Wadebridge and Camel Estuary Practice

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Wadebridge and Camel Estuary Practice on Wednesday 25 March 2015.

Overall the practice is rated as good.

We found the practice to be good for providing safe, well led, effective, caring and responsive services. It was also rated good for providing services for the six population groups of older people, people with long-term conditions; mothers, babies, children and young people; the working-age population and those recently retired; people in vulnerable circumstances who may have poor access to primary care

and people experiencing poor mental health

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

There was a track record and a culture of promptly responding to incidents, near misses and complaints and using these events to learn and change systems so that patient care could be improved.

Staff were aware of their responsibilities in regard to consent, safeguarding and the Mental Capacity Act 2005 (MCA).

The practice was clean and tidy and there were infection control procedures in place.

Medicines were generally managed well within the dispensaries and at the practice and there were effective systems in place to deal with emergencies.

The GPs and other clinical staff were knowledgeable about how the decisions they made improved clinical outcomes for patients although patients care plans were not always kept under review.

Most data outcomes for patients were either equal to or above the average locally.

Patients were complimentary about the staff and how their medical conditions were managed.

Practice staff were professional and respectful when providing care and treatment.

Summary of findings

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

There were clear recruitment processes in place. There were robust induction processes in place, although this was not always in place for all locum staff.

The practice had a vision, clear ethos and mission statement which were understood by staff. There was a leadership structure in place and staff felt supported.

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

The Provider should:

- Ensure all locums receive an induction to ensure they are familiar with emergency procedures and local guidelines.
- Have systems in place to make sure personalised care plans are kept under review.
- Consider sharing action and learning following a significant event or complaint with the whole team.
- Ensure the infection control audit is able to identify latest good practice guidelines.
- Adopt systems to ensure the safe storage of prescription stationary and GP's bags when the GPs are not present in their room.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

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

The practice was clean, tidy and hygienic. Arrangements were in place that ensured the cleanliness of the practice was consistently maintained, although there were no structured programmes in place to ensure clinical equipment is cleaned.

Significant events and incidents were responded to in a timely manner and investigated systematically and formally. There was a culture to ensure that learning and actions were communicated to staff involved following such investigations, although learning was not always shared across the whole staff team.

Staff had an awareness of the Mental Capacity Act 2005 (MCA) and of their responsibilities regarding safeguarding adults and children. All staff had received training in safeguarding awareness.

There were arrangements for the efficient management, storage and administration of medicines within the dispensaries and practice with systems in place to identify when equipment needed to be replaced.

Staff turnover was low. Recruitment procedures and checks were completed on permanent staff as required to help ensure that staff were suitable and competent. There were robust induction processes in place for permanent staff; this was not always in place for all locum staff.

There were clear processes to follow when dealing with emergencies. Staff had received basic life support training and emergency medicines were available in the practice.

Are services effective?

Good

The practice is rated as good for providing effective services.

Systems were in place to help ensure that all GPs and nursing staff were up-to-date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines. The nursing team and dispensary staff used clear evidence based guidelines and patient directives when treating patients.

The practice used the national Quality Outcome Framework (QOF- a national performance measurement tool) scheme and knew where additional actions were needed to improve these targets. Data

Summary of findings

showed that the practice was performing equally when compared to neighbouring practices in the clinical commissioning group (CCG). Risks to patients were assessed and care was planned and well managed.

Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessment of patients' capacity to make informed choices about their treatment and the promotion of good health.

Patients with complex care needs and vulnerable patients had their care planned in line with NICE guidelines. Some patients had been involved in forming personalised care plans to assess and show how care would be delivered. However, some patient care plans had not been recently reviewed.

Audits were performed and completed regarding patient outcomes, which showed a safe, consistent level of care and effective outcomes for patients.

Patients told us staff asked for their consent before any treatment was provided. There was a chaperone service available.

There was a systematic induction and training programme in place with a culture of further education to benefit patient care and increase the scope of practice for staff. However, the locum GPs were not always provided with this.

The practice worked together efficiently with other services to deliver effective care and treatment. Information sharing and decision making was shared well with external health care professionals and providers.

Are services caring?

Good

The practice is rated as good for providing caring services.

Feedback from patients about their care and treatment was consistently positive. The patients we spoke with on the day, the comment cards we received, a friends and family survey reflected this feedback. Patients described the practice as caring, well organised and said they trusted the staff and GPs, who knew them well.

We observed a person centred culture. We found strong evidence that staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieve this.

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

Summary of findings

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

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

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

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

The practice planned and provided appropriate services for patients and worked well with commissioners and other health care providers to ensure patients received effective care.

There was an effective appointment system. Patients said they could get an appointment easily in advance or with a GP on the same day.

Are services well-led?

Good

The practice is rated as good for being well led.

The practice had a formal vision, ethos and mission statement which included being on the patients side. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure in place and a number of policies and procedures to govern activity. There were systems in place to monitor and improve quality and identify risk.

There was a culture of wanting to improve and learn following any significant event or complaint. Action and learning was shared with the staff involved, but not always with the whole team. The practice welcomed feedback from patients through the surveys and from the patient participation group (PPG).

Permanent staff had received induction, training, regular performance reviews and attended whole staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice had an open list. Patients aged 75 and over had their own allocated GP but had the choice of seeing whichever GP they prefer. Treatment was organised around the individual patient and any specific condition they have.

A programme of pneumococcal, shingles and influenza vaccinations were provided at the practice for older people. Vaccines, for older people who have problems getting to the practice or those in local care homes are administered in the community by the community nurses. GPs undertook home visits for older people and patients who require a visit following discharge from hospital.

The practice had a system to identify older patients and coordinated the multi-disciplinary team (MDT) for the planning and delivery of palliative care for people approaching the end of life. This included the community matron, district nurses and a palliative care specialist nurse. Patients on the palliative care register were discussed at monthly MDT meetings.

The practice worked to avoid unnecessary admissions to hospital and collaborated with other health care professionals to provide joint working. This included providing personal care plans for those at high risk. Vulnerable patients were discussed at the monthly MDT meetings.

The practice had in house physiotherapy clinics for those unable to attend the hospital.

The dispensary provided medicines in blister packs for older people with memory problems.

Both premises were all one level for easy access. Chairs in the waiting room included some with arm rests to assist patients to stand.

People with long term conditions

Good

The practice identified patients who might be vulnerable, have multiple or specific complex or long term needs and ensured they were offered consultations or reviews where needed.

The staff at the practice maintained links with external healthcare professionals for advice and guidance. Particular clinics operated for patients with diabetes, cardiovascular disease, asthma and chronic respiratory conditions. The nurses attended educational updates to keep sure their lead role knowledge and skills up to date.

Summary of findings

The asthma and chronic lung disorders clinics used spirometry to assess the evolving needs of this patient group. The practice promoted independence and encouraged self-care for these patients. There was a blood pressure machine in the waiting area so patients could monitor their own blood pressure. Scales in the waiting room allow patients to monitor their own weight. Patient information leaflets were available in the waiting areas and corridors of the practice.

There were regular diabetic clinics, with GP input, to treat and support patients with diabetes. These clinics included education for patients to learn how to manage their diabetes through the use of insulin. Patients were able to start insulin at the practice which was supervised by the practice nurse and saved the patients going to hospital for this. Health education was provided on healthy diet and lifestyle and access to weight management programmes facilitated by the GPs and practice nurses.

The practice referred carers to a carer support worker for support and guidance on social care issues.

Patients receiving certain medicines were able to access monitoring services at the practice to ensure the medication they receive was effective and not damaging.

Families, children and young people

Good

GPs performed 24 hour post natal baby checks following discharge from hospital or home delivery and carried out six week checks on all babies registered.

There were well organised baby and child immunisation programmes available to ensure babies and children could access a full range of vaccinations and health screening. Regular immunisation clinics were held at the practice.

Ante-natal care was provided at the practice by a midwife who had access to the practice computer system and could speak with a GP should the need arise. The practice had effective relationships with health visitors and school nursing team. Systems were in place to alert health visitors when children had not attended routine appointments and screening.

The practice held regular meetings with the health visitor to discuss any vulnerable babies, children or families.

Patients had access to a full range of contraception services (including coils and implants) and sexual health screening including chlamydia testing and cervical screening. There were quiet private areas in the practice for women to use when breastfeeding.

Summary of findings

The practice had an arrangement with the local comprehensive school to allow same day access for pupils who require contraceptive advice.

Appropriate systems were in place to help safeguard children or young people who may be vulnerable or at risk of abuse.

Working age people (including those recently retired and students)

Good

Advance appointments (up to two weeks in advance) and evening appointments were available once a week to assist patients not able to access appointments due to work commitments. There was an online appointment booking system. Patients were able to opt in to a text message reminder service for appointments.

Travel advice was available from the GPs and nursing staff. The practice website allowed patients to submit information on line for a personal vaccination plan.

The staff offered opportunistic health checks on patients as they attend the practice. This included offering referrals for smoking cessation, providing health information, routine health checks and reminders to have medication reviews. The practice also offered age appropriate screening tests such as cholesterol testing. Smoking cessation clinics were held in-house on a weekly basis.

Patients could order repeat medication online, by post or in person and said this system worked well. Dispensing patients could collect from either surgery. Non-dispensing patients could collect from a chemist of their choice.

People whose circumstances may make them vulnerable

Good

The practice had a learning disabilities register. These patients were offered a health check each year, during which their long term care plans were discussed with the patient and their carer if appropriate. Practice staff liaised with the community disabilities nurse who saw those patients who had difficulty attending clinic.

Practice staff were able to refer patients with alcohol addictions to an alcohol service for support and treatment. The support service visits the practice on a fortnightly basis.

The practice worked with and referred patients to a community matron who visited vulnerable patients to assess and facilitate any equipment, mobility or medication needs they may have. These patients were discussed at regular multidisciplinary meetings.

There were a small number of patients whose first language is not English. A translation service was available.

Summary of findings

People experiencing poor mental health (including people with dementia)

Good

The practice had a register which identified patients who had mental health problems.

There was a practice attached community dementia care practitioner who attended regular MDT meetings. There were nationally recognised examination tools used for people who were displaying signs of dementia.

Patients had access to an in house counsellor for depression, alcohol issues or more general issues. Patients who had depression were seen regularly and were followed up if they did not attend appointments.

In house mental health medicine reviews were conducted to ensure patients received appropriate doses of their medicines. Blood tests were regularly performed on patients receiving certain mental health medications.

There was communication, referral and liaison with the psychiatry specialist. Monthly meetings were held at the practice with the consultant psychiatrist, community psychiatric nurse, counsellor and third sector mental health charity representatives. Patients were able to be assessed at home or in Bodmin.

Staff were aware of the Mental Capacity Act (2005) but had not received training on this.

Summary of findings

What people who use the service say

We spoke with 13 patients during our inspection and with a member of the patient participation group.

The practice had provided patients with information about the Care Quality Commission prior to the inspection. Our comment box was displayed and comment cards had been made available for patients to share their experience with us. We collected 11 comment cards, all of which contained positive comments. There were no negative comments.

Comment cards were detailed and stated that patients appreciated the helpful staff, caring and respectful service provided, the clean and tidy building and the for the GPs.

These findings were reflected during our conversations with the 13 patients we spoke with and from looking at the practice's 156 friends and family test results from January 2015 to March 2015 and from the practice patient survey from 2014. The feedback from patients was consistently good. Patients told us about their experiences of care and praised the level of care and support they received at the practice. Patients said they were happy, very satisfied and said they had no complaints and received good treatment. Patients told us that the GPs and nursing staff were excellent. Of the 156 friends and family test results we saw 143 patients said they were extremely likely or likely to recommend the practice. There were 7 other results which stated patients were either unlikely or extremely unlikely. There were many positive comments to support the findings. Negative comments related to staff approach and waiting time when at the practice. We spoke with patients about the waiting times. None of the patients said this was a problem as they were never rushed when they were being seen by the GP or nurse.

Patients were happy with the appointment system. We were told patients could either book routine appointments two weeks in advance or could make an appointment on the day. Parents said they could always make a same day appointment for their children. We were told that no patient would be turned away and that 'sit and wait' appointments were available should the day time appointments be full.

Patients knew how to contact services out of hours and said information at the practice was good. Patients knew how to make a complaint. None of the patients we spoke with had done so but all agreed that they felt any problems would be managed well. Patients said they felt listened to and felt confident the practice would listen and act on complaints.

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

Patients said they found it easy to get repeat prescriptions processed.

Areas for improvement

Action the service SHOULD take to improve

- Ensure all locums receive an induction to ensure they are familiar with emergency procedures and local guidelines.
- Have systems in place to make sure personalised care plans are kept under review.
- Consider sharing action and learning following a significant event or complaint with the whole team.
- Ensure the infection control audit is able to identify latest good practice guidelines.
- Ensure systems are in place to ensure the safe storage of prescription stationary and GP's bags when the GPs are not present in their room.

Wadebridge and Camel Estuary Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The team also included a GP specialist advisor, a practice manager specialist advisor, a practice nurse specialist advisor and an expert by experience. Experts by Experience are people who have experience of using care services.

Background to Wadebridge and Camel Estuary Practice

Wadebridge and Camel Estuary Practice was inspected on Wednesday 25 March 2015. This was a comprehensive inspection.

The main practice is situated in the Cornish town of Wadebridge, with a smaller branch surgery located in the village of Rock. Together, the practice provides a primary medical service to approximately 7,500 patients of a diverse age group. The practice also see approximately 1000 temporary residents per year. Each branch has a dispensary. A dispensing practice is where GPs are able to prescribe and dispense medicines to patients who live in a rural setting which is a set distance from a pharmacy. The practice are a training practice for GPs who are training to become GPs.

There was a team of six GP partners and one salaried GPs within the organisation. Partners hold managerial and financial responsibility for running the business. There were six male and one female GPs. The team were supported by a practice manager, a deputy manager, three practice nurses, two health care assistants and three phlebotomists (staff who take blood). The practice also employed four dispensing staff.

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

The practice is open from Monday to Friday, between the hours of 8.30am and 6.00pm. Evening routine appointments until 8.30pm were available for people who were unable to access appointments during normal opening times and the practice operated a sit and wait end of day service with the duty GP if no same day appointments were available.

The practice had opted out of providing out-of-hours services to their own patients and referred them to another out of hours service.

Why we carried out this inspection

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

Detailed findings

How we carried out this inspection

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

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

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

• Older people

• People with long-term conditions

• Mothers, babies, children and young people

• The working-age population and those recently retired

• People in vulnerable circumstances who may have poor access to primary care

• People experiencing poor mental health

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

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

We carried out our announced visit on Wednesday 25 March 2015. We spoke with 13 patients, six GPs, five of the nursing team and members of the management, reception and administration team. We collected 11 patient responses from our comments box which had been displayed in the waiting room. We observed how the practice was run and looked at the facilities and the information available to patients.

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

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

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, the practice used 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 told us that when they were involved in a complaint or incident it was discussed with them but they were also supported through the process. However, staff said they were not always aware of all complaints or events that occur and would find/consider? the learning from these useful.

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

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last year and we were able to review these. Significant events was a standing item on the practice meeting agenda to review actions from past significant events and complaints. There was evidence that the practice had learned from these. For example a significant event where an emergency prescription had not been processed in a timely way. This had resulted in a review of the policy and reminding staff about the process. Records showed that the findings were shared with relevant staff but not always the wider staff group. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager who coordinated the process and monitored incidents. We tracked two incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result which included staff development and support. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

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

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. For example, GPs had received level 3 training and nursing staff had received level 2 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 dedicated GPs as leads in safeguarding vulnerable adults and children. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern. The safeguarding GP met with the health visitor to discuss and review vulnerable children and families. The GP then communicated any actions to the wider team.

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. This included children subject to child protection plans and vulnerable adults.

There was a chaperone policy, which was visible 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 and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

Good

Are services safe?

Medicines management

We checked medicines stored in the dispensaries at the Wadebridge and Rock surgeries, and found they were stored securely and were only accessible to authorised staff. However, we found one vaccine fridge at the Wadebridge branch was not always locked after use. The practice manager had identified this and was introducing systems to ensure this could be locked when not in use. The temperatures in the medicines refrigerators were monitored to show that these medicines were stored within the recommended ranges. The refrigerator at the Rock dispensary had been showing higher than recommended maximum temperatures on occasions recently, however staff were aware of this and were taking action to get the issue sorted out. There were no records of room temperature monitoring kept, however the temperature felt acceptable at the time of our inspection. Systems were in place to check that medicines were within their expiry date and suitable for use. Expired and unwanted medicines were disposed of in line with waste regulations. Systems were in place to deal with any medicines alerts or recalls, and records kept of any actions taken.

There were clear operating procedures in place for dispensary processes. Systems were in place to ensure all prescriptions were signed before the medicines were dispensed and handed out to patients. Dispensary staff explained the procedure for generating repeat prescriptions, and how the system highlights medicines approaching their review dates and those that have passed this date. Systems were in place to handle high risk medicines, to help make sure that any necessary monitoring and tests had been done and were up to date.

Medicines were scanned using a barcode system to help reduce any dispensing errors, and controlled drugs and any new medicines were checked by a second trained dispenser or GP. Any incidents were recorded, monitored and actions put in place to reduce the risks of any recurrence. The practice had signed up to the Dispensing Services Quality Scheme, which rewards practices for providing high quality services to patients of their dispensary. We saw records showing that dispensary staff had received appropriate training and had regular appraisals of their competence.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. There were suitable arrangements in place for the storage, recording and destruction of controlled drugs, and regular checks of stock levels were undertaken and recorded. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

Blank prescription pads and printer forms were held securely on arrival in the practice, before use. Records were held of forms received, and systems were set up to record when these forms were taken for use, during our inspection. This enabled an audit trail to be maintained, of the whereabouts of these forms. Blank prescription forms kept in printers in the consulting rooms and in GPs bags were not always secure, as we were told that these rooms were not kept locked when they were not being used.

Suitable emergency medicines were held at both the practice and at Rock. Regular checks were recorded to make sure that they were within expiry date, available and suitable for use if needed. There was one medicine on the list that was out of stock at the Rock dispensary, however staff were aware of this and had taken action to order a replacement.

Liquid nitrogen was used at the practice for certain treatment. This was appropriately stored and handled using protective equipment. Risk assessments were in place for the management and storage of this.

Cleanliness and infection control

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

The practice had a lead nurse and GP for infection control, although the infection control audit was carried out by a health care assistant. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that infection control audits had been conducted at both branches within the last month. One action from these audits had resulted in the introduction of new cleaning staff. However, the audit had not highlighted unsuitable flooring in a treatment room where minor surgery sometimes took place, unsuitable shelving or a need for a clinical cleaning schedule.

Good

Are services safe?

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

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

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water). The practice contracted this testing and were in the process of receiving records to confirm the regular checks had been conducted.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this had taken place in February 2015. All portable electrical equipment was routinely tested and last checked in December 2014. A schedule of testing was in place.

Staffing and recruitment

Recruitment records were structured and well organised. They contained evidence that appropriate recruitment checks had been undertaken on permanent staff prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. We saw individual staff risk assessments in place to show the decision making process when not performing criminal records checks on non-clinical staff. We spoke with a locum GP who had just started working at the practice. They said they had worked with the clinical computer system and within the CCG so were familiar with many county wide procedures. However, they had not been given the locum pack prepared by the practice.

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. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative. Many health and safety checks were performed by Cornwall NHS Estates. We were told the agreement worked well and that the practice manager was gathering evidence of the checks carried out by the estates department.

Identified risks were included on a risk assessment document. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks or health and safety issues were discussed at GP partners' meetings and within team meetings.

Arrangements to deal with emergencies and major incidents

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

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included

Good

Are services safe?

those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia Emergency and urgent medicines were also kept in GPs bags so they could carry out home visits and have access to medicines in the rural places they visited. Processes were in place to check whether emergency medicines and GP bag medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

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

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

Risks associated with service and staffing changes, both planned and unplanned, were required to be included on the practice risk log. We saw an example of this where a GP absence had been covered by a locum to manage this.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. Staff explained any updates were shared at the monthly educational meetings and by email. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff 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 and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Staff were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of respiratory disorders. Our review of the clinical meeting minutes confirmed that this happened.

We spoke with a GP partner about data from the local CCG of the practice's performance for antibiotic prescribing and found this was comparable to similar practices. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We found that these had been formed with patient involvement but had not always been kept under regular review.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of suspected cancers. We saw audit results from the last year which checked and showed that this was happening.

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 clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to carry out reviews of policies and clinical audits.

The practice showed us an overview of 16 clinical audits that had been undertaken in the last two years. Seven of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example a change in use of medicine. Other examples included audits to confirm 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. For example, the audit of minor surgery had been performed each year since 2004 and looked for complication rates, diagnosis and to check consent procedures had been followed.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, we saw an audit regarding the prescribing of antibiotics to make sure the prescribing levels were in line with the CCG. Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines, increased awareness amongst the GPs and altered their prescribing practice, in line with the guidelines.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 96.1% of patients had received cervical screening in the last five years and 95.2% of patients on the dementia care register had received a medication review in the last year. Other data showed that the practice met all the

Good

Are services effective?

(for example, treatment is effective)

minimum standards for QOF in asthma and chronic obstructive pulmonary disease (lung disease). This practice was not an outlier for any QOF (or other national) clinical targets.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. For example, the practice had identified they were running slightly below target for some diabetic screening and had introduced plans to address this.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. Patients said they were sent reminders for when their condition and medicines were due to be reviewed. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice had achieved and implemented the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. There was a lead GP for palliative care who coordinated collaborative working.

Effective staffing

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

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. As the practice was a training practice, GPs who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology, ear syringing, travel health and extended roles such as asthma, COPD, diabetes and coronary heart disease.

Working with colleagues and other services

The practice worked well with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

The practice held multidisciplinary team meetings to discuss the needs of complex patients. These were divided into separate meetings. For example a monthly MDT meeting included community nurses, dementia specialist nurses, palliative care team and GPs to discuss palliative and vulnerable patients. A psychiatric 'hub' meeting was held every month to discuss patients with mental illness with the local counsellor, community psychiatric nurse and representatives from a local mental illness charity. The practice also invited district nurses to meet with practice staff each week. This was an opportunity to review patients

Good

Are services effective?

(for example, treatment is effective)

who were on the practice palliative care register. Decisions about care planning were documented in the patients shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner for the benefit of patients. For example, the practice used 'special patient notes' document to fax relevant information to out of hour's providers to provide continuity of care. The practice also used a dated pre notification of death form for patients who were likely to reach the end of their life to avoid unnecessary or unwanted treatments.

Electronic systems were also in place for making referrals through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that this system was easy to use.

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

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it and had completed training or had this booked. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. 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).

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. We were shown an audit that had been repeated over the last 10 years which confirmed the consent process for minor surgery had being followed in over 94% of cases each year.

Health promotion and prevention

The GP and practice nurses were informed of all health concerns detected on new patients and these were followed up in a timely way. The practice used nurses to summarise patient notes which helped identify conditions which needed to be prioritised. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering dietary and smoking cessation advice to smokers.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and 42 out of 51 had been offered an annual physical health check. Practice records showed 36 of these patients had received a check up in the last 12 months. The practice had also identified the smoking status of 92% of patients over the age of 16 and actively offered nurse-led smoking cessation clinics to these patients. There was evidence that 96.5% of patients who smoked had been offered support to give up smoking.

The practice's performance for cervical smear uptake was 96.1%, which was better than others in the CCG area. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend. There was also a named nurse responsible for following up patients who did not attend screening. Performance for other screening was monitored at the practice to ensure the performance was either above or equal to CCG averages.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with

Good

Are services effective?

(for example, treatment is effective)

current national guidance. Last year's performance for all immunisations was above average for the CCG. For example 91.3% of babies had received their first immunisation. There was a clear policy for following up non-attenders by the named practice nurse.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the patient participation group survey from February 2015, 156 friends and family test results and details from the 11 comment cards we collected. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, the 156 results from the friends and family group showed that 143 would be extremely likely or likely to recommend the practice to their friends and family.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 11 completed cards which were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. We did not receive any negative comments on the comment cards.

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk and was shielded by a wall which helped keep patient information private.

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

Care planning and involvement in decisions about care and treatment

Patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, patients felt the GP was good at explaining treatment and results and patients felt confident in the care and treatment they received. We saw that patients with complex needs had a personalised care plan in place which showed they had been involved in decision making. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available.

Patient/carer support to cope emotionally with care and treatment

Patients were positive about the emotional support provided by the practice and rated it well in this area. For example, we were given examples where practice staff had given advice and help to patients to help them manage their treatment and care when it had been needed. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer.

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found 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 systems were in place to address identified needs in the way services were delivered.

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). For example, patients had complained about the waiting times to see the GP when at the practice. As a result the GPs had altered their appointment times to allow catch up slots during clinic times. Other changes included decluttering notice boards and changing the way patients were called to the treatment rooms.

Tackling inequity and promoting equality

The practice had access to online and telephone translation services and had a hearing loop for patients with hearing loss.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months and said that this training had been interesting.

The premises and services had been adapted to meet the needs of patient with disabilities which included a ramp leading to the front door, widened doorways, automatic doors and accessible toilet facilities. However, there were no designated disabled parking bays at the practice. Staff said patients knew that although there was no parking at the practice they could drop patients outside.

The practice was situated on the ground floor of the building. There were areas which could be used for turning circles in the wide corridors for patients with pushchairs and mobility scooters. This made movement around the practice easier and helped to maintain patients' independence.

We saw that 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.

Access to the service

The practice at Wadebridge was open between 08.30am and 6pm and 8.45am and 12.30 at Rock. Appointments were available from 9am to 5.20pm on weekdays at Wadebridge and 9am and 11.30am at Rock. Patients were able to see a GP on the same day and could attend the sit and wait clinic at the end of each day if routine appointments were full. Patients could also book advance appointments up to two weeks in advance. Evening appointments at Wadebridge were available one day per week. The practice closed on the last Friday of each month for training. Patients could access a duty GP during this time by telephone.

Comprehensive information was available to patients about appointments on the practice website and within the practice leaflet. 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.

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to local care homes by a named GP and to those patients who needed one.

Patients were generally satisfied with the appointments system but said it was sometimes difficult to get through on the telephone. They confirmed that they could see a GP on the same day if they needed to. They also said they could see another GP if there was a wait to see the one of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

Listening and learning from concerns and complaints

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice manager was the designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system. Information on making a complaint was located in the waiting room, within the practice information leaflet and on the practice website. Patients we spoke with were aware of the process to follow if they wished to make a complaint but none of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at five complaints received in the last 12 months and found these had been handled in an open and timely way. We saw examples where patients had received an apology and explanation and saw correspondence to show patients were informed at stages of the process and were informed of where to pursue their complaint if they were not satisfied.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear mission statement which read 'The practice is committed to delivering ever improving, high quality primary care services to patients both now and in the future. We were informed of the practice values which included fostering an open approach and being on the patients side.

We spoke with staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. Staff explained that the monthly training days were a time when the vision and values were focused upon.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. These were kept under review and monitored by the practice manager

There was a leadership structure with named members of staff in lead roles. We spoke with members of the administration and nursing team who were clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

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

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. These demonstrated a clear full cycle to show outcomes were kept under review.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings or the monthly educational meetings. We also noted that GP team away days were held yearly.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, including the recruitment policy and induction policy which were in place to support staff. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received. We looked at the results of the annual patient survey and friends and family test which had highlighted issues with customer service issues. As a result the practice had included customer service training and managing difficult patients as part of the education programme. Patients had also complained about the tannoy system used, which had resulted in patients being called through to their appointments using the television display screen or by the member of staff coming to collect the patient.

The practice had a patient participation group (PPG) and advertised for new members in the practice information leaflet. We spoke with a representative from the group who said the group had managed to influence a change of the front door, to an automatic door.

The practice had gathered feedback from staff through staff meetings, appraisals, informal discussions and the monthly educational meetings. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning and improvement

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

Are services well-led?

Good

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

development plan. Staff told us that the practice was very supportive of training and that they had educational days where topical subjects were provided. These had included CQC awareness and customer service.

The practice was a GP training practice for GPs who wished to become GPs. Two of the GPs were trainers. We did not speak with any trainees on this occasion.