Old Bridge Surgery

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

Old Bridge Surgery was inspected on Tuesday 24 February 2015. This was a comprehensive inspection. Overall the practice is rated as good.

Old Bridge Surgery provides primary medical services to people living in East Looe and the surrounding areas. The practice provides services to a homogeneous population and is situated in a rural coastal location. The practice had a General Medical Services (GMS) NHS contract to supply health services to the local population.

At the time of our inspection there were approximately 9,500 patients registered at the service with a team of 6 GP partners. There were three male and three female GPs. GP partners held managerial and financial responsibility for running the business. There were four nurses and four health care assistants at the practice. In addition there was a practice manager, and additional administrative and reception staff.

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.

Our key findings were as follows:

We rated this practice as good. Patients reported having good access to appointments at the practice and liked having a named GP which improved their continuity of care. The practice was clean, well-organised, had good facilities and was well equipped to treat patients. There were effective infection control procedures in place.

The practice valued feedback from patients and acted upon this. Feedback from patients about their care and treatment was consistently positive. We observed a patient centred culture. Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. Views of external stakeholders were positive and were aligned with our findings.

Summary of findings

The practice was well-led and had a clear leadership structure in place whilst retaining a sense of mutual respect and team work. There were systems in place to monitor and improve quality and identify risk and systems to manage emergencies.

Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessment of a patient's mental capacity to make an informed decision about their care and treatment, and the promotion of good health.

Suitable staff recruitment, pre-employment checks, induction and appraisal processes were in place and had been carried out. Staff had received training appropriate to their roles and further training needs had been identified and planned.

Information received about the practice prior to and during the inspection demonstrated the practice performed comparatively with all other practices within the clinical commissioning group (CCG) area.

Patients told us they felt safe in the hands of the staff and felt confident in clinical decisions made. There were effective safeguarding procedures in place.

Significant events, complaints and incidents were investigated and discussed. Learning from these events was communicated and acted upon.

We found an area of outstanding practice;

Patients with learning disabilities were offered and provided a health check every year during which their long term care plans were discussed with the patient and their carer if appropriate. The practice had supported one of the nurses to become a learning disability specialist. This nurse ensured all patients with learning disabilities had regular check ups. In addition, she had set up and led a group of volunteers to support patients with learning disabilities. This included organised field trips, activities and days out every three weeks. The practice had won a local award for outstanding contribution, as voted by patients in 2014.

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

The practice had systems to help ensure patient safety and staff had appropriately responded to emergencies.

Recruitment procedures and checks were completed as required to help ensure that staff were suitable and competent. Risk assessments had been undertaken to support the decision not to perform a criminal records check for administration staff.

Significant events and incidents were investigated both informally and formally. Staff were aware of the learning and actions taken.

Staff were aware of their responsibilities in regard to safeguarding and the Mental Capacity Act 2005. There were suitable safeguarding policies and procedures in place that helped identify and protect children and adults from the risk of abuse.

There were suitable arrangements for the efficient management of medicines within the practice. Policies had been updated every 12 months or more frequently if appropriate.

The practice was clean, tidy and hygienic. Suitable arrangements were in place to maintain the cleanliness of the practice. There were systems in place for the retention and disposal of clinical waste.

Are services effective?

Good

The practice is rated good for being effective. Supporting data obtained both prior to and during the inspection showed the practice had effective systems in place to make sure the practice was efficiently run.

The practice had a clinical audit system in place and a full audit cycle had been completed.

For example, audits on prescription management and minor surgery had been completed and shared learning undertaken.

Care and treatment was delivered in line with national best practice guidance. The practice worked closely with other services to achieve the best outcome for patients who used the practice.

Information obtained both during and after the inspection showed staff employed at the practice had received appropriate support, training and appraisal. GP partner appraisals and revalidation had been completed.

Summary of findings

The practice had extensive health promotion material available within the practice and on the practice website.

Are services caring?

Good

The practice is rated as good for being caring. Data showed patients rated the practice higher than others for many aspects of care. Feedback from patients about their care and treatment was consistently positive.

We observed a patient centred culture and found evidence that staff were motivated to offer kind and compassionate care and worked to overcome obstacles to achieving this. We found many positive examples to demonstrate how patients' choices and preferences were valued and acted on. Views of external stakeholders were very positive and aligned with our findings.

Patients spoke positively about the care provided at the practice. Patients told us they were treated with kindness, dignity and respect. Patients told us how well the staff communicated with them about their physical, mental and emotional health and supported their health education.

Patients told us they were included in the decision making process about their care and had sufficient time to speak with their GP or a nurse. They said they felt well supported both during and after consultations

Are services responsive to people's needs?

Good

The practice was rated good for being responsive. Patients commented on how well all the staff communicated with them and praised their caring, professional attitudes.

Patients told us they felt the practice responded well to their needs. There was information provided on how patients could complain. Complaints were managed according to the practice policy and within timescales. There was an accessible complaints system with evidence that action was taken within a reasonable timescale.

The practice recognised the importance of patient feedback and had encouraged the development of a patient participation group to gain patients' views.

Practice staff had identified that not all patients found it easy to understand the care and treatment provided to them and made sure these patients were provided with relevant information in a way they understood.

Patients said it was relatively easy to get an appointment at the practice and were able to see a GP on the same day if it was urgent.

Summary of findings

Are services well-led?

Good

The practice is rated as good for being well led. The practice had a vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. Nursing staff, GPs and administrative staff demonstrated they understood their responsibilities including how and to whom they should escalate any concerns.

Staff spoke positively about working at the practice. They told us they were actively supported in their employment and described the practice as having an open, supportive culture and being a good place to work.

The practice had a number of policies to govern the procedures carried out by staff and regular governance meetings had taken place. There was a programme of clinical audit in operation with clinical risk management tools used to minimise any risks to patients, staff and visitors.

Significant events, incidents and complaints were managed as they occurred and through a more formal process to identify, assess and manage risks to the health, welfare and safety of patients.

The practice sought feedback from patients, which included using new technology, and had an active patient participation group (PPG).

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 providing care to older people.

Old Bridge Surgery has a high proportion of elderly patients. All patients have a named GP and the practice runs a personal list system to ensure continuity of care so important to this population group.

An Avoiding Unplanned Admissions to hospital enhanced service was delivered by the practice. IT systems were in place to assist GPs in finding all the information on patients required. These systems provided easily accessible information on patient's conditions and previous treatment. For example, reduced mobility, falls, emergency admissions and home visits.

Practice administrative staff had developed an easy to use system for access to comprehensive care plans, care plan updates and reviews. This made it easier for GPs to keep care plans up to date. It also meant a reduced administrative burden for clinical staff. The impact of this was that more time was available for patients.

GPs worked closely with local care homes to ensure older patients' best interests were considered and End of Life Care Plans were agreed where appropriate and in place. The practice liaised regularly with the Community Matron and District Nurse team to support patients in this population group. The practice also enjoyed support from and regular contact with an Early Intervention team, Acute Care at Home team and a Memory services team.

The practice had kept older patients appraised of a local Living Well Scheme (launched by Age Concern) which had recently been extended to the area. The practice could also refer patients in this population group to a new "Welcome Home" service, which assisted patients after discharge from hospital. Patients could also self refer.

People with long term conditions

Good

The practice is rated as good for providing care to people with long term conditions.

The practice had implemented a revised recall system with the aim of reducing the number of appointments for patients with more than one long term condition. A receptionist telephoned the patient to make appointments in order to improve uptake and reduce the number of patients who did not attend.

Summary of findings

The practice worked closely with the local community nurses. This included local specialist nurses in heart failure, respiratory diseases, diabetes, the Macmillan nurse and the community matron. Home visits from these teams were arranged according to patient needs.

The practice had helped to set up clinics relevant to this population group such as "Looe Breathers' Group" to support patients with respiratory conditions. Practice nurses had helped to set up the group for patients with COPD. These patients now received sessions for social support and gentle exercise.

The practice recognised frailty as a long term condition. Clinicians were familiar with Rockwood scores, which is grading system relevant to measuring the frailty risk of a patient.

The practice emphasized the importance of palliative care. Patients at this rural coastal practice often chose to die at home with appropriate support in place. Monthly multi disciplinary team meetings were held with other health professionals. All patients at risk were reviewed. The practice had written evidence of letters of thanks from families of patients with long term conditions.

Families, children and young people

Good

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

The practice carried out monthly multi disciplinary team meetings with health visitors, midwives and school nurses to ensure vulnerable children were identified and actions discussed and agreed. The practice used NHS 111 Reports and Emergency Admissions data as useful sources of new information which helped to identify any causes for concern. The midwifery team contacted the practice about any pregnant women about whom they had concerns to enable a joint approach.

The practice maintained a register of children aged under 18 who may be at risk. There were numerous criteria for risk. These included medical conditions or any safeguarding concerns. GPs met regularly with other health professionals to ensure support was in place for children on the risk register.

The practice wrote to parents of children who had failed to attend for immunisations to remind them of the range of vaccinations available and the reasons for them.

The practice provided baby and child immunisation programmes to ensure babies and children could access a full range of vaccinations and health screening.

The GPs training in safeguarding children from abuse was at the highest level. This met best practice. Details of children's attendance

at A&E were routinely copied to the health visitor for review and if necessary discussed at the GP meeting. Information relevant to young patients was displayed and health checks and advice on sexual health for men, women and young people included a range of contraception services and sexual health screening including chlamydia testing and cervical screening.

Working age people (including those recently retired and students)

Good

The practice is rated as good for providing care to working age people.

The practice offered early morning appointments from 7.00am – 8.00am on Wednesdays plus an additional ad hoc day every week. GP, phlebotomy and practice nurse appointments available during this time. The practice reported that this was of particular assistance to Truro College students, as buses from the college returned after 6pm. The impact of this was students could use early morning appointments prior to attending their place of education.

Appointments and telephone consultations could be pre-booked or booked on the day with a GP of patient's choice. The practice informed us that pre-bookable appointments had historically been subject to a wait of up to four weeks but this had since been improved to two weeks for most GPs due to increases in clinical staffing.

There were numerous services available on site at Old Bridge Surgery relevant to patients in this population group. These included; retinal screening, physiotherapy, osteopathy, substance abuse support, memory clinics, a stop smoking Service, a consultant psychiatrist, a nail cutting service, and a dermatology clinic.

The Practice website had the nationally recognised "The Waiting Room" facility. This enabled patients to order repeat prescriptions and book appointments online.

GPs at the practice also had ease of access to make to local support services which offered a range of services to enable people to get back into work, or undertake social activities.

People whose circumstances may make them vulnerable

Outstanding

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

Patients with learning disabilities were offered and provided a health check every year during which their long term care plans were discussed with the patient and their carer if appropriate. The practice had supported one of the nurses to become a learning

disability specialist. This nurse ensured all patients with learning disabilities had regular check ups. In addition, she had set up and led a group of volunteers to support patients with learning disabilities. This included organised field trips, activities and days out every three weeks. The practice had won a local award for outstanding contribution, as voted by patients in 2014.

The practice stated that they do not turn any patients away. The practice had registered several patients who are of no fixed abode who use the practice's address as their registered address. These patients pick up their mail regularly from the practice. If they have a mobile phone the practice had obtained these contact details in order to be able to contact them urgently.

Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff had all received appropriate levels of safeguarding training in order to support patients in this population group.

Vulnerable patients were reviewed at the multidisciplinary team meetings. A counsellor was available within the practice. Staff told us that there were a few patients who had a first language that was not English, however, interpretation requirements were available to the practice and staff knew how to access these services. Reception staff were able to identify vulnerable patients and offer longer appointment times where needed and send letters for appointments.

Patient under witness protection programmes, with significant health needs, were registered using the Practice address by arrangement with the police. This procedure was used when patients were in fear of being traced. For example, following incidents of domestic violence.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for providing care to people experiencing poor mental health.

There was signposting and information available to patients. The practice referred patients who needed mental health services as well as support services being provided at the practice. The practice provided patients with mental health issues the time they need, and arranged for an early follow up appointment within a few days or weeks as appropriate with the individual GP before they left the practice

The practice discussed psychological therapies with patients. The practice encouraged self-referral to local mental health support services and also an additional support service which dealt with alcohol and drug abuse.

Summary of findings

GPs told us they offered to phone services direct to arrange an appointment during patient consultations. Referral to early intervention team and home treatment teams were made for higher risk patients. There was evidence of co-operation and communication between the practice and the support services available for the patient. This joined up approach had been facilitated by the practice's monthly meetings with other health professionals.

GPs at the practice made appropriate arrangements with the patient for regular reviews, and encouraged follow up with the same GP where possible. Patients suffering poor mental health were offered annual health checks and testing for depression and anxiety as recommended by national guidelines. If a patient did not attend a booked follow up appointment the practice had a system in place to contact the patient by telephone or letter.

The practice had a system in place to follow up on patients who had attended accident and emergency where there may have been mental health needs identified.

Summary of findings

What people who use the service say

We spoke with 12 patients during our inspection. We spoke with a representative 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 38 comment cards which contained detailed positive comments.

Comment cards stated that staff were polite, professional and took the time to listen and act on patient's wishes. Comments also highlighted a confidence in the advice and medical knowledge, access to appointments and praise for the continuity of care.

These findings were reflected during our conversations with patients and discussion with the PPG members. The feedback from patients was positive. 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 courteous, friendly and caring.

Patients were happy with the appointment system and said it was easy to make an appointment.

Patients appreciated the service provided and told us they had no complaints but knew how to make a complaint should they wish to do so.

Patients were satisfied with the facilities at the practice. Patients commented on the building being clean and tidy. Patients told us staff used gloves and aprons where needed and washed their hands before treatment was provided.

Patients found it easy to get repeat prescriptions and said they thought the website was a useful facility.

Outstanding practice

Patients with learning disabilities were offered and provided a health check every year during which their long term care plans were discussed with the patient and their carer if appropriate. The practice had supported one of the nurses to become a learning disability specialist. This nurse ensured all patients with learning disabilities had regular check ups. In addition, she had set up and led a group of volunteers to support patients with learning disabilities. This included organised field trips, activities and days out every three weeks. The practice had won a local award for outstanding contribution, as voted by patients in 2014.

Old Bridge Surgery

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 nurse specialist adviser and an expert by experience.

Background to Old Bridge Surgery

Old Bridge Surgery provides primary medical services to people living in East Looe and the surrounding areas. The practice is situated in a rural coastal location. The practice had a General Medical Services (GMS) NHS contract to supply health services to the local population.

At the time of our inspection there were approximately 9,500 patients registered at the service with a team of 6 GP partners. There were three male and three female GPs. GP partners held managerial and financial responsibility for running the business. There were four nurses and four health care assistants at the practice. In addition there was a practice manager, and additional administrative and reception staff.

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.

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

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

The practice is open between Monday and Friday 8.30am – 6.00pm. Early morning appointments were available from 7.00am every Wednesday. These are pre-bookable appointments designed to be used by patients going to work.

Outside of these hours a service is provided by another health care provider by patients dialling the national 111 service.

Routine appointments are available daily and are bookable up to two weeks in advance. Urgent appointments are made available on the day and telephone consultations also take place.

Old Bridge Surgery provides regulated activities from a main site and from two sub branches in this rural coastal area. The main site is located at Old Bridge Surgery, Station Road, Looe, Kernow PL13 1HA. The first sub branch is Polperro Surgery, The Coombs, Polperro, Kernow PL13 2RQ. The second sub branch is Pelynt Surgery, Summer Lane, Pelynt, Kernow PL13 2JW. Pelynt also contains a small dispensary. As part of this inspection we visited Old Bridge Surgery in Looe and we also visited Pelynt Surgery.

Detailed findings

Why we carried out this inspection

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

How we carried out this inspection

Before visiting Old Bridge Surgery, 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, the local clinical commissioning group and local voluntary organisations.

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 24 February 2014. We spoke with 12 patients and ten staff at the practice during our inspection and collected 38 patient responses from our comments box which had been displayed in the waiting room. We obtained information from and spoke with the practice manager, four GPs, receptionists/clerical staff, practice nurses and health care assistants. 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.

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

Good

Are services safe?

Our findings

Safe Track Record

The practice had a system in place for reporting, recording and monitoring significant events.

The practice kept records of significant events that had occurred and these were made available to us. GPs at the practice met up every Monday to discuss any significant events. All reports were discussed at monthly quality meetings and at full review meetings as required. Significant event forms were recorded in writing and entered onto a computer system by a medical secretary. Evidence from these forms showed that appropriate learning had taken place where necessary and that the findings were communicated to relevant staff.

Staff were aware of the significant event reporting process and how they would verbally escalate concerns within the practice. All staff we spoke with felt very able to raise any concern however small. Staff knew that following a significant event, the GPs undertook an analysis to establish the details of the incident and the full circumstances surrounding it. Staff explained that these monthly meetings were well structured, well attended and not hierarchical.

There were systems in place to make sure any medicines alerts or recalls were actioned by staff.

These alerts were received by the practice manager, who cascaded them to all relevant staff. These had been discussed at team meetings.

Learning and improvement from safety incidents

At Old Bridge Surgery the process following a significant event or complaint was both informal and formalised. GPs discussed incidents daily and also monthly at clinical meetings. GPs, nurses and practice staff were able to explain the learning from these events. This had been recorded on the practice computer based significant event system.

Learning had taken place following a suicide attempt at a local care home where a patient had taken an overdose of medicine. The patient had been able to hoard their 28 day prescription in order to make this attempt. One of the learning points the practice had taken forward was reducing the amount of prescription medications to seven days instead of 28.

Reliable safety systems and processes including safeguarding

Patients told us they felt safe at the practice and staff knew how to raise any concerns. A named GP had a lead role for safeguarding older patients. There was also a lead GP for safeguarding children and young people.

They had been trained to the appropriate advanced level, which was level three. There were appropriate policies in place to direct staff on when and how to make a safeguarding referral. The policies included information on external agency contacts, for example the local authority safeguarding team. These details were displayed where staff could easily find them.

There were monthly multidisciplinary team meetings with relevant attached health professionals including social workers, district nurses, palliative care, physiotherapist and occupational therapists where vulnerable patients or those with more complex health care needs were discussed and reviewed. Health care professionals were aware they could raise safeguarding concerns about vulnerable adults at these meetings.

Practice staff said communication between health visitors and the practice was good and any concerns were followed up. The practice maintained a rolling spreadsheet of all at risk children registered with the practice and agreed any actions at monthly meetings.

The practice held meetings to discuss the frailty risk of individual patients. These were conducted once a month. Community nursing staff and care of the elderly consultants were invited to monthly unplanned admissions meetings. Patients who were at risk had a risk grading score which had been measured by their GP in line with national guidance. This met best practice.

Patients who had treatment escalation plans (TEP) for their end of life care had these kept up to date in agreement with their named GP.

The computer based patient record system allowed safeguarding information to be alerted to staff in a discreet way. When a vulnerable adult or 'at risk' child had been seen by different health professionals, staff were aware of their circumstances. Staff had received three yearly safeguarding training. The most recent session had been in September 2012. Staff were aware of who the safeguarding leads were. Staff also demonstrated knowledge of how to

make a patient referral or escalate a safeguarding concern internally using the whistleblowing policy or the safeguarding policy. Both were reviewed annually and had last been reviewed in March 2014.

We saw training plans which indicated that staff would next receive safeguarding training in February 2015.

We discussed the use of chaperones to accompany patients when consultation, examination or treatments were carried out. A chaperone is a member of staff or person who acts as a witness for a patient and a medical practitioner during a medical examination or treatment. Patients were aware they were entitled to have a chaperone present for any consultation, examination or procedure where they feel one is required.

All GPs and nursing staff had received a criminal records bureau check via the disclosure barring service (DBS). Some administration staff had also received these checks depending on their role. If a check was not required for a role, a written risk assessment had been completed.

The practice had a written policy and guidance for providing a chaperone dated December 2014 for patients which included expectations of how staff were to provide assistance. Administration staff at the practice acted as chaperones as required. They understood their role was to reassure and observe that interactions between patients and GPs were appropriate and record any issues in the patient records.

Medicines Management

Pelynt Surgery, a small sub branch of Old Bridge Surgery is a dispensing practice. We looked at the procedures for storage and safe dispensing of medicines and found them to be safe.

The GPs were responsible for prescribing medicines at the practice.

The control of repeat prescriptions was managed well. Patients were not issued any medicines until the prescription had been authorised by a GP. Patients were satisfied with the repeat prescription processes. They were notified of health checks needed before medicines were issued. Patients explained they could use the box in the practice, send an e-mail, or use the on-line request facility for repeat prescriptions.

There were effective systems in place for obtaining, using, safekeeping, storing and supplying medicines. Storage cabinets were robust and made national guidelines. Clear checks and temperature records were kept to strengthen the audit of medicines issued and improve medicine management.

All of the medicines we saw were in date. Storage areas were clean and well ordered. Deliveries of refrigerated medicines were immediately checked and placed in the refrigerator. This meant the cold chain and effective storage was well maintained. There were fridge temperature monitors in place. Daily checks took place on these.

We looked at the storage facilities for refrigerated medicines and immunisations, the refrigerator plug was not easily accessible therefore was very unlikely to be switched off. Staff had received accredited training in the management of medicines. Staff were aware of how to raise concerns around controlled drugs with the local controlled drug accountable officer, should they need to do so.

Patients were informed of the reason for any medicines prescribed and the dosage. Where appropriate patients were warned of any side effects, for example, the likelihood of drowsiness. All patients said they were provided with information leaflets supplied with the medicine to check for side effects.

Improvements which the practice had made to their systems included a repeat prescription computer system which monitored any potential hoarding of medicines. This made it easier for staff to recognise when to order new medicines and to manage their workload.

Cleanliness & Infection Control

The practice had a lead GP for infection control. The practice had conducted an infection control audit in January 2015. This audit had identified improvements which were required. For example, toy cleaning to be made a standard routine each day, monitoring of the condition of furniture to ensure it remained free of rips and tears. These actions had been implemented and a re-audit was planned for six months time to ensure a full audit cycle was in place.

We left comment cards at the practice for patients to tell us about the care and treatment they receive. We received 38 completed cards. Of these, fourteen specifically commented on the building being clean, tidy and hygienic. Patients told us staff used gloves and aprons and washed their hands.

Good

Are services safe?

The practice had policies and procedures on infection which had been reviewed in January 2015. We spoke with the infection control lead GP. We saw cleaning schedules were in place for all areas of the practice. Checks were made to ensure the cleaning was carried out. Staff had access to supplies of protective equipment such as gloves and aprons, disposable bed roll and surface wipes. The nursing team were aware of the steps they took to reduce risks of cross infection and had received updated training in infection control.

Treatment rooms, public waiting areas, toilets and treatment rooms were visibly clean. There were hand washing posters on display to show effective hand washing techniques.

Clinical waste and sharps were being disposed of in safely. There were sharps bins and clinical waste bins in the treatment rooms. The practice had a contract with an approved contractor for disposal of waste. Clinical waste was stored securely in a dedicated secure area whilst awaiting its collection from a registered waste disposal company.

Equipment

Emergency equipment available to the practice was within the expiry dates. There were emergency oxygen masks of a range of different sizes for both adult and child patients at the practice. The practice had a system using checklists to monitor the dates of emergency medicines and equipment so they were discarded and replaced as required.

Equipment such as the weighing scales, blood pressure monitors and other medical equipment were serviced and calibrated where required. Evidence showed calibration checks had been conducted in January 2015.

Portable appliance testing (PAT) where electrical appliances were routinely checked for safety was last carried out by an external contractor in May 2015.

Staff told us they had sufficient equipment at the practice including sufficient blood pressure monitors and spirometers.

Staffing & Recruitment

Staff told us there were suitable numbers of staff on duty and that staff rotas were managed well. The practice had recently recruited one additional health care assistant and one phlebotomist.

The practice said they used locums as staff cover for one GP who was on maternity leave. The practice used the same locum for continuity. GPs told us they also covered for each other during shorter staff absences.

The practice used a team approach where the workload for part time staff was shared equally. Each team had appointed clerical support. Staff explained this worked well but there remained a general team work approach where all staff helped one another when one particular member of staff was busy. GPs told us they enjoyed a strong team working ethic at the practice.

Recruitment procedures were safe and staff employed at the practice had undergone the appropriate checks prior to commencing employment. Clinical competence was assessed at interview. Once in post staff completed an induction which consisted of ensuring staff met competencies and were aware of emergency procedures.

Criminal record checks via DBS disc barring service, were only performed for GPs, nursing staff and administrative staff who had direct access with patients. Recorded risk assessments had been performed explaining why some clerical and administrative staff had not had a criminal records check.

The practice had disciplinary procedures to follow should the need arise. Written evidence showed that the policy had been used appropriately in the past.

Each registered nurse Nursing and Midwifery Council (NMC) status was completed and checked annually to ensure they were on the professional register to enable them to practice as a registered nurse.

Monitoring Safety & Responding to Risk

The practice had a suitable business continuity plan which had been reviewed in November 2014. This plan documented the practice's response to any prolonged events that may compromise patient safety. For example, this included flooding, heavy snow, computer loss and lists of essential equipment. The practice had flood boards prepared and ready for installation due to adverse weather in previous years.

Nursing staff received any medical alert warnings or notifications about safety by email or verbally from the GPs

Good

Are services safe?

or practice manager. These were also discussed at meetings. We saw that an alert from January 2015 regarding risks around pregnancy had been appropriately circulated to staff.

There was a system in operation to ensure one of the nominated GPs covered for their colleagues when necessary, for example home visits, telephone consultations and checking blood test results.

Arrangements to deal with emergencies and major incidents

Appropriate equipment was available and maintained to deal with emergencies, including if a patient collapsed. Administration staff appreciated that they had also been included on the basic life support training sessions. All staff had received emergency first aid training in September 2014. This was repeated annually.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care & treatment in line with standards

There were examples where care and treatment followed national best practice and guidelines. For example, emergency medicines and equipment held within the practice followed the guidance produced by the Resuscitation Council (UK). The practice followed the National Institute for Health and Care Excellence (NICE) guidance and had formal meetings to discuss latest guidance. Where required, guidance from the Mental Capacity Act 2005 had been followed. Guidance from national travel vaccine websites had been followed by practice nurses.

The practice used the quality and outcome framework (QOF) to measure their performance. The QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice in their surgeries. The QOF data for this practice showed they generally achieved higher than national average scores in areas that reflected the effectiveness of care provided. The local clinical commissioning group (CCG) data demonstrated that the practice performed well in comparison to other practices within the CCG area. For example, 2,200 patients at the practice suffered from hypertension. Of these, 89% had received a health check within the last 12 months. This compared with a QOF target of 44%. The practice was above the CCG average.

Management, monitoring and improving outcomes for people

The practice told us they were keen to ensure that staff had the skills to meet patient needs and so nurses had received training including immunisation, diabetes care, cervical screening and travel vaccinations.

The practice used QOF effectively to monitor and improve outcomes for patients. For example, 83.4% of practice patients who suffered from dementia had received a health check in the last 12 months. This compared with a CCG average of 70%. The practice had ensured that these patients had also received a care plan review and was taking steps to contact the remaining patients.

The GPs referred patients to staff in the acute community team, who provided support in the patient's home for short term treatment and rehabilitation. This enabled patients to remain at home and to be treated for a short period of time, avoiding a hospital admission where appropriate. Clinical staff had provided infusions and complex procedures to nationally recognised high standards.

GPs in the practice undertook minor surgical procedures and joint injections in line with their registration and NICE guidance. The staff were appropriately trained and kept up to date. There was evidence of regular clinical audit in this area which was used by GPs for revalidation and personal learning purposes. For example, audits had taken place on excisions and incisions, minor surgery and prescriptions. A quality group scrutinised all of the findings of these audits and ensured that a full audit cycle was in place.

Effective Staffing

All of the GPs in the practice participated in the appraisal system leading to revalidation of their practice over a five-year cycle. The GPs we spoke with told us and demonstrated that these appraisals had been appropriately completed. All the GPs are appraised by external GPs from Kernow CCG. These appraisers are rotated every two years to ensure the impartiality of the process.

The practice was a teaching practice for new GPs. Three of the GPs are accredited trainers. There was a trainee GP at the practice who told of the support they had received from the other staff and their positive experience at the practice.

Nursing staff had received an annual formal appraisal and kept up to date with their continuous professional development programme, documented evidence to confirm this. A process was also in place which showed clerical and administration staff received regular formal appraisal. This was completed by a GP who had a lead role for the nursing team.

There was a comprehensive induction process for new staff which was adapted for each staff role. There was 360 degree feedback in place which enabled staff to give and receive transparent feedback on their own and others performance in their roles.

The staff training programme was monitored to make sure staff were up to date with training the practice had decided was mandatory. This included basic life support, safeguarding, fire safety and infection control. Staff said that they could ask to attend any relevant external training to further their development. Staff had individualised training programmes according to their roles and any

Good

Are services effective?

(for example, treatment is effective)

specialised interests. For example, the practice had supported dispensary staff to complete national vocational qualifications (NVQ) level three in dispensing. This met best practice.

A medical secretary had been provided with the resources and support to complete an NVQ level two in medical business practice.

There was a training matrix in place to monitor mandatory training. This included annual training on fire safety, emergency first aid and manual handling. Online e-learning was available from Skills For Health and other e-learning government approved sites.

There was a set of policies and procedures for staff to use and additional guidance or policies located on the computer system.

Working with colleagues and other services

The practice worked effectively with other services. For example, the practice had identified the need for prompt referrals to a heart failure specialist nurse. This nurse worked closely with the practice and patients at risk of heart failure. Other examples included GPs at the practice having effective liaison with mental health services, health visitors, specialist nurses, hospital consultants and community nursing.

Every month there was a multidisciplinary team meeting to discuss vulnerable patients, high risk patients and patients receiving end of life care. This included the multidisciplinary team such as physiotherapists, occupational therapists, health visitors, district nurses, community matrons and the mental health team.

Communication with the out of hour's service was good. Plans were in place which would enable the out of hours GPs to access detailed patient records with their consent, using a local computer system. The practice GPs were informed when patients were discharged from hospital. This prompted a medication review.

Information Sharing

The practice worked effectively with other services. Examples given were regular liaison with mental health services, health visitors, specialist nurses, hospital consultants and community nursing staff. For example, the GPs shared relevant information with health visitors regarding at risk children.

Information was shared effectively to ensure positive outcomes for all patients. For example, the GPs held monthly meetings with community psychiatric nurses to discuss specific cases. GPs engaged regularly with health visitors to discuss such topics as the management of violent and aggressive patients.

Consent to care and treatment

Patients told us they were able to express their views and said they felt involved in the decision making process about their care and treatment. They told us they had sufficient time to discuss their concerns with their GP and said they never felt rushed. Feedback given on our comment cards showed that patients were very satisfied with the care and treatment they received at Old Bridge Surgery. Patients stated they had different treatment options discussed with them, together with the positive or possible negative effects that treatment can have.

Staff had access to different ways of recording that patients had given consent to treatment. There was evidence of patient consent for procedures including immunisations, injections, and minor surgery. Patients told us that nothing was undertaken without their agreement or consent at the practice.

Staff had good local knowledge of any patients at the practice who needed support under the Mental Capacity Act 2005 (MCA). The MCA is a legal framework which protects people who need support to make important decisions.

Where patients did not have the mental capacity to consent to a specific course of care or treatment, the practice had acted in accordance with the Mental Capacity Act (2005) to make decisions in the patient's best interest. Staff were knowledgeable and sensitive to this subject. We were given specific examples by the GPs where they had been involved in best interest decisions and where they had involved independent mental capacity assessors to ensure the decision being made regarding the patient who could not decide themselves, was in the patient's best interest.

Health Promotion and Prevention

There were regular appointments offered to patients with complex illnesses and diseases. The practice manager explained that this was so that patients could access care at a time convenient to them. A range of screening tests were offered for diseases such as aortic aneurisms, cervical

Good

Are services effective?

(for example, treatment is effective)

cancer and ovarian cancer. Vaccination clinics were organised on a regular basis which were monitored to ensure those that needed vaccinations were offered. Patients were encouraged to adopt healthy lifestyles and were supported by services such as smoking cessation clinics.

The practice liaised with the Cornwall Health Promotion Service run by Cornwall Council which supplied patients with a walking for health programme as part of their healthy weight project.

Patients with diabetes were invited to a weekly clinic where staff discussed how changes to lifestyle, diet and weight could influence their diabetes.

The practice had a named lead nurse to support patients with learning disabilities. All patients with learning disability were offered a physical health check each year. The practice used easy to read information leaflets, pictures and models to assist communication with patients where required.

Staff explained that when patients were seen for routine appointments, prompts appeared on the computer system to remind staff to carry out regular screening, recommend lifestyle changes, and promote health improvements which might reduce dependency on healthcare services.

The diabetic appointments supported and treated patients with diabetes which included education for patients to learn how to manage their diabetes through the use of insulin. Health education was provided on healthy diet and life style.

The practice recognised the need to maintain fitness and healthy weight management and its importance for good mental health. The practice worked with a local support agency which organised sailing activities to support patients in this coastal area. Patients had also been referred to exercise programmes and gyms.

The practice carried out skin care protection and promotion campaigns during the summer months as this was a popular holiday destination. The importance of sun protection, sun cream, using sun hats and limiting your time exposed to the sun was highlighted during these campaigns. GPs at the practice had referred patients in the past to skin cancer specialists. The practice also organised extra mole clinics during the summer.

There was a range of leaflets and information documents available for patients within the practice and on the website. These included information on family health, travel advice, long term conditions and minor illnesses. Website links were easy to locate.

Family planning, contraception and sexual health screening was provided at the practice. Three GPs provided contraception implantation services. The practice also offered a travel vaccination service.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We spoke with 12 patients during our inspection. All the patients we spoke with told us they felt well cared for at the practice. They told us they felt they were communicated with in a caring and respectful manner by all staff. Patients spoke highly of the staff and GPs. We received one negative comment about one member of staff not always appearing to listen to a patient's view.

We left comment cards at the practice for patients to tell us about the care and treatment they received. We collected 38 completed cards which contained very detailed positive comments. All comment cards stated that patients were grateful for the professional and caring attitude of the staff.

We looked at the latest results of the 2014 GP Patient Survey. 136 patients at Old Bridge Surgery had submitted their views about the practice. Of these, 92% of respondents describe their overall experience of this practice as good. This was higher than the Kernow CCG average of 90%.

Patients were not discriminated against and told us staff had been sensitive when discussing personal issues.

We saw that patient confidentiality was respected within the practice. The waiting areas had sufficient seating and were located away from the main reception desk which reduced the opportunity for conversations between reception staff and patients to be overheard. There were additional areas available should patients want to speak confidentially away from the reception area. We heard, throughout the day, the reception staff communicating pleasantly and respectfully with patients.

Conversations between patients and clinical staff were confidential and conducted behind a closed door. Window blinds, sheets and curtains were used to ensure patient's privacy. The GP partners' consultation rooms were also fitted with dignity curtains to maintain privacy.

We discussed the use of chaperones to accompany patients when consultation, examination or treatment were carried out. A chaperone is a member of staff or person who is present with a patient during consultation, examination or treatment. Posters displayed informed patients they were able to have a chaperone should they wish. Administration staff at the practice acted as chaperones as required. They understood their role was to reassure and observe that interactions between patients and GPs were appropriate.

Patients gave us examples of the empathy shown by staff towards them. One example of exceptional service included when a patient had been taken unwell unexpectedly, resulting in an emergency admission to hospital during the patient's visit to the practice. The patient had been anxious about their pet as there had been no friends or family to assist. A practice receptionist had arranged for the patient's dog to be housed in kennels.

Care planning and involvement in decisions about care and treatment

Patients told us that they were involved in their care and treatment and referred to an ongoing dialogue of choices and options. Comment cards related patients' confidence in the involvement, advice and care from staff and their medical knowledge, the continuity of care, not being rushed at appointments and being pleased with the referrals and ongoing care arranged by practice staff. We were given examples where the GPs and nurses had taken extra time and care to diagnose complex conditions.

The 2014-15 GP Patient Survey showed that 89% of the 136 respondents said the last GP they saw or spoke to was good at involving them in decisions about their care. This was higher than the KCCG average of 86%.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 86% of 136 respondents said the last GP they saw or spoke to was good at treating them with care and concern. This was higher than the KCCG average. The patients we spoke to and the comment cards we received were consistent with this information.

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

Good

Are services caring?

Staff told us families who had suffered bereavement were contacted by their usual GP. GPs said the personal list they held helped with this communication. There was a counselling service available for patients to access.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Patients told us they felt the staff at the practice were responsive to their individual needs. They told us that they felt confident the practice would meet their needs. GPs told us that when home visits were needed, they were normally made by the GP who was most familiar with the patient. GPs at the practice carried out a higher than average number of home visits. This was to meet the needs of an older population in the local area.

Systems were in place to ensure any referrals, including urgent referrals for hospital care and routine health screening including cervical screening, were made in a timely way. Patients told us that any referral to secondary care had always been discussed with them.

An effective process was in place for managing blood and test results from investigations. When GPs were on holiday the other GPs covered for each other and results were reviewed within 24 hours, or 48 hours if test results were routine. Patients said they had not experienced delays receiving test results.

The practice was responsive to patient needs. The practice manager had responded to increasing patient demand by including two extra appointments to each GP's schedule during the afternoon sessions. A patient participation group (PPG) had been set up. Members of this group had been consulted about any changes at the practice. There was information available on the practice website about joining the PPG.

Tackle inequity and promote equality

The practice had recognised the needs of different groups in the planning of its services. Staff said no patient would be turned away. Staff had received annual training on equality and diversity.

GPs told us about a patient who did not wish to visit the busy main practice due to a medical condition. The GPs had offered appointments to the patient at one of the quieter branch practices at Pelynt or Polperro instead.

The number of patients with a first language other than English was low. The vast majority of patients were Cornish. The practice experienced a large influx of tourists during the summer months. The practice staff knew how to access language translation services if information was not understood by the patient, to enable them to make an informed decision or to give consent to treatment.

The patient participation group (PPG) were working to recruit patients from different backgrounds to reflect the needs of the local population. The PPG had representatives from most of the six different population groups.

General access to the building was good. The practice had an open waiting area and sufficient seating. The reception and waiting area had sufficient space for wheelchair users.

There was no evidence of discrimination when making care and treatment decisions.

Access to the service

Patients were able to access the service in a way that was convenient for them and said they were very happy with the system. Of the 38 comment cards we received, one mentioned that they sometimes had to wait to see a GP of their choice. However, all other comments, discussions and feedback indicated that patients were very satisfied with the arrangements for access.

The GPs provided a personal patient list system. These lists were covered by colleagues when GPs were absent. Patients appreciated this continuity and GPs stated it helped with communication.

The 2014-15 GP patient national survey showed that 88% of 136 respondents found it easy to get through to this practice by phone. This was higher than the KCCG average.

These findings were reflected during our conversations. Patients were happy with the appointment system and said they could get a same day appointment if necessary.

Information about the appointment times were found on the practice website and on notices at the practice. Patients were informed about the out of hours arrangements by a poster displayed in the practice, on the website and on the telephone answering message.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. Survey results showed

92% of 136 respondents found the receptionists at this practice helpful. This confirmed our conversations with 12 patients during our inspection.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Patients told us they had no complaints but knew how to complain should they wish to do so.

The posters displayed in the waiting room and patient information leaflet explained how patients could make a complaint. The practice website also stated that the surgery welcomed patient opinion by sharing ideas, suggestions, views, and concerns.

The complaints procedure stated that complaints were handled and investigated by the practice manager and would initially be responded to within three days. There had been 18 complaints in the last 12 months. Records were kept of complaints which showed that patients had been offered the chance to take any complaints further, for example to the parliamentary ombudsman.

Staff were able to describe what learning had taken place following a complaint. Complaints were also discussed as a standing agenda item at the practice meetings every week. There was an annual review of complaints held every year and any learning points had been shared appropriately with staff.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision and strategy which staff were engaged with. The vision stated the practice aimed;

- To provide highly effective, efficient and above all safe healthcare services for our patients.
- To maintain a practice team and environment which is welcoming, caring and accessible for all our patients.
- To provide access to services for patients in a timely way, in a manner that meets their needs and takes into account their own circumstances.
- To continue with our longstanding GP list based care system with every patient having a named GP regardless of age while still providing a choice to patients.
- To treat our patients fairly and equally, and with dignity and respect at all times.
- To listen, communicate and collaborate with patients effectively to improve services.

Staff knew and understood the vision and values and knew what their responsibilities were in relation to these. Staff spoke positively about communication, team work and their employment at the practice. They told us they were actively supported in their employment and described the practice as having an open, supportive culture and being a good place to work. There was a stable staff group and staff were positive about the open culture.

We were told there was mutual respect shared between staff of all grades and skills and that they appreciated the non-hierarchical approach and team work at the practice.

Staff said the practice was small enough to communicate informally through day to day events and more formally though meetings, formal staff appraisal and 360 degree feedback.

Governance Arrangements

Staff were familiar with the governance arrangements in place at the practice and said systems used were both informal and formal. For example, there were reception meetings every two months and dispensary meetings every three months in addition to the regular weekly practice meetings. We saw records which provided minutes of these governance arrangements.

Issues were often addressed immediately and communicated through a process of face to face discussions or email. These issues were then followed up more formally at monthly clinical meetings where standing agenda items included significant events, near misses, complaints and health and safety. Staff explained these meetings were well structured, well attended and a safe place to share what had gone wrong.

The practice used the quality and outcomes framework (QOF) to assess quality of care as part of the clinical governance programme. The QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice in their surgeries. The QOF scores for Old Bridge Surgery were consistently above the national average. For example, 96% of patients with COPD had been seen and reviewed within the last 12 months. The target for this was 80%.

The practice held a monthly QOF meeting. A member of staff prepared a QOF summary to show how the practice was performing across the board prior to each meeting. Any areas of concern were then tackled and an action plan agreed at the QOF meeting.

The clinical auditing system used by the GPs assisted in driving improvement. All GPs were able to share examples of audits they had performed. In addition to the incentive led audits the GPs told us they wanted to perform audits to improve the service for patients and not just for their revalidation or QOF scores. These examples included audits on minor injury treatments and minor surgery performed. Audits followed a complete audit cycle. Examples of audits were readily available to provide a resource for trainees and other staff.

Leadership, openness and transparency

Staff were familiar with the leadership structure, which had named members of staff in lead roles. For example there was a lead nurse for infection control, a lead GP for safeguarding and a lead GP for the nursing team. Staff spoke about effective team working, clear roles and responsibilities and talked about a supportive non-hierarchical organisation. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns. Staff described an open culture within the practice and opportunities to raise issues at team meetings.

The practice manager was responsible for human resource policies and procedures. Staff were aware of where to find these policies if required.

Are services well-led?

Good

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

Practice seeks and acts on feedback from users, public and staff

Patients we spoke with in the waiting room were aware there were suggestion boxes in the waiting room. The website signposted patients to give feedback if they chose.

The practice had a patient participation group (PPG). The practice manager and GPs were keen to encourage patient feedback and involvement. The PPG had suggested and supported recent changes. These included rearrangement of the chairs in the waiting room to create more space and privacy. A visual display unit had been wall mounted to provide useful health related information to patients whilst they waited. This was not operational on the day of our visit. The PPG was advertised on the practice website.

Management lead through learning & improvement

During our inspection a safeguarding meeting took place at the practice. We were invited to attend the meeting. We observed that the meeting was well led by the practice management and that staff were open to shared learning and improvement.

A process was followed so that learning and improvement could take place when events occurred or new information was provided. For example, GPs from the practice attended regular KCCG meetings, frailty forums and other forums with specialisations relevant to the local population of the practice.

GPs and practice management attended best practice forums to discuss any updates or current topics and review any newly released national guidelines and the impact for patients. There was formal protected time set aside for continuous professional development for staff and access to further education and training as needed.

The practice had systems in place to identify and manage risks to the patients, staff and visitors that attended the practice. The practice had a suitable business continuity plan to manage the risks associated with a significant disruption to the service. This included electricity or IT loss, heavy snow or flooding.

There were environmental risk assessments for the building. For example, annual legionella testing for water quality. One of the staff was a nominated health and safety officer. They had completed building and room safety assessments, emergency lighting and equipment checks and ensured control of substances hazardous to health (COSHH) assessments had been conducted. A fire drill had been successfully conducted in January 2015. Health and safety meetings were held on a fortnightly basis.