Quality Report

Bottreaux Surgery
Boscastle
Cornwall
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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	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Outstanding
Are services well-led?	Requires improvement

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Bottreaux Practice on 20 January 2015. This was a comprehensive inspection covering the main practice at Bottreaux Surgery, and Tintagel Surgery. Both practices provide primary medical services to people living in the coastal village of Boscastle and surrounding villages in Cornwall covering approximately 100 square miles. Transport links within the area are limited. Bottreaux Surgery covers coastal villages, which are rural, with high percentage of agriculture and mid-range deprivation. The practice provides primary medical services to a diverse population and supports patients living in two adult social care homes in the area. Both surgeries have dispensaries, which we inspected on the same day.

At the time of our inspection there were approximately 5000 patients registered at the service with a team of three GP partners. GP partners held managerial and financial responsibility for running the business. The practice also had one salaried GP. In addition there were two registered nurses who are both independent prescribers. Bottreaux Surgery is a training practice, with two GP partners approved to provide vocational training for GPs, second year post qualification doctors and medical students.

Patients who use the practice have access to community staff including district nurses, community psychiatric nurses, health visitors, physiotherapists, mental health staff, counsellors, chiropodist and midwives.

Overall the practice is rated as REQUIRES IMPROVEMENT.

Specifically, we found the practice to be outstanding for providing responsive services. We found the practice to be good for providing effective and caring services. It was also good for providing services for older people, people with long term conditions, families, children and young people and people experiencing poor mental health (including people with dementia), working age people

Summary of findings

(including those recently retired and students) and people whose circumstances may make them vulnerable. It required improvement for providing safe and well led services.

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.
- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses.
- Patients' needs were assessed and care was planned and delivered following current practice guidance. The practice had a very good skill mix which included two advanced nurse practitioners (ANPs) and was able to see a broader range of patients than the practice nurses.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified with individuals.
- 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 staffs were flexible and found same day gaps for patients needing routine appointments.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- There was a strong commitment to providing well-co-ordinated, responsive and compassionate care for patients nearing the end of their lives. This included proactive management of emergency and short term pain relief medicine to counteract access to very limited out of hours pharmacist services in the practice area. This enabled carers to avoid having to travel long distances for these medicines.

We saw areas of outstanding practice:

- The practice understood the needs of the patient list and the challenges of the coastal location and had developed a responsive service accordingly. There were many examples of this seen at the inspection. Patients were experiencing advanced care and treatment from staff that were skilled in delivering a flexible and integrated service with other providers. This was significant for patients living in an isolated coastal area and promoting access to services normally run at the main hospital some 37 miles away

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

Importantly the provider must:

- Establish and operate effective recruitment procedures to ensure that information regarding pre-employment checks are kept regarding persons employed. This must include recording when checks of the performers list are carried out for all GPs, including locum GPs.
- Establish and operate effective systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients and others. This must include regular review and updating of policies to meet current guidance, monitoring the training needs of the whole team (including temporary staff), identification of any trends and risks in relation to complaints, significant events, incidents and accidents that could impact patient care and business continuity.

In addition the provider should:

- Review communication systems so these are audited and ensure all staff including temporary staff such as locum GPs are included.

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. Information about incidents was recorded, monitored, appropriately reviewed and addressed.

Although risks to patients who used services were assessed, the systems and processes to address some of these risks were not implemented well enough to ensure patients were kept safe. These included recruitment processes for staff, which did not demonstrate that pre-employment checks had been consistently performed. The risk of legionella was not assessed and protocols were not in place to mitigate potential risks to people. Medicines management required improvement to ensure that nominated staff had written authorisation to carry out vaccinations.

The practice had effective procedures for dealing with emergencies and demonstrated how the advanced resuscitation skills of GPs had saved the lives of two children over the course of the previous 12 months.

Are services effective?

Good

The practice is rated as good for providing effective services.

Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams, which included strong links with other health and social care professionals supporting patients at the end of their lives.

Are services caring?

Good

The practice is rated as good for providing caring services.

Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions

Summary of findings

about their care and treatment. National patient survey data showed 95.1% of practice respondents said the GP involved them in care decisions and 93.4% felt the GP was good at explaining treatment and results. Information to help patients understand the services available was easy to understand. Staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Outstanding ☆

The practice is rated as outstanding for providing responsive services.

The practice reviewed the needs of its local population and engaged with NHS England and Kernow Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients were experiencing advanced care and treatment from staff that were skilled in delivering a flexible and integrated service with other providers. For example, the practice had integrated services for people with complex mental health needs by holding monthly care plan reviews looking at risk, treatment and support needed with the consultant psychiatrist and community mental health workers. This lead to responsive support and treatment being implemented for patients averting the need for hospital admission.

GPs and nurses had extended skills and qualifications which enabled them to provide services, which would normally be carried out at the main hospital. These included 24 hour ECG plus seven day loop for patients of the practice and other surrounding practices. Endometrial biopsies for investigation of peri-menopausal bleeding were carried out for women at the practice by a female GP with advanced qualifications. Joint injections were provided for patients needing them, avoiding secondary care referrals for this procedure. This had a positive impact for patients as transport links were very limited and the nearest main hospital is a considerable distance away along rural/coastal routes (37 miles). Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints with staff and other stakeholders was reviewed and acted upon.

The practice hosted specialist clinics at the practice for procedures normally offered at the main hospital such as diabetic retinal screening (held twice a year) regular hospital nurse specialist appointments for patients with complex diabetes and leg ulcer

Summary of findings

treatment. Equipment obtained provided greater access to health monitoring. This included a centrifuge, which had increased the lifespan of blood samples so that patients did not have to travel for up to five hours on public transport to the local hospital.

In the summer months the demand on the practice could increase by a third at the height of summer, with over a 1000 temporary patients visiting each year, as it was situated in a popular holiday resort. The practice increased staffing at these times so that permanent patients were not affected.

The practice is geographically isolated and remote from emergency services, so all of the GPs hold advanced resuscitation qualifications, including paediatric resuscitation.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for being well-led.

They had a clear vision and strategy as being 'small and family friendly'. Staff we spoke with was clear about their responsibilities in relation to the vision or strategy.

Governance systems needed strengthening to promote consistency and assurance that policy and procedures were being followed and in line with current practice. There were systems in place to monitor and improve quality and identify risk. However, these tended to be stand alone and had not picked up gaps in the management of safe systems. The practice proactively sought feedback from staff and patients, which it acted on, but the practice lacked oversight and management of some safety risks. The patient participation group (PPG) was active and encouraged to help develop the services for patients. Staff had received inductions and had annual performance reviews. Staff meetings and events took place but had been curtailed due to the pressure on the team resulting from staff sickness.

Summary of findings

The six population groups and what we found

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

Older people

Good

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

All older patients at the practice had a named GP and had been informed in writing of this. Telephone assessment of older patients calling the practice was prioritised. Longer appointments were made available for older patients where needed to ensure that there was time to review their needs.

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.

Patients with complex care needs were well monitored by the practice working in partnership with other agencies. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. Information systems enabled the practice to share important clinical and social information about patients with complex needs. This facilitated continuity of care for those patients and data showed that there was a low rate of unplanned admissions for patients at the practice.

There was a strong commitment to providing well co-ordinated, responsive and compassionate care for patients nearing the end of their lives. Patients were experiencing proactive management of emergency and short term pain relief medicine, which helped carers avoid having to travel long distances for these medicines. For example, four drop off points were available in villages for the delivery of medicines from the practice dispensary to patients. Repeat and acute medicines were occasionally delivered direct to the home of vulnerable patients on a needs basis.

Newly discharged patients were contacted and/or visited within three days of leaving hospital to ensure their needs were met.

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.

The practice provides space for regular carer's clinics and works with a community support worker to provide additional help for carers.

Summary of findings

The practice supports older patients living at an adult social care home nearby. Home visits were prioritised. Annual reviews took place with a Kernow CCG pharmacist to identify potential risks caused by poly pharmacy and to reduce these where ever possible for patients.

People with long term conditions

Good

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

Nursing staff had lead roles 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 those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. The practice held multidisciplinary meetings every month to review the needs of all patients with complex long term conditions.

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

The practice had invested in various specialist equipment. For example, a centrifuge was used to extend the lifespan of blood samples so that they could be taken at any time during the day and still be viable for assessment when collected the following day at 11am and taken to the hospital.

The practice recognised the needs of patients and their difficulty with transport to the hospital for appointments. They had arranged for screening for certain conditions to be taken at the practice. For example, eye screening took place at the practice every year for patients at risk of developing diabetic retinopathy. This was appreciated by patients we spoke with who were in this position as it avoided them having to travel to the ophthalmology clinic based at the main hospital approximately 37 miles away

The practice had links with the external health care professionals to provide advice, guidance and treatment as required. GPs and/or nurses from the practice attended quarterly a virtual Diabetic clinic with hospital specialists to review patient care and treatment. The practice hosted weekly physiotherapy sessions on site so patients with less complex issues could be treated at the practice and avoid having to travel to either Bodmin or Treliske Hospitals for treatment.

Summary of findings

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.

Children were triaged quickly and prioritised for immediate assessment where needed. The practice recognised the isolation of the coastal location and considerable distance to the nearest main hospital. GPs held advanced life saving qualifications and had specialist equipment on site to deal with paediatric emergencies. We saw evidence showing that this had been effective in treating a young child who had suffered anaphylactic shock as a result of a reaction to a particular food and a baby in a critical condition.

There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations.

Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. The waiting room had a separate child friendly play area, with handmade toys and a playhouse to occupy children whilst they were waiting for their appointment.

Emergency processes were in place for acutely ill children, young people and acute pregnancy complications.

The practice worked collaboratively with midwives, health visitors and school nurses to deliver antenatal care, child immunisation and health surveillance. Monthly meetings were held with the health visitor to discuss children and young people who were or could be at risk and agreed actions put in place.

Support was being accessed for parents from children's workers and parenting support groups where relevant. All staff had been given safeguarding training, which included level 3 children safeguarding for all GPs.

The practice was proactive in getting feedback from patients and the patient participation group included parents with young families.

Summary of findings

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 in place. The practice was an approved young person friendly service through the EEFO scheme in Cornwall. It provided information about contraception for young people on the website and offered a choice of staff for young people to see. The practice offered advice and carried out confidential chlamydia screening.

Parents with children attending the practice confirmed that they were always present during consultations. They told us that all of the staff spoke to their child at their level and helped to reduce any anxiety they might be feeling.

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).

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. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. For example, appointments could be booked up in advance. Telephone consultations with a GP were available on request. Extended evening appointments were available every Tuesday until 9pm. Patients could request repeat prescriptions online, via email, or in person at the practice. Repeat prescriptions were being given for up to six months where agreed with the patient.

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.

The practice was proactive in seeking feedback and the patient participation group at the practice included working age members.

People whose circumstances may make them vulnerable

Good

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

Summary of findings

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. Home visits by GPs were being carried out jointly with the community nursing team to reduce stress and improve communication. The practice liaised closely with the learning disability nurse specialist to ensure information was communicated in a person centred way, for example in easy read or picture formats so that appropriate consent could be obtained.

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.

The practice worked closely with the community matron 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 and communicate with homeless people. The majority of temporary patients resulted from an influx of people visiting the surrounding area on holiday during the summer months. GPs said this amounted to approximately 1000 extra patients each year. The practice made arrangements to provide additional cover at these times so the impact on permanent patients was lessened.

Carer checks were carried out and the practice hosted a carer support worker clinic every month to support patients.

People experiencing poor mental health (including people with dementia)

Good

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

The service was responsive and compassionate with patients who had mental health needs. Staff was innovative in the way they engaged with patients with complex mental health needs. Monthly shared care management meetings were held at the practice with

the consultant psychiatrist and community mental health workers, where risk and changing patient needs were discussed. This resulted in timely interventions being put in place to support people so they were able to avoid hospital admission where possible

The practice was proactive in sharing the care of patients with complex mental health needs and those with addictions. 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. Monthly meetings were held with the consultant psychiatrist and other members of the community mental health team to review risks and proactively manage these through co-ordinated care. This resulted in reducing hospital admissions for patients in crisis, who were enabled to stay at home with complex support in place.

GPs had extended their skills and obtained qualifications, which enabled them to provide community drug and alcohol treatment and home detoxification services for patients with addictions. The practice hosted in house sessions for patients with addiction with a drug and alcohol counsellor.

The practice had a list of patients with known mental health needs and worked to engage them in healthy living programmes. Care plans were in place and included health screening tailored to each patient's needs. Each appointment with a patient was seen as an opportunity to screen patients and signpost them to additional services. In house mental health medication reviews were conducted to ensure patients received appropriate doses. For example, patients taking lithium had regular blood tests to ensure safe prescribing.

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.

Advice and support was sought as appropriate from the psychiatric team with referrals made for psychiatry review or access into psychological therapies for patients with complex needs. Patients with depression, needing time limited, low key counselling services were able to refer themselves to the counselling service hosted at the practice each week. The practice had a system in place to follow up patients diagnosed with depression if they did not attend appointments.

The practice had a dementia care practitioner and worked closely with the nurse specialist to provide support to anyone suspected or

Summary of findings

diagnosed with dementia. Early identification of patients with suspected dementia were being screened and referred to the memory clinic for diagnostic tests. Advanced care planning was promoted, with 88.5% patients having been reviewed. The GPs told us they were not actively seeking reimbursement for early identification of patients who could be presenting with symptoms and changes in behaviour associated with dementia.

Systems were in place to help safeguard vulnerable adults.

Summary of findings

What people who use the service say

The practice sought feedback from patients in several ways. Three surveys, including the 2014 national GP survey showed that results for Bottreaux Surgery were better in all areas compared to the clinical commissioning group (CCG) and national average. The practice had a complaints and suggestion box in the surgery, with comments reviewed at practice meetings.

During the inspection, we spoke with 11 patients and two representatives of the patient participation group (PPG). The practice had provided patients with information about the Care Quality Commission prior to the inspection. Our comment box was displayed and comment cards had been made available for patients to share their experiences with us. We collected 31 comment cards, which contained detailed positive feedback about the practice.

The overarching theme from patients in their responses was that all of the staff had a caring attitude and took time to listen. Staff was described by patients as being kind, compassionate and responsive when they saw them. Patients were confident about the advice given and medical knowledge of their GPs. Access to appointments and the length of time given was described as a high point by patients who told us they never felt rushed. Patients were positive about the continuity of care they received from the team. Some patients were also carers and told us they received excellent support, which helped them care for their loved ones.

These findings were reflected during our conversations with 11 patients and discussion with the PPG members. All of the patients gave positive feedback. The appointment and repeat prescription systems were described by patients as being easy to use. Patients confirmed they could get urgent appointments when they needed to and were not unduly concerned with the waiting time for routine appointments. Patients told us about their experiences of care and praised the level of care and support they consistently received at the practice. Patients stated they were happy, very satisfied and said they received good treatment. Patients told us that the GPs were excellent and thorough when it came to diagnosis and treatment.

Parents told us the staff treated their children with respect. We were told the staff was good at communicating with children and young people, which in turn helped reduce any anxieties they might have had about visiting the practice.

The practice PPG met every three months, with 13 members ranging in age between 35 to 74. Representatives from the PPG told us there was a health relationship with the practice, in which they were encouraged to develop and improve services there.

Areas for improvement

Action the service MUST take to improve

- Establish and operate effective recruitment procedures to ensure that information regarding pre-employment checks are kept regarding persons employed. This must include recording when checks of the performers list are carried out for all GPs, including locum GPs.
- Establish and operate effective systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients and others. This must include regular review and updating of policies to meet current guidance, monitoring the training needs of the whole team (including temporary staff), identification of any trends and risks in relation to complaints, significant events, incidents and accidents that could impact patient care and business continuity.

Action the service SHOULD take to improve

- Review communication systems so these are audited and ensure all staff including temporary staff such as locum GPs are included.

Summary of findings

Outstanding practice

- The practice understood the needs of the patient list and the challenges of the coastal location and had developed a responsive service accordingly. There were many examples of this seen at the inspection. Patients were experiencing advanced care and treatment from staff who were skilled in delivering a flexible and integrated service with other providers. This was significant for patients living in an isolated coastal area and promoting access to services normally run at the main hospital some 37 miles away

Bottreaux Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP, pharmacist inspector, second CQC inspector, another specialist who was a quality manager and an Expert by Experience.

Background to Bottreaux Surgery

The GP partnership run the practice known as Bottreaux Surgery and provide primary medical services to people living in the coastal village of Boscastle and surrounding villages. The practice has a branch practice at Tintagel. There are dispensaries at both Bottreaux and Tintagel practices.

At the time of our inspection there were 5041 patients registered at the practice. More than 25% of the patients registered at the practice were over 65 years of age. The practice is contracted to provide personal medical services. This includes childhood vaccination and immunisation, influenza and

pneumococcal immunisation, extended hours access, facilitation of timely diagnosis and support for people with dementia and the identification of patients with learning disabilities who are offered annual health checks.

There are three GP partners, two male and one female, who held managerial and financial responsibility for running the business. In addition there is one male salaried GP. The GPs were supported by two female registered nurses, both of whom are independent prescribers, a healthcare assistant, two phlebotomists and a practice manager supported by additional administrative and reception staff. The practice also has a dispensary manager and four dispensers responsible for running the two dispensaries based at Bottreaux and Tintagel practices. Bottreaux Surgery is a training practice, with one GP partner approved to provide vocational training for GPs, second year post qualification doctors and medical students. When we inspected there was one trainee GP on placement at the practice.

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

Bottreaux Surgery is open from 8.15 am - 6pm Monday to Friday. Extended opening hours are held once a week at Boscastle every Tuesday between 6.30pm to 8.45 pm. At Tintagel Surgery opening hours are 8.30-6pm every day, except on Wednesday and Fridays when it closes at 12.30pm. Patients could attend the practice at Boscastle when the one in Tintagel was closed. The dispensaries at both practices are open during opening hours. During evenings and weekends, when the practice is closed, patients are directed to an Out of Hours service delivered by another provider. This is in line with the contract held by 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.

Detailed findings

How we carried out this inspection

Before visiting the practice, we reviewed a range of information we held about the service and asked other organisations, such as the local clinical commissioning group, local Health watch and NHS England to share what they knew about the practice. We carried out an announced visit on 20 January 2015.

During our visit we spoke with a total of 12 staff, including three GPs, the practice manager, two registered nurses, a phlebotomist, dispensary manager, dispensers, administrative and reception staff. We also spoke with 11 patients who used the practice and met two representatives of the patient participation group. We observed how patients were being cared for and reviewed 31 comments 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. Staff explained they would report the issue and would complete a document which was then managed by the GPs and practice manager for action. Issues were reviewed at the monthly clinical governance meetings.

Learning and improvement from safety incidents

There were systems for reporting, recording and monitoring significant events and accidents. Staff used electronic forms on the practice intranet and knew who to report significant events to. The practice manager verified that these were collated and discussed with GP partners. We saw the last two clinical meeting minutes for November and December 2014, which showed significant events had been discussed and learning shared with staff. For example, the results of a patient's repeat urine test had been sent to the wrong practice and was not picked up until they were seen by hospital specialist. Minutes showed that systems had been improved to follow up results. Staff confirmed the minutes of these meetings had been sent to them.

However, the practice did not take a systematic approach towards analysing and identifying trends with reported incidents, events, accidents or complaints to ensure that risks were always mitigated for patients. For example, the practice did not have a risk register or have a standing item to discuss all written and verbal complaints. We identified that a number of complaints highlighted individual staffing concerns. GP partners confirmed that they were aware of this and had been taking action, however there was no record of these actions. Staff told us that verbal complaints were not routinely logged but the practice always took immediate steps to rectify matters. This was confirmed by some of the patients we spoke with.

National patient safety alerts were disseminated by email to practice staff. We were given an example of

increased cardiovascular risks related to the prescribing of a particular medicine. The practice undertook a search for patients who were on this particular medicine following the alert and where appropriate had discontinued or given an alternative medicine. Staff told us that the particular medicine was now only prescribed to patients for short courses and patients were closely monitored whilst on it.

Reliable safety systems and processes including safeguarding

Systems were in place to manage and review risks to vulnerable children, young people and adults. Training records showed that all staff had received relevant role specific training on safeguarding. GPs, nurses and administrative staff were able to describe recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed a dedicated GP lead in safeguarding vulnerable adults and children. However, the vulnerable adults policy did not outline who was the lead GP. The lead GP had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who the safeguarding lead GP was and who to speak with in the practice if they had a safeguarding concern. We saw posters with information about reporting processes in every consultation room.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans and linked with other siblings and family members registered at the practice. GPs were using the required codes appropriately on the electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as the police and social services. For example, a GP

had liaised with the adult safeguarding team about a patient with altered mental capacity who they were concerned about. Safety measures had been put in place to support the patient at home.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure. All nursing staff, including health care assistants, had been trained to be a chaperone. Reception staff confirmed they did not act as a chaperone if nursing staff were not available.

Medicines management

The practice dispensaries at Bottreaux and Tintagel surgeries were inspected and we found that medicines were managed safely with the exception of authorisations required to give vaccinations including the winter flu vaccination programme. The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. However, we found that the assistant practitioner had also administered vaccines but this had not taken place in accordance with legal requirements or national guidance. We saw up-to-date evidence that nurses and the assistant practitioner had received appropriate training to administer vaccines. Following the inspection, the practice verified that patient specific directives had been put in place to authorise a health care assistant to undertake specific flu vaccinations with named patients. Members of the nursing staff were qualified as independent prescribers and received regular support in their role as well as updates in the specific clinical areas of expertise for which they prescribed. For example, one of these nurses saw patients with minor injuries and treated them, which meant patients did not have to travel a long distance to the nearest minor injury unit.

Medicines were stored securely in the treatment rooms and medicine refrigerators and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The reception area at the branch practice in Tintagel was not secure enough to reduce the risk of unauthorised persons gaining access to records and dispensed medicines. Immediately following the inspection, the practice confirmed that a lock had been fitted to a door leading into this area to prevent unauthorised persons access.

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

Records of practice meetings demonstrated that actions taken in response to a review of prescribing data. For example, patterns of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice were average when compared with local and national data. This showed the practice worked closely with the medication optimisation team at the clinical commissioning group (CCG). The practice held a list of patients on high risk medication, which required close monitoring and were doing this.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. Appropriate action was taken based on the results. For example, patients on lithium were closely monitored through regular blood screening. Their needs and changing risks were discussed each month with the consultant psychiatrist and other community mental health workers at the practice.

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

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

Practice staff undertook regular audits of controlled drug prescribing to look for unusual products, quantities, dose, formulations and strength. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

Requires improvement

Are services safe?

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. Records showed that all members of staff involved in the dispensing process had received appropriate training and their competence was checked regularly.

The practice had established a service for patients to pick up their dispensed prescriptions at four locations and had systems in place to monitor how these medicines were collected. They also had arrangements in place to ensure that patients collecting medicines from these locations were given all the relevant information they required.

Cleanliness and infection control

The premises were clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. In 31 comment cards, patients remarked that they were satisfied with the standard of cleanliness at the practice. All thirteen patients we spoke were also satisfied with the cleanliness and infection control at the practice.

The practice had a lead nurse for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. New staff had received induction training about infection control specific to their role. The lead nurse had carried out audits for each of the last three years and improvements identified for action were completed on time. Minutes of practice meetings showed that the findings of the audits were discussed and the actions implemented. Over the course of three years, the infection control audits showed improvement in areas previously highlighted. For example, the practice had introduced single use equipment so that minimal equipment needed to be sent to the central sterilisation unit at the main hospital in Truro. Nursing staff had safe systems in place for cleaning and storing used equipment until it was taken for sterilisation. We saw used equipment was bagged and labelled and stored separate to sterile equipment.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. Staff were able to describe how they would use these to comply with the practice's infection control policy. For example, we saw there was a designated box for patients to put samples in and a protocol followed each time it was emptied. The healthcare assistant and nursing staff handled the samples, carried out checks and then safely disposed of the contents. The practice had a needle stick injury policy in place and staff knew the procedure to follow in the event of an injury.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms at both Bottreaux and Tintagel Surgeries.

The infection control policy made reference to other related policies such as the control of substances hazardous to health (COSHH), management of legionella risk, cleaning procedures and risk assessment. COSHH data sheets were held at the practice for all substances used and provided staff with appropriate guidance to reduce potential risks. We asked to see evidence showing that suitable procedures for the management, testing and investigation of legionella were being carried out This is a bacterium that can grow in contaminated water and can be potentially fatal. The practice sent us evidence demonstrating that a contractor carried out a legionella check of the water systems in September 2014. However, the practice was unable to produce any records to show that regular checks had been carried out up to the end of January 2015 in line with national guidance to reduce the risk of infection from legionella to staff and patients were being done. These would normally include a risk assessment, written procedures in place to reduce any risks identified and evidence of procedures having been carried out.

Equipment

Staff told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. The practice did not have a schedule of testing in place to proactively maintain equipment to reduce potential risks associated with this. However, we found equipment was tested and maintained and records demonstrated this was happening. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. Staff confirmed that equipment were calibrated for accuracy for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer.

Requires improvement

Are services safe?

Staffing and recruitment

There were gaps in the recruitment policy. For example, there were no governance arrangements listed or review date for the recruitment policy and key information was missing with regard to pre-employment checks and links with disciplinary and safeguarding procedures. The practice had done a risk assessment, which identified key checks required for each role at the practice. For example, which roles required an enhanced Disclosure and Barring Service (DBS).

Three out of twenty three staff records were looked at and did not demonstrate that appropriate recruitment checks were undertaken consistently prior to employment. For example, one file for a member of staff in which the practice risk assessment stated that a DBS check was required did not have evidence this had been done. Identity checks had not been carried out.

The practice did not consistently record that entries on the performers list for GPs had been checked. For example, there was no evidence that the entries on the performers list or GMC had been checked prior to a locum GP working at the practice. The practice manager verified that checks were done by Kernow Clinical Commissioning Group (CCG) or the Peninsular Deanery before these staff were issued an NHS smartcard to get access to IT systems.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. For example, nursing staff told us that they worked at Bottreaux and the branch practice at Tintagel to ensure there was continuity of professional practises. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

GP partners told us that the practice had been through a challenging period due to long term sick leave of key staff working at the practice. During this period, we were told that staff morale had been low as there was increased pressure on the team during the busy winter months. Staff told us that this had improved and there were enough staff to maintain the smooth running of the practice and to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements. The turnover was low.

Monitoring safety and responding to risk

The practice had some systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. A risk assessment was carried out in November 2014, which was thorough with regard to all parts of the building. This concentrated on health and safety matters but did not cover security or corporate risks. The practice did not have a risk log, where each risk had been assessed and rated and mitigating actions recorded to reduce and manage the risk. Staff told us that risks were raised with the practice manager and GP partners and actions were recorded in minutes and were disseminated to the team. We saw that any risks were discussed at GP partners' meetings and within team meetings. The lack of a risk log prevented the practice having proper oversight of emerging and actual risks relating to health and safety, security or corporate risks.

Checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment took place. However, these were not carried out consistently at the frequencies expected, recorded or adequately monitored by accountable staff. There were gaps in recording some fire safety arrangements at the practice. For example, a fire risk assessment was completed in 2011 and reviewed prior to the inspection. However, we found that this only covered the Bottreaux practice. There were no records of testing the burglar and smoke detectors. The practice had fire training records or nominated fire wardens in the event of a fire. A fire drill had taken place in January 2015 and staff confirmed these took place. At the branch practice in Tintagel, we found an oxygen cylinder had a label showing it was last serviced in 2009. Nursing staff showed us tick list showing this equipment had been checked by them in January 2015. The tick list showed the checks completed, but there was no description of what the checks had involved and covered the oxygen, medicines cupboard, first aid box, suction equipment and dressings. We asked for clarification about whether there was any corresponding guidance for staff to follow, but the practice was unable to produce any. Immediately following the inspection, we received written confirmation from the practice that systems had been put in place to address the issues highlighted throughout the inspection.

Requires improvement

Are services safe?

The practice had a health and safety policy. Health and safety information was displayed for staff to see and highlighted that the practice manager and three GP partners were responsible for management of health and safety matters.

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. Staff gave us examples of referrals made for patients whose health deteriorated suddenly and this was supported by patients comments. For example, a child who was temporary resident staying in the area had experienced an anaphylactic response to a particular food. The child was given emergency treatment including oxygen and medicines before an ambulance could reach the practice.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records demonstrated that all staff had received training in basic life support. All the GPs had received up to date life support training with Automated External Defibrillation (AED), anaphylaxis and airways management for adults and children. GPs told us that the latter was particularly important given that the practice and surrounding villages were isolated and approximately 37 miles away from the main hospital. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). This also included appropriate equipment used to resuscitate children. All of the staff we spoke with knew the location of this equipment and records confirmed that it was checked regularly.

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

The practice had practical experience of a major incident, when Boscastle flooded in 2004. The senior GP partner told us about the impact of that major event, when the practice became the centre of rescue operations for the village playing a key role in co-ordinating rescue, triaging and treating patients who were then transferred to the main hospital in Truro. The practice had a written business continuity plan to record the range of emergencies that may impact on the daily operation of the practice.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. Monthly meetings were held at which the latest guidelines and research was discussed. For example, one of the GPs had presented a summary of the latest guidance about how to manage patients with high lipid levels. Minutes were held of these meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. Our discussions with the GPs and nurses demonstrated that they completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease, asthma, women's health and family planning. Practice nurses had additional qualifications which allowed the practice to focus on specific conditions, for example diplomas in asthma, respiratory disease, diabetes and heart disease management. Both nurses held advanced nurse practitioner qualifications. Data for the local CCG showed that the practice performance for monitoring patients with long term conditions was comparable with other practices.

Data from the local CCG of the practice's performance for antibiotic prescribing demonstrated that this was comparable to similar practices. The practice had also completed a review of case notes for patients with diabetes to determine whether the GPs had tried recommended first line treatment with these patients. This showed all were receiving appropriate treatment for their needs and had been regularly reviewed.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. The practice reviewed patients every month and had on site meetings with other health and social care professionals supporting them. For example, patients with complex mental health needs were reviewed every month at the practice with a consultant psychiatrist, counsellor and other community mental health workers. This review considered any behavioural changes, potential and actual risks and support networks for the patient. Information was shared between teams to help support patients with early interventions such as increasing medicines or arranging additional support where needed. GPs told us the aim of this was to be proactive in supporting patients to remain in the community and avoid hospital admission wherever possible.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of patients with suspected cancer. Data showed that patients with suspected cancers were referred and seen within two weeks.

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.

Management, monitoring and improving outcomes for people

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

The practice showed us four 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. Audits seen also confirmed that the GPs who undertook minor surgical procedures were doing so in line with their registration and National Institute for Health and Care Excellence guidance.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. For example, the practice prescribing patterns for all non-steroidal anti-inflammatory medicines was comparable with other practices nationally.

Good

Are services effective?

(for example, treatment is effective)

A GP partner completed a full cycle of audit to review prescribing practice as part of their revalidation. This took into account national guidance about the safe length of time a specific bone sparing treatment should be used for patients at risk of fractures. The audit reviewed 34 patients who had been on this long term treatment. In the first cycle, the GP identified 14 patients who needed or were waiting for the results of a bone density scan to inform any decisions taken about on-going treatment. Another 16 patients had the treatment stopped and one patient had already been advised to do so. Three patients continued on the treatment and had a review date planned. The second cycle of audit showed that patients remaining on the treatment had a review date planned with their GP, been referred for a bone scan or an end date set when an alternative treatment would be prescribed. The full cycle of audit showed that the identification of patients and actions taken had reduced the risk of potential harm caused by long term use of this medicine.

There was a protocol for repeat prescribing which was in line with national guidance. Repeat prescription requests were reviewed 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 used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines.

The practice had achieved and implemented the gold standards framework for end of life care. GPs told us that the nearest hospice was approximately 40 miles away. As such, they demonstrated with the examples shared the lengths they went to enable patients to remain at home at the end of their life. A palliative care register was held and reviewed regularly with the community matron, palliative care nurse and community nurses. This included monthly multidisciplinary meetings to discuss the care and support needs of patients and their families.

Patients with long term medical conditions were offered yearly health reviews. Nursing staff told us the frequency of each patient's health review was agreed with the person and based on their level of need. Both nurses held advanced qualifications, which enabled them to take the lead in running clinics to carry out reviews of patients.

An annual flu vaccination programme was underway when we inspected. This included older patients, those with a long term medical condition, pregnant women, babies and young children. For appropriate patients a vaccination against shingles was also available. Patients were contacted via text, phone or email. Data showed that 97.3% diabetic patients had been vaccinated against flu.

Data showed 94.2% 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. This was comparable with national average of 96%.

Data showed that the percentage of women aged between 25 and 65 years old whose notes recorded that a cervical screening test had been performed in the preceding five years was 79.7% which was comparable with the national average of 82%.

Effective staffing

Staffing at the practice included medical, nursing, managerial and administrative staff. We reviewed training records and saw that all staff were up to date with attending mandatory courses such as annual basic and advanced life support for adults and children. There was a good skill mix across the team, with the GPs each having their own specialist interests areas such as women's health, child care, learning disabilities and complex mental health care. Each GP also had specific interests in developing their skills and disseminating this to the team covering long term conditions such as diabetes, chronic respiratory disease asthma and female sexual health. This included advanced qualifications, which benefitted patients. For example, a female GP specialised in women's health and had advanced qualifications which enabled her to carry out endometrial biopsies for investigation of peri-menopausal bleeding for female patients at the practice. All GPs were qualified to perform joint injections held qualifications which enabled them to do joint injections for patients at the practice, which also avoided the patient having to be referred to secondary care services some 40 miles away.

All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by the GMC can the GP continue to practice and remain on the performers list with the NHS England.

Good

Are services effective?

(for example, treatment is effective)

All staff undertook annual appraisals with the practice manager and a GP which identified learning needs. Mandatory training was provided on-line. Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses.

The nursing staff received their clinical appraisal from a GP at the practice. All of the nurses told us that they had the opportunities to update their knowledge and skills and complete their continuing professional development in accordance with the requirements of the Nursing and Midwifery Council. The nurses had received extensive training for their roles, for example, seeing patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease as well as the administration of vaccines and undertaking cervical smears. For example, one of the practice nurses had completed and master class in insulin initiation, which enabled them to introduce and support patients starting insulin treatment. Two nurses had advanced qualifications and were able to prescribe medicines and treat minor injuries.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. Blood results, X-ray results, letters from the local hospital including discharge summaries, out of hour's providers and the 111 service were received both electronically and by post. There were policies in place outlining the responsibilities of all relevant staff in passing on, reading and actioning any issues arising from communications with other care providers on the day they were received. The partner GPs were responsible for seeing these documents and results and for the action required. Staff understood their roles and felt the system in place worked well. Results and discharge summaries were followed up appropriately and in a timely way.

The practice worked effectively with other services. Meetings were held with the health visitor and school nurse to discuss vulnerable children. A multidisciplinary team meeting was held every month to discuss high risk patients and patients receiving end of life care. This included physiotherapists, occupational therapists, health visitors, district nurses, the community matron and the mental health team. Liaison with community team members was frequent as the majority of patients were enabled to stay at home with support due to the considerable distance to the nearest hospice. The practice had a list of vulnerable adults and worked closely with community professionals. For example, the practice worked closely with learning disability nurse specialist to build a trusting rapport so that the health and wellbeing of patients with complex learning disabilities was monitored. Data showed that the practice performed better than expected for completing annual health checks for patients with learning disabilities.

GPs shared the care of patients with mental health specialists. For example, the community drug and alcohol treatment team worked in conjunction with GPs at the practice to support patients undergoing seamless home detoxification.

Information sharing

The practice used several electronic systems to communicate with other providers. GPs told us they felt information sharing was crucial to facilitate continuity of care and were early up takers to the concept of shared access to patient summaries. Community health staff, for example a physiotherapist saw patients at the practice and was able to record their assessment and ongoing treatment so that the GPs could constantly review the patient's progress. We were told that all of the staff followed data protection procedures and had been vetted by the NHS to allow them to do this. There was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals. Special notes were shared with the 111 and Out of Hours services for patients with complex needs who needed continuity of care and treatment overnight.

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

Consent to care and treatment

Staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in promoting patient rights. Staff shared recent incidents that had required further assessment of a patient's ability to weigh up and understand information to give informed consent. For example, a GP had recently carried out a home visit to a patient diagnosed with dementia and had concerns about

their ability to retain information to weigh up risks and remain safe living in their own home alone. The GP had carefully considered how best to support this person's wishes, whilst also ensuring their safety and well-being was maintained. Records showed that they had involved the complex care team and initiated a request for home care support so that the patient was able to stay at home whilst undergoing further assessment of their mental capacity.

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. The practice was an approved young person friendly service, which provided information about sexual health matters and contraception in suitable formats. Young people contacting the practice were offered an appointment with either a named GP or practice nurse. The practice offered advice and carried out confidential chlamydia screening. Parents with children attending the practice confirmed that they were always present during consultations. They told us staff involved their children in a non-threatening way and gained their trust so that examinations or treatment could take place.

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure. Nursing staff also recorded patient consent for procedures such as wound dressing, blood taking or cervical screening.

Health promotion and prevention

Information about numerous health conditions and self-care was available in the waiting area of the practice. The practice website contained information and advice about other services which could support them. The practice offered new patients a health check with a healthcare assistant or with a GP if a patient was on specific medicines when they joined the practice.

The practice recognised the needs of patients and their difficulty with transport to the hospital for appointments. They had arranged for screening for certain conditions to be taken at the practice. For example, eye screening took place at the practice every year for patients at risk of developing diabetic retinopathy. This was appreciated by patients we spoke with who were in this position as it avoided them having to travel to the ophthalmology clinic based at the main hospital approximately 40 miles away. Outside agencies used the consulting rooms at the practice. For example, two counsellors, a physiotherapist, addiction counsellor and health visitor ran clinics at the practice for patients who were referred to them by the GPs.

Child immunisation rates at the practice were comparable and some exceeded national rates. For example, 38 children were eligible for pertussis vaccination and 100% had received it.

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Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

GPs said they aimed to promote patient dignity and respect in the way they approached requests for a home visit. They told us they did so by overriding the normal triage system in place at the practice and assessed patients at their home where needed.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 31completed cards and all were positive about the care and treatment experienced. Patients said they felt the practice offered very good services and staff were caring, helpful and professional. They said staff treated them with dignity and respect and showed great empathy towards them and their families. Patients were complimentary about reception staff and told us that every effort was made to give them a same day appointment even for routine issues.

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.

We saw staff were discreet when discussing patients' treatments in order that confidential information was kept private. There were additional areas available should patients want to speak confidentially away from the reception area. We observed patient experiences as they arrived for appointments. Reception staff were welcoming and treated patients with respect.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Staff were able to explain how they diffused situations to avoid further escalation of a patient's frustration or anger.

Care planning and involvement in decisions about care and treatment

Patients told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. Staff were described as being good at listening to their needs and acting on their wishes. Patients said they had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the 31 comment cards we received was also positive and aligned with these views.

Patient survey information demonstrated that the practice achieved a better than expected level of patient involvement in planning and making decisions about their care and treatment. For example, data from the national patient survey showed 95.1% of practice respondents said the GP involved them in care decisions and 93.4% felt the GP was good at explaining treatment and results.

Data showed that the practice was performing better with regard to maintaining a palliative care register for patients. GPs told us that treatment escalation plans were routinely discussed with patients on the register and their wishes about end of life care needs recorded. Minutes of the monthly multidisciplinary meeting demonstrated these were being followed for patients.

Staff told us that translation services were available for patients who did not have English as a first language. Notices in the reception areas and information on the practice website explained the translation services available in a number of languages.

Patient/carer support to cope emotionally with care and treatment

The 31 comment cards we received were consistent in describing positive experiences about the care and treatment they had received. Patients highlighted that staff were understanding, listened and treated them well. The practice ran a monthly carers clinic in conjunction with a community support worker, to provide practical and emotional support for patients who were carers. GP patient survey data showed 95% patients described the overall experience of their GP surgery as fairly good or very good when compared with the national rate of 85.7%.

Notices in the patient waiting room and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. Written information was also displayed in the waiting room explaining the various avenues of support available to carers. For example, information about the Bude Carers' Support Group was advertised in waiting rooms at Boscastle and Tintagel. There was a telephone number to refer a new carer to a Cornwall Carers Centre in Truro.

Good

Are services caring?

Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. The patients we spoke with gave us examples of the support received from practice staff when they had experienced difficult and challenging times in their lives. For example a patient who was also a carer for their spouse who was diagnosed with dementia described the emotional support they had received after a telephone consultation with their GP. They told us they were pleasantly surprised when within an hour of the call the GP arrived at their home to help support them.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and isolation of the practice taken into account in the planning of services delivered. For example, the practice had trained staff so that they could provide a 24 hour electrocardiogram service for patients, which included a 7 day loop. This service was also provided for patients in neighbouring practices to avoid them having to travel 37 miles to the nearest hospital where these were normally done. A GP specialised in women's health and held qualifications which meant that investigations into peri-menopausal bleeding could be done at the practice instead of the main hospital. Joint injections were carried out at the practice, which meant that patients did not need to be referred to secondary health care services.

The practice delivered person centred and responsive treatment and support for patients with complex mental health needs. The practice had integrated services so that joint meetings were held every month with the consultant psychiatrist and community mental health workers with reviews taking place of every patient with complex mental health needs. Treatment and support was reviewed and increased quickly in response to early signs of mental health crisis for patients. This meant patients were able to avoid hospital admission and better supported by an early intervention approach.

Various other clinics run by healthcare workers were hosted at the practice. For example, one day per week a physiotherapy clinic was held. Other community workers held clinics to support patients experiencing mental health issues such as depression, addiction or bereavement. Counselling sessions were run by two counsellors, which had increased patient access to these services over and above what was available through the mental health partnership trust.

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. We saw minutes showing that GPs worked in collaboration with other health and social care professionals to support patients at home. GPs told us they were proud of the care close to home service which was promoted by the practice.

Thirty one patients commented in feedback cards and a further 11 in person told us that the prescription system was good. Some patients used the on line request service, whilst others called in to collect their prescription from the dispensary. The practice had arrangements in place for more vulnerable patients so that prescriptions were delivered to their homes or drop off points at four local post offices for collection. All patients said the process was efficient and took no more than a couple of days.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). An action plan was published on the website, showing the response and current status of actions taken. For example, two representatives told us that patients had raised concerns about the quality of the seating in waiting rooms and it had been replaced.

Tackling inequity and promoting equality

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

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed or were completing the equality and diversity training. All of the staff told us that equality and diversity was regularly discussed at staff appraisals and team events.

The practice buildings at Boscastle and Tintagel were single level. The practice was accessible for patients in wheelchairs with ramp access to the side of both of the premises. The waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities. The practice had an audio loop in the waiting room for those with hearing aids.

The practice had systems in place to support patients whose circumstances may make them vulnerable. For example, the practice had a register of patients who may be living in vulnerable circumstances, with specific

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

information in individual records about potential risks and support that was needed. GPs told us there were no barriers for homeless patients and workarounds were in place to record contact information. For example, patients mail about hospital appointments could be sent to the practice for them to pick up or messages left on their mobile phone. Staff told us they would fit patients in for appointments if they presented on the day, making appointments accessible. However, GPs told us the practice rarely had any homeless patients due to its geographical location and extremely limited public transport to the area.

Patients in 31 comment cards confirmed they were satisfied with the appointment system.

Access to the service

Bottreaux Surgery is open from 8.15 am - 6pm Monday to Friday. Extended opening hours are held once a week at Boscastle every Tuesday between 6.30pm to 8.45 pm. At Tintagel Surgery opening hours are 8.30-6pm every day, except on Wednesday and Fridays when it closes at 12.30pm. Patients could attend the practice at Boscastle when the one in Tintagel was closed. The dispensaries at both practices are open during opening hours. During evenings and weekends, when the practice is closed, patients are directed to an Out of Hours service delivered by another provider. This is in line with the contract held by GP practices in the Kernow clinical commissioning group and includes covering 6-6.30pm every evening.

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

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

Feedback cards completed by 31 patients had a recurring theme highlighting that they were able to get an appointment when they needed it. Eleven patients we spoke with told us the appointment system was accessible, by telephone, online or bookable in person. They confirmed urgent appointments were available on the same day. We saw reception staff answered the telephone to patients in a friendly way and were accommodating in getting them appointments to see the GPs or nurses.

The practice used a triage system and offered telephone appointments for patients. Patients told us their GP usually telephoned them back after morning surgery or during the evening between appointments on a Tuesday, which they felt was a good alternative to attending in person for minor issues. There was a skill mix of staff, including nurses with advanced qualifications which enabled them to provide clinics for patients and treat minor injuries.

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 up to an hour at a time. Onsite counselling services were available on site provided by the local mental health partnership trust and other counsellors. Information was displayed in waiting areas for patients and highlighted they could self-refer to these counselling services if they wished to.

The practice was in a coastal rural location, with extremely limited transport links to the main hospital situated some 37 miles away. Through fundraising various specialist equipment had been purchased to promote patient access to services. For example, the practice had a centrifuge, so could process blood samples to be useable by the laboratory whatever time of day they were taken. Community nurses also came to the practice to centrifuge their samples and send them with the NHS courier.

In the summer months the demand on the practice could increase by a third at the height of summer, with over a 1000 temporary patients visiting each year, as it was situated in a popular holiday resort. The practice increased staffing at these times so that permanent patients were not affected.

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.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

There was a designated responsible person who handled all complaints at the practice. Information about making a complaint was clearly displayed in several areas at Bottreaux and Tintagel practices.

We looked at 7 complaints received from patients over a 12 month period, all of which had received a prompt acknowledgement and outcome in writing. All 12 staff we spoke with told us that the practice approach was to take immediate steps to rectify any issues with patients and they were proud of this. The practice was able to demonstrate some evidence of learning from patient complaints. For example, the practice made changes to the telephone system providing an extra phone line and increased receptionist to answer telephone calls from patients. The practice did not, however, analyse or identify trends with complaints to ensure that risks were always mitigated for patients. Following the inspection, the practice verified that a complaint log had been set up to capture all written and verbal complaints and learning from these which would then be shared with staff.

The feedback we received from the eleven patients we spoke with and 31 written comment cards was positive. This confirmed that staff treated them with respect and listened and acted on their needs. None of the patients raised any concerns or complaints. Patients confirmed they would either speak to the receptionists, the GP or practice manager should they have any concerns.

Are services well-led?

Requires improvement

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The team aimed to provide a responsive, supportive and well co-ordinated service for patients which centred on care at home. The practice vision and values included to offer a friendly, caring good quality service that was accessible to all patients. We spoke with 12 members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. Patients comments in person and in the 31 comment cards received confirmed this was their experience of the practice.

Staff morale was said to be improving at the practice after experiencing additional pressures whilst some key staff were on long term sickness. Staff said they felt valued and were encouraged to do the best for patients. The practice team was managed in an open and transparent way at the practice.

Governance arrangements

The practice did not have effective assurance systems to proactively monitor potential safety risks. We found several areas of potential risk. For example, there was no overall risk log to identify business, safety or patient feedback risks with which to monitor actions being taken. We found several areas of potential risk, which we highlighted at the inspection. Examples seen included the fire safety risk assessment had not been reviewed regularly and did not cover the branch practice at Tintagel, written authorisation was not in place and legally required for vaccinations carried out by an assistant practitioner. Procedures set out in policies such as the recruitment procedure and role risk assessment were not being followed and had not been identified prior to the inspection. Appraisal and monitoring of individual performance, identification of training needs and communication of significant information was not consistent across the whole practice and did not include temporary staff such as locum GPs.

The practice had experienced a major incident in the last 10 years when Boscastle experienced a serious flood with potential risk to life. Staff told us the practice become the central operations centre, triaging and treating people rescued. The team told us that there had been significant learning from this event, which help develop the emergency response services at the practice, which could be called into operation at any time. A known risk for the practice continues to be the rare but potential flooding risk of the village. The isolated position of the area delays transportation of critical patients to the main hospital emergency department and the GP partners had mitigated these risks by extending their skills through advanced life support qualifications and appropriate equipment.

The practice had a number of policies and procedures in place to govern activities. Some of these but not all were available to staff on the desktop on any computer within the practice. The practice was not utilising the NHS information governance tool kit fully. The tool kit was developed by the Department of Health to encourage services to self assess so that they could be assured that practices, for example, have clear management structures and responsibilities set out, manage and store information in a secure, confidential way that meets and data protection. We looked at some of the policies and procedures at the practice, which included those covering safeguarding, infection control and recruitment. Policies had not always been reviewed in line with review dates and were missing some references to the latest legislation. The leadership governance, which was in place was not always clear or apparent in the written policies and procedures seen.

We spoke with 12 members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued and the majority felt well supported. They told us that they knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice for 2013-2014 showed it was performing in line and in some instances better than expected with national standards. Staff told us that QOF data was discussed at partners meetings, which were not attended by the practice manager. Clinical staff told us they were clear about areas they had to maintain or improve outcomes for patients and we saw reference to these in clinical meeting minutes held each month. For example, minutes of a meeting held in September 2014 recorded that there was nothing to report and advised staff to review the practice monitoring system for QOF.

The practice carried out clinical audits which it used to monitor quality and systems to identify where action should be taken. The majority of these were incentive

Are services well-led?

Requires improvement

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

driven initiated by the Kernow clinical commissioning group (CCG). For example, infection control audits had been carried out annually and we saw these for 2013, 2014 and 2015. We discussed the findings from the audit carried out in January 2015. These highlighted changes in the way urine samples were stored before being collected by courier and taken to the hospital for analysis. GPs undertook minor surgery audits to

The practice had thorough arrangements for identifying, recording and managing risks for patients. For example, vulnerable patients including adults and children were monitored well and risks assessed and acted upon. Clinical meeting minutes each month highlighted emerging risks and agreed actions with the multidisciplinary team. The electronic patient recording system was used effectively with codes which denoted risks and monitoring required. Another example demonstrated how the practice responded to national alerts, which often highlighted potential risks for patients. For example, an alert had highlighted risks with a medicine used the relieve symptoms of nausea and vomiting. Clinical meeting minutes for September 2014 highlighted that all patients on this medicine should be reviewed face to face and those with heart disease be prioritised first. GPs confirmed this had been done.

Leadership, openness and transparency

The practice leaders were open with us from the outset of the inspection about the challenges it faced of being in an isolated coastal location. They told us this meant they needed to be very self-reliant and were developing services for patients along these lines. Succession planning was in progress to consider the future needs of the patient population at practice as some staff were nearing retirement. GPs told us the challenge would be to attract staff to this pretty but isolated area, on top of the nationally recognised shortage of qualified GPs.

Staff told us that practice meetings were usually held every 3 months. However, staff told us that the pressure of reduced staff numbers due to long term sick leave of staff had impacted on the frequency of this. For example, there had been two meetings in the previous 14 months and we saw minutes of these. This was confirmed by senior staff.

Clinical meetings were held regularly every month and included other community health professionals supporting patients. For example, minutes for November and December 2014 showed this had taken place. We saw that the second part of the meetings focussed on learning, with presentations about particular issues followed by discussion. GPs told us about other meetings they held each month to discuss vulnerable patients, including those on the palliative care and safeguarding registers. These were also seen as an opportunity to discuss ways to develop working across the community and improve patient experience. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues outside of team meetings with key staff such as GP partners.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, induction policy and management of health and safety which were in place to support staff. Staff knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The importance of patient feedback was recognised and there was an active patient participation group (PPG). Prior to 2014, the PPG was a virtual group and had been encouraged to hold face to face meetings to help the practice hear feedback and act upon it. We met two members of the PPG who told us that the practice listened and acted on suggestions made. They explained that none of the GP partners had attended meetings, but were satisfied that the practice manager reported their views to the GP partners and changes had been made to the service. For example, changes to the telephone system had been made making it easier to get through and information, including patient questionnaires had been streamlined with the input of the PPG.

Management lead through learning and improvement

A random selection of five staff files showed that four annual appraisal were carried out. The practice did not have any mechanisms in place to provide feedback to temporary staff such as locum GPs. As a training practice, it was regularly assessed by the Peninsular Deanery to determine whether it was a suitable placement for trainee GPs, doctors and medical students.

Training needs were identified with each member of staff during appraisal, present conduct discussed and future plans were agreed upon. Nursing staff files contained evidence of professional training and reflection on specific issues. Clinicians were appraised by clinicians and

Are services well-led?

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administration staff appraised by administration staff. Competencies were assessed by a line manager with the appropriate skills, qualifications and experience to undertake this role.

The practice undertook a range of audits and professional groups had specific objectives to achieve. GPs and nurses are subject to revalidation of their qualifications with their professional bodies. We saw a cycle of audit taking place at individual level. For example, the revalidation of nurses in cervical screening was required every three years. Nurses held records of anonymised cervical screening results, which were peer reviewed. All inadequate result cervical smears carried out for patients, were reviewed by the nurse and their GP appraiser. Mentoring and support was provided where needed to improve skills and accuracy with such testing. Nursing staff verified that the level of valid cervical smears taken from female patients were within the accepted national range and therefore had not altered the frequency of the update training they were required as standard to undertake.

Complaints and significant events were seen as opportunities to learn from and improvements made by the team as a result of these.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

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

Regulated activity	Regulation

This section is primarily information for the provider

Compliance actions

Diagnostic and screening procedures

Family planning services

Maternity and midwifery services

Surgical procedures

Treatment of disease, disorder or injury

Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision

We found that the registered person had not protected people against risks. This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17(2)(a,b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems or processes must be established to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of patients in receiving those services) and assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity

How the regulation was not being met:

· There was no overall risk log to record business, safety or patient feedback risks with which to monitor actions being taken. We found several areas of potential safety risk, which we highlighted at the inspection. Examples seen included the fire safety risk assessment had not been reviewed regularly and did not cover the branch practice at Tintagel, legionella risks had not been assessed and procedures put in place to mitigate these, written authorisation was not in place and legally required for vaccinations carried out by a health care assistant. Procedures set out in policies such as the recruitment procedure and role risk assessment were not being followed and had not been identified prior to the inspection. Appraisal and monitoring of individual performance, identification of training needs and communication of significant information was not consistent across the whole practice and did not include temporary staff such as locum GPs.

· Policies and procedures had not been consistently reviewed to provide staff with the most up to date and current guidance to follow.