Stillmoor House Medical Practice

Quality Report

Stillmoor House
Bell Lane
Bodmin
Cornwall
PL31 2JJ
Tel: 01208 72488
Website: www.stillmoorhousemedicalpractice.co.uk

Date of inspection visit: 3 February 2015
Date of publication: 13/08/2015

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

Ratings

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

Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	2
The five questions we ask and what we found	4
The six population groups and what we found	7
What people who use the service say	12
Areas for improvement	12

Detailed findings from this inspection

Our inspection team	13
Background to Stillmoor House Medical Practice	13
Why we carried out this inspection	13
How we carried out this inspection	13
Detailed findings	15
Action we have told the provider to take	29

Overall summary

Letter from the Chief Inspector of General Practice

We inspected Stillmoor House Medical Practice on 3 February 2015. This was a comprehensive inspection.

Overall the practice is rated as good. Specifically we found the practice to be good for providing effective, responsive, caring and well led services, but improvements are required for providing safe services. It was good for providing care for all the population groups: older people; people with long term conditions; families, children and young people; people experiencing poor mental health, people in vulnerable circumstances; working age people and those recently retired.

There are seven GP partners, who work the equivalent of five full time GPs. The practice provides primary medical services to around 10,500 patients who live in Bodmin and the surrounding villages in Cornwall. The practice provides services to a diverse population age group and is based in the town centre. The practice has a dispensary attached.

Our key findings were as follows:

- Patients felt they were treated with dignity and respect and in a professional manner that showed kindness and care towards them.
- Some patients reported difficulties in seeing the practitioner of their choice. During this visit staff were seen helping patients to access GPs, and explaining the appointment system.
- Good systems were in place to maintain a clean and hygienic service.
- GPs and nurses kept up to date with professional guidance on treatment of disease and management of long term conditions.
- The practice operated a college based service in the town offering lunchtime appointments to pupils aged 13-19 years at the college. These appointments were with either a GP or practice nurse and offered counselling, contraception, lifestyle advice, as well as routine medical care. Patients did not have to be

registered with the practice to use this service. The drop in clinic was provided by this practice two days per week, and by another practice in the town on another two days.
- The local community team had instigated a ‘Single Point of Access’ for all referrals by patients with mental health problems including access to urgent care on the day, using e-mail to the duty community psychiatric nurse team for assessment. The practice found this was a useful system for obtaining good outcomes for patients.

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

Importantly, the provider must:

- Monitor the significant events that are reported, as well as any complaints received, ensure that appropriate staff are included in the discussion and that any learning and subsequent action to be taken in response is recorded and shared with the team.
- Ensure that fridges used to store medicines are reliable and the medicines are stored at correct temperatures at all times.

In addition the provider should:

- Review the policy and procedures for updating patients' medicine records after discharge from hospital, and for repeat prescribing.
- Maintain a record of checks made when employing locum staff, and maintain on-going records of GP validations, nurse registration and staff training.
- Introduce a system for identifying informal carers, assessing their needs and signposting them to support.
- Introduce a system to ensure that staff have read and understood policies and procedures.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

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

Alerts were brought to the attention of staff appropriately so they could check and adjust their work accordingly.

Significant events were reported and recorded, but not monitored to identify trends, and learning points were not shared effectively with the whole team. Some of these involved medicines management.

Good systems were in place to maintain a clean and hygienic service. Risks to patients were assessed and well managed. There were enough staff to keep patients safe. The practice had systems to manage safeguarding and review risks to children, young people and vulnerable adults.

Are services effective?

Good

The practice is rated as good for providing effective services.

There were effective processes in place to monitor patients' long term conditions and ensure they received suitable treatment.

The practice had a system in place for completing clinical audit cycles. Following each clinical audit, changes to treatment or care were made, for example, audits of minor surgery had been carried out annually. These showed a reduction in both complications and infection rates. We saw records of the discussion in the clinical meeting that led to change.

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. There was an expectation that staff read and acted on any issues arising from communications with other care providers on the day they were received and a requirement for 24 hour turnaround for typing of referrals to secondary care.

GPs maintained close working relationships with health care professionals in the area.

Are services caring?

Good

The practice is rated as good for providing caring services.

Patients who spoke with us said they had been able to get urgent care when they needed it, and if they wanted to see a particular GP,

they could book two or three weeks in advance. We were told that patients had phoned and spoken with a GP who arranged for a prescription that they received that afternoon so they thought the telephone access was good.

Patients who completed comment cards told us of their experiences of being helped by the service. For example, staff had phoned back to say they had doubled appointments so the frail older patient would not be rushed. One person told us they had received good care over many years, but over the past year when their health had deteriorated the response from all members of staff had been excellent.

Conversations with reception staff could be heard by other people in the area. However, we saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments.

Patients who completed comment cards said that staff responded compassionately when they needed help and provided support when required. GPs visited patients at home for end of life care.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

Getting an appointment with the GP of their choice was the issue raised most by patients. The practice had taken measures to deal with this but, but providing a response on the day for urgent needs was prioritised. The practice booked 100% of routine appointments in advance, up to four weeks ahead. Some GPs were fully booked, three weeks in advance. In order to deal with the demand for on-the-day urgent calls two duty GPs triaged incoming telephone calls from patients. An emergency care practitioner joined the practice team to increase patient access to a health care professional on the day. This was in response to the Patient Participation Group (PPG) reporting patients' priorities. The nurse practitioner dealt with 'on the day' appointments, dealing with minor injuries and illness, mostly in children and elderly patients. Under 11s were not triaged, but all given an appointment.

On the day of this inspection there were freezing conditions and snow on the ground. Frailer patients who could not get to their early appointments because of the ice had been fitted in later in the day when the pavements were clear.

Suitable and timely responses had been made to complaints, with information provided to the patient where appropriate. When the complaint was in respect to a young child we saw the practice had contacted the family the same day.

Summary of findings

Are services well-led?

Good

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

Leadership was provided by having named members of staff in lead roles. The team currently had no designated senior partner but took decisions as a group. The GPs met monthly for a clinical meeting, where significant events and medical reviews of patients were discussed. Nursing and administrative teams also met monthly. We saw that headline records were kept of all these meetings, but no details of action to be taken and how they were shared .

The practice had policies to guide by staff in their work and staff were familiar with procedures. The staff handbook included guidance with regards to employment such as the disciplinary and grievance procedures. Other policies were available on the practice's intranet, although not user friendly for staff to find and refer to.

All team members who spoke with us considered that informal communication was good, with a culture where the benefit of raising concerns is valued. Staff were comfortable in expressing differences of opinion, saying GPs and staff were supportive of each other.

Summary of findings

The six population groups and what we found

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

Older people

Good

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

The practice held a register of all patients aged 75 and over and provided these patients with details of their named GP. Patients at risk of an unplanned admission had a personal care plan which had been reviewed by the GP and/or the community matron.

Housebound patients were offered home visits which included a review of any chronic disease they had including diabetes, COPD or coronary heart disease. The practice provided urgent telephone access to a GP on the same day for patients to discuss urgent medical concerns and this allowed older patients easy access to medical advice when needed.

The practice worked as part of a multi-disciplinary team for older patients, comprising community nurses, the practice nursing team, Macmillan nurse, and social worker to provide additional support, ensure that medical care was co-ordinated, and ensure patients were well cared for in the community.

When patients were discharged from hospital, the GP or practice manager phoned them to ensure patients on-going needs were met.

People with long term conditions

Good

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

There was a system in place to review medication for patients with multiple conditions. Longer appointment times were given for these reviews to ensure a ‘one-stop’ approach.

Over 90% of patients with diabetes, COPD, or coronary heart disease had a minimum of an annual review with a specific health care professional. As part of the review the practice routinely discussed anxiety and mood. GPs and nurses had training to support their lead roles in providing care for specific disease areas.

In the previous year, 80% of asthmatic patients had a full review of their symptoms and medication. Where necessary home visits were provided with practice nurses providing care and support.

The practice met fortnightly with the palliative care team including the Macmillan nurse and community nurse to discuss patients under their care.

The practice held a register of patients with raised blood glucose levels and recalled these patients for regular monitoring. Patients

were offered lifestyle advice with respect to prevention of diabetes and if appropriate were referred to a weight management service. The practice carried out health checks for patients aged 40-74 years, calculating their risk for developing diabetes, heart disease etc. and measuring cholesterol levels.

Patients within this group who were at high risk of hospital admission were included in the practice admission avoidance plan. Each had a care plan in place with GP and community matron input as appropriate.

Families, children and young people

Good

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

The practice had a system in place to identify and follow-up children at risk, with a GP holding bi-monthly meetings with the health visitor team to look at families in this group.

The practice achieved over 95% success for childhood vaccination, and patients who failed to attend were contacted by the practice.

The midwife attended the practice and held an ante-natal clinic each Wednesday afternoon. She entered patient information into the practice clinical system, which aided continuity of care during pregnancy.

A&E letters were reviewed routinely by the safeguarding lead for children and young people to screen for any safeguarding concerns.

The practice offered appointments outside of school hours, but also had evening and alternate Saturday morning surgery to allow routine access to GP and nurses at convenient times for parents and children.

The practice operated a college based service in the town offering lunchtime appointments to pupils aged 13-19 years at the college. These appointments were with a GP or practice nurse and offered counselling, contraception, lifestyle advice, as well as routine medical care. Patients did not have to be registered with the practice to use this service. The drop in clinic was provided by this practice two days per week, and by another surgery in the town on another two days. Staff told us the patients were presenting mainly with mental health issues and contraception. We observed that good quality assessments had been made of patients' mental health needs and a responsive service was provided. Staff were using the principles of the Gillick judgements to assess young patients' ability to give informed consent. Some young patients also came to the surgery during school time, and they would be given an appropriate appointment even if not registered with this practice.

Summary of findings

The practice was EEFO registered (Cornwall Council) as a service which offers supportive and confidential advice to under 18's. EEFO kite marks services that meet young person friendly quality standards across Cornwall and the Isles of Scilly. The term EEFO is not an abbreviation. EEFO is a word that has been designed by young people, to be owned by young people.

Working age people (including those recently retired and students)

Good

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

The practice is open from 8am to 6pm every day with telephone access until 6.30pm. Extended hours appointments with both GPs and practice nurses were available on alternate Wednesday and Thursday evenings until 8pm as well as Saturday appointments on alternate weeks.

The practice offered same-day access to speak to a GP and patients could specify a convenient time for a call back to suit their needs. If necessary, after speaking with the GP, they could be offered a suitable appointment for their health care needs.

Patients could apply on-line for appointments, as well as on-line ordering for repeat medication. There was a telephone answering service for repeat medication. The patients could nominate a pharmacy where they wanted to collect their prescription avoiding a separate journey to the surgery.

The practice offered health promotion through a dedicated stop-smoking clinic, via telephone or by appointment with a smoking adviser. Patients could be referred to weight management programmes and exercise programmes through local council providers at introductory reduced rates.

Health checks were offered to patients aged 40-74 years at which their risk for developing diabetes and heart disease were assessed. Patients were advised of this service by a letter of invitation.

People whose circumstances may make them vulnerable

Good

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

The practice held a register for patients with learning disabilities, and offered an annual extended appointment with an appropriately trained nurse to review their health and social care needs. The nurse lead worked closed with the community based learning disability nurse and visited housebound patients at their home address. Comprehensive health plans were produced and placed in the patients' electronic records.

Staff had received training to enable them to recognise signs of abuse for children and vulnerable adults and were aware of their responsibilities with respect to sharing information and reporting concerns. The practice safeguarding lead and their deputy were available for staff to discuss any issues raised.

The practice had close working relations with the St Petroc's Society who provide accommodation for homeless people in the area. The practice registered patients at the home's request. When a homeless patient presented at the practice they were given an emergency appointment and did not need to provide a telephone number for triage call-back. These patients were able to use the practice address as a 'care of' address for hospital appointments.

The practice was registered under the local Cornwall Council 'safe places' scheme and offered a safe place for vulnerable people. Patients coming to the practice under this scheme presented a card then the practice contacted their next of kin or chosen primary contact to keep them safe.

National data showed the practice performing well in maintaining registers of patients with learning disabilities.

People experiencing poor mental health (including people with dementia)

Good

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

The practice held a monthly mental health 'HUB' meeting where representatives from all aspects of the mental health team attended. This included clinical psychiatrists, community mental health nurses, and staff from a counselling service, local day centre, employment and training support, and the dementia support team. These meetings allow for multidisciplinary review of patients with poor mental health and signposted access to services and support for patients.

The practice participated in in the Dementia Screening scheme as a directed enhanced service. Patients identified in accordance with NICE guidelines received active screening as part of their chronic disease reviews and access to memory clinic services was arranged when appropriate. Follow-up by a consultant psychiatrist was arranged for newly diagnosed dementia patients.

Patients with mental health concerns were offered an annual review including a review of their physical health. Over 90% of patients had received a health check, and over 50% of patients had a care plan in place. GPs said they had a high number of patients with a diagnosed mental health issue due to a mental health hospital in the area having been closed. The former inpatients did not have active

Summary of findings

mental health issues and were happy to have screening but not keen to have a care plan and so did not turn up for appointments. For this year they had introduced a comprehensive new template and the care plan was drawn up at the medication review. There were 130 patients with severe and enduring mental illness on the register.

The practice provided primary care for patients living in a nursing home for older people with mental health problems. They also provided support for patients in community hospital beds under the care of a local psychiatrist.

The local community team had instigated a 'Single Point of Access' for all referrals of patients with mental health problems including access to urgent care on the day using e-mail to the duty community psychiatric nurse team for assessment. The practice found this was a useful system for obtaining good outcomes for patients. Communication between GPs and community psychiatric nurses (CPN) or the consultant or staff grade psychiatrist was enhanced due to some GPs regularly working at the psychiatric hospital. This was useful when a formal approach was not necessary, for example, to check their care management plan was appropriate for the patient's needs.

Summary of findings

What people who use the service say

We spoke with five patients during our inspection.

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 36 comment cards, the majority of which contained positive comments. Patients told us staff were caring, treated them with dignity and respect and they received the right care and treatment at the right time.

Patients who spoke with us said they had been able to get urgent care when they needed it, and if they wanted to see a particular GP, they could book two or three weeks in advance. We were told that patients had phoned and spoken with a GP who arranged for a prescription that they received that afternoon so they thought the telephone access was good. Another patient commented on the easy booking-in panel.

Patients who completed comment cards told us of their experiences of being helped by the service. For example, staff had phoned back to say they had doubled appointments so the frail older patient would not be rushed. One person told us they had received good care over many years, but over the past year when their health had deteriorated the response from all members of staff had been excellent.

A small minority said they felt they had not been listened to, and that staff had made assumptions about them. One patient said there had been delays in the return of blood test results. Some patients said they did not like having to wait for a call back from the duty GP to see whether they needed an appointment as this interfered with their job. We had been advised that patients could say what would be a convenient time for a call back.

Patients who had needed to be referred to a hospital service told us this had been achieved smoothly. The availability of GPs and the length of time to wait to see a GP of choice were mentioned as issues, but patients recognised they received a good service from a very busy practice.

Areas for improvement

Action the service MUST take to improve

- Monitor the significant events that are reported, as well as any complaints received, ensure that appropriate staff are included in the discussion and that any learning and subsequent action to be taken in response is recorded and shared with the team.
- Ensure that fridges used to store medicines are reliable and the medicines are stored at correct temperatures at all times.

Action the service SHOULD take to improve

- Review the policy and procedures for updating patients' medicine records after discharge from hospital, and for repeat prescribing.
- Maintain a record of checks made when employing locum staff, and maintain on-going records of GP validations, nurse registration and staff training.
- Introduce a system for identifying informal carers, assessing their needs and signposting them to support.
- Introduce a system to ensure that staff have read and understood policies and procedures.

Care Quality Commission

Stillmoor House Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a **CQC Lead Inspector.** The team included a GP specialist advisor and a practice manager specialist advisor.

Background to Stillmoor House Medical Practice

The practice provides primary medical services to around 10,500 patients who live in Bodmin and the surrounding villages in Cornwall. The practice provides services to a diverse population age group and is based in the town centre. The practice is open Monday to Fridays from 8.30am to 6pm. Extended opening on alternate Saturday mornings from 8am, and alternate Wednesday and Thursday evenings from 6.30pm is available for pre-booked appointments for patients with on going medical conditions.

There are seven GP partners, who work the equivalent of five full time GPs. Three are women and four are men. We were told that plans for increasing GP numbers were under discussion but with the current GP cover this practice has a challenging case load. There are also a nurse practitioner who was qualified as a prescriber, three practice nurses, and two healthcare assistants who provide nursing care.

The practice has a dispensary attached. A dispensing practice is where GPs are able to prescribe and dispense medicines directly to patients who live in a rural setting. Stillmoor House Medical Practice dispensed to patients who did not have a pharmacy within a mile radius of where they lived.

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

The practice assists in the provision of in-patient medical care at Bodmin Community Hospital. GPs provided 20 hours care at the community hospital, on the general ward and the specialised stroke ward, alternating with another practice.

The practice provided primary care for patients living in a nearby care home with nursing for older people with mental health problems. GPs said they had a high number of patients with a diagnosed mental health issue due to a hospital in the area having been closed. They also provided support for these patients in community hospital beds.

The practice is involved in a shared initiative with other practices in the town, providing a drop-in service at the local college, offering advice and treatment to young people.

The practice does not offer an out of hour's service itself, but patients are directed to an out of hours service delivered by another provider and the NHS 111 service.

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

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

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

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

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

Before conducting our announced inspection of Stillmoor House Medical 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 or during the inspection.

We carried out our announced visit on Tuesday 3 February 2015. We spoke with five patients, five GPs, and medical students who were present on the day. We met with five of the nursing team and several of the management, dispensing and administration teams. We collected 36 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.

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts (NPSA) as well as comments and complaints received from patients. The NPSA were received by the practice manager, who then emailed them on to relevant teams. Paper copies were kept which were ticked when actioned. The practice manager recognised that the system did not work in her absence so planned to have them sent to the practice's generic email address which was monitored frequently. The GP partners discussed these at their monthly meetings. A recent example was an alert about a batch of faulty syringes. Staff checked and found their stocks were not affected.

There was a good framework for the monitoring and improvement of health and safety with a proactive health and safety team led by the deputy practice manager. Team leaders took responsibility for their areas attending bi-monthly meetings to consider any risks and update assessments and action needed. The minutes of the two-monthly meeting were sent to all members of the team. We saw these had included discussion of checking of alarms, provision of cupboards to enable removal of clutter, replacement and cleanliness of curtains and carpets and removal of records from the dispensary to give more room for storage of prescriptions. Staff took responsibility to ensure that actions were followed up.

We saw the practice manager disseminated new guidance to team members. For example, new guidance about cremation had been passed to the five partners.

Learning and improvement from safety incidents

The practice had a system in place for reporting and recording significant events. GPs and staff reported significant events and told us if they were about nursing issues they were discussed at the monthly nurse team meetings. GPs and staff felt that concerns were taken seriously and that change would happen as a result of the reporting. However, records of discussions were not always evident in the GP partners meeting minutes to support that significant event analysis (SEA) had been discussed. Where potential learning was identified staff told us that changes would be made and learning disseminated, but this was not recorded. Nursing staff told us about a recent event when a patient was booked into the flu clinic, and was given a flu injection, although the patient thought they were attending for a screening clinic.

Trends had not previously been monitored. We saw a log of the previous year's SEAs in preparation for this inspection, which enabled identification of a trend relating to medicine management. The dispensing manager had not attended clinical meetings. Nurses met with the GPs at alternate clinical meetings. Administrative, nursing and dispensary staff met monthly. Minutes of meetings were in handwritten note form, with reliance on verbal communication.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to children, young people and vulnerable adults. There were policies in place to give guidance to staff and contact details for raising concerns were easily accessible. The GP for child protection had achieved level three training. The practice had registered with the skills council for safeguarding training. Some GPs had achieved level three, while the others were working towards it. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours.

Staff had not had safeguarding concerns to raise. Guidance about safeguarding was displayed on the wall of the treatment room, including contact details for the multi-agency safeguarding hub (MASH). They said they would discuss with a health visitor any concerns about a child at risk. A&E letters were reviewed routinely by the safeguarding lead for children and young people to screen for any safeguarding concerns. Staff were not aware of the whistleblowing policy but said they would raise a concern with the practice manager or the senior partner.

Notices displayed in the waiting room and in treatment rooms offered a chaperone service. (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). GPs, nursing and reception staff had

Are services safe?

attended chaperone duty training . Some reception staff had volunteered to perform chaperone duties. The practice manager was in the process of obtaining Disclosure and Barring Service (DBS) clearances for all health care professionals and any staff who had one to one contact with patients. A risk assessment was undertaken to assess the safety of employing staff in roles for which this check was not carried out.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a power failure. Two of the three medicine fridges did not record maximum and minimum temperatures and although staff had recorded regular intermittent temperature checks they could not be sure that a constant safe temperature had been maintained. The fridges used for storing medicines had not been services or their thermometers calibrated, we were told this would be arranged.

The nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance, with the HCA administering vaccines in accordance with patient specific directions. We saw up-to-date copies of both sets of directions and evidence that nurses and the HCA had received appropriate training to administer vaccines.

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

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse). Both keys were on the same key ring which was not stored in a safe place but staff returned it during our visit to the safe place that had been provided. Stocks of controlled drugs had been checked after each dispensing episode, and a record kept showing the correct number remained in stock.

A GP was on the medicines management group for the CCG. GPs told us they carried out audits as part of the medicines management plan, in accordance with prescribing incentive schemes. For example, we were shown that appropriate changes to prescribing practice had been made in response to an audit of an inhaler for patients with asthma.. A GP took the lead for prescribing practice and was involved in initiatives with other Cornwall practitioners for example, the New National TB strategy, using the Royal Society of Medicine website. They also dealt with alerts, for example when a patient attempted to obtain medicines from more than one practice. The practice participated in a pharmacy review for patients prescribed four or more medications and those resident in nursing and care homes (jointly with CCG pharmacy adviser) to check polypharmacy.

We looked at the management of a high risk medicine. The practice did not have a protocol to give guidance on the process for prescribing and dispensing this medicine but in practice we saw that a clear warning was entered onto the patient records, to remind the reader that repeat prescriptions must not be dispensed until a blood test has been carried out. We saw on a repeat prescription that the result of the blood test was recorded and was within the expected range. A GP signing prescriptions on the day of this visit checked whether the blood test had been carried out, which it had. We were shown a shared care protocol stating that patients were not prescribed the medicine until the results of the blood test had been seen by the duty GP who then authorised the next repeat prescription.

Dispensing staff had all achieved NVQ level three in pharmacy services. Patients could write, phone or email their requests and electronic prescribing started during the week of this inspection. Staff found the patient's medicine record on the computer and sent it to the GP to sign on screen, then it went to the pharmacy of the patient's choice. If the patient was able to use the practice's dispensary, the necessary processes were in place. A second staff member checked and signed each dispensed medicine.

A specific staff member scanned in post received. When informed by a consultant of a prescription of a new medicine for a patient, they highlighted to the GP that a change was indicated. For example, a letter was received from the out of hours team for a prescribed medicine. It was added to the record, showing that it had been prescribed by a health care professional outside the practice. The patient's prescription was not altered until the GP approved it. Serious event analysis had been

undertaken in January 2015 and July 2014 which referred to dispensary staff adding a medicine or altering a dosage without referring to a GP. There was no written protocol regarding what changes administrative staff could make to patient records and what changes must be made by a GP. Staff who spoke with us were not aware of a medicines reconciliation policy or repeat prescribing policy.

The telephone system allowed patients to leave a message for repeat prescription orders, thus freeing up receptionist time and also allowing patients to order their medication at any time during the day. We did not see any incidence of errors, but nor did we see any audit had taken place to check for accuracy or any misunderstandings.

Cleanliness and infection control

The practice had a policy for infection control, which undertook to maintain the premises, equipment, drugs and procedures in accordance with professional guidance, while providing facilities and financial resources to ensure that all reasonable steps were taken to reduce or remove risk of infection. The policy with the supporting procedures enabled staff 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.

A GP lead, administrative lead and nursing lead had been appointed for infection control. A nurse was given responsibility for the maintenance of personal protective equipment and the provision of personal cleaning supplies within clinical areas and a cleaner was responsible for the maintenance of the provision of personal cleaning supplies within non-clinical areas. Cleaners were employed by the practice and comprehensive training was provided by the hospital. A GP and health care assistant had attended additional training to support the introduction and maintenance of good practice in respect of infection control.

Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. We observed the premises to be clean and tidy. Flooring and work surfaces were smooth and easily cleanable. Staff told us they had wipes for cleaning the chairs and the trolley, desk and computer. Disposable pillow cases were provided, and white paper roll for the couch was replaced after each patient. The screens around couches were washed daily, and disposable screens had been ordered.

Specific staff had responsibility for checking bins and the hand-wash provided for patients. There was a safe procedure for dealing with urine specimens. Speculums and instruments used for in-growing toe nails were sent to the central sterile services department (CSSD) at the local hospital. Other instruments used were disposable.

Clinical waste was collected safely, disposed of legally and consignment notes were kept.

Equipment

All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence that calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices was carried out annually. Fire alarms and fire fighting equipment had been checked and serviced annually. Fire alarms and toilet alarms were checked monthly by staff.

There were two wheelchairs which had been kept clean but had not been serviced.

Staffing and recruitment

The practice had a policy on recruitment to ensure equal opportunities for candidates and safe appointments. It had been reviewed in January 2015, and included the need to carry out Disclosure and Barring Service (DBS) checks appropriately or complete a risk assessment. During recruitment, DBS checks had been carried out for all candidates for positions that involved one to one contact with patients and risk assessments were in place when it was decided this was not needed.

Locum GPs were employed but there was no system for checking their suitability to work at the practice. Documents we saw on file included a curriculum vitae (CV). The practice manager told us the NHS performers list had been checked , which would show the person was qualified and registered with the GMC, but there was no record of this.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to

Are services safe?

meet patients' needs. 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. Rotas were in place for duty GPs and clinics.

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. The practice also had a health and safety policy which was shared with staff during induction training. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Urgent phone calls from patients were entered by reception staff onto the computer screen of the duty GP, so they would phone the patient immediately. In the event of an urgent occurrence such as a patient collapsing, staff would phone through to the duty GP. A second duty GP was available as a contingency, so as to avoid disruption to patients who were attending non-urgent booked appointments. GPs told us this was working well and they were able to be more responsive to emergencies. An example given was a case of a young person with asthma who became acutely unwell in the practice. The GP was able to give immediate urgent care (nebuliser and steroids) and arrange admission to hospital with a good outcome.

Should a patient with an acute mental illness arrive at the practice, the GP would speak to staff on the acute mental health team. GPs at the practice told us of a good working relationship with the community psychiatric nurses (CPN) and the consultant or staff grade psychiatrist, with whom they would discuss issues or take advice and check their care plan was appropriate.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received annual 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. The emergency trolley had been checked weekly, with a list showing what was being checked. The drawers were labelled and equipment needed in the event of a cardiac arrest was kept together in one drawer. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

Staff told us there was an alarm call on the computer and in addition they would shout for assistance if there was an emergency in their treatment room.

Records showed that staff were up to date with fire training and that they practised regular fire drills. These were included in induction training for new staff.

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. There was no lead for NICE guidance. Local referral guidance was available on the practice intranet. GPs told us they checked this regularly and when there were new guidelines the GPs discussed them in their monthly clinical meeting. Nurses did not go to those meetings and were expected to keep themselves up to date. We were shown a good example of a GP changing their diagnosis and management of hypertension following a change of guidelines.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses also had additional training to support this work, which allowed the practice to focus on specific conditions. For example, the GP lead for diabetes had completed training in insulin initiation. We met with the lead practice nurse for diabetes, who described clearly and accurately to us what changes to management and treatment could be implemented for a patient on the day of this visit. The practice used a template for the annual review which ensured a comprehensive assessment was made. If they had any concerns, for example about results of blood tests, they referred to the lead GP who then decided on a management plan for the patient. Monthly clinics were held with the diabetic nurse specialist to discuss complex patients. The practice nurse updated their training regularly with new guidance and was up to date with new medicines.

The nurse practitioner was also qualified as a prescriber: they carried out medicines reviews, for example for patients with asthma or COPD, and brought any concerns such as the patient's polypharmacy to discuss with the GP.

The practice had raised the funding for a machine 16 years ago that provided a prompt test for blood clotting, in response to the health needs of a young patient. Now the practice provided this test for many patients including those not registered with this practice.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. National data showed the practice performing well in holding regular case review meetings for patients needing palliative care, and was also above the national average for cervical screening test being performed in the preceding 5 years.

Management, monitoring and improving outcomes for people

The practice had a system in place for undertaking clinical audit cycles. Following each clinical audit, changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved. The practice showed us four examples of audits that had been carried out over the past two years. These included audits of testing for and management of coeliac disease, including screening for bone loss. These had been discussed at a partners meeting and recorded in the minutes. They had investigated whether patients with a diagnosis of irritable bowel syndrome (IBS) had been tested for coeliac disease. Of the 412 patients, the records of 100 were sampled and it was found that 25 had been tested. This meant that in 75% of cases this possible diagnosis had not been excluded. The records of the 24 patients with confirmed coeliac disease were examined and it was found that 50% had not been tested for osteoporosis. The GPs recorded that NICE suggested this was a commonly under-diagnosed disease and suggested GP considered coeliac serology before making a diagnosis of IBS and carry out an audit of all patients with IBS to find whether they had been tested for coeliac disease. GPs suggested offering a scan for bone mass to all coeliac patients at diagnosis and to offer women a repeat scan when they reached the age of 55 years. A second audit had been carried out which showed a significant improvement in the patient care that had been implemented.

Audits of minor surgery had been carried out annually. These showed a reduction in both complications and infection rates. GPs told us it also identified that the consent form needed to be improved and a new version had been produced to improve clarity and accountability. We saw records of the discussion in the clinical meeting that led to change, although practice nurses and dispensing staff were not included in clinical meetings.

Nursing staff used a template for clinics, accessed through the computerised patient record. One example record we saw was for a patient with chronic obstructive pulmonary disease (COPD), where spirometry was used to assess and

Are services effective?

(for example, treatment is effective)

record how breathless they were. This score was then used to guide discussions and enhance GP-patient communications, with the ultimate aim of improving the management of COPD and quality of life. A nurse did follow ups to monitor for any deterioration, including in low mood or memory, and would advise the patient to see the GP if there were concerns.

There were no GPs registered with a Special Interest but GPs in the practice undertook minor surgical procedures in line with their registration and NICE guidance. The staff were appropriately trained and kept up to date.

The practice had 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.

Clinical audits had been 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, an arrangement had been made for a representative from the CCG to carry out an audit of antibiotic prescribing to check whether the practice was working in accordance with guidelines. The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, the practice performed slightly better than the minimum standards for QOF in diabetes and hypertension.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. With the equivalent of five full time partner GPs to provide care for the 10,500 patients registered with the practice, this was a challenging case load. GPs recognised this and were discussing possibilities of recruiting to increase the team of GPs.

We saw evidence of the revalidation of some of the GPs but no central record was maintained of GPs' revalidation or of their essential training. (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). The practice manager had recently asked the lead nurse to check the nurses' registrations with the Nursing and Midwifery Council and confirmed this had been done, but there was no system for checking again at renewal date.

Currently the practice is a teaching practice for medical students, it is considering also becoming a training practice.

No central record was kept of staff training. We looked at a sample of records, which showed that mandatory courses such as annual basic life support had been provided. The practice manager could not tell us, for example, which staff had received training in moving and handling, but said that all nurses would have done an on-line session at some time in the past.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties, for example, administration of vaccine. Those with extended roles, for example, diabetes were also able to demonstrate that they had appropriate training to fulfil these roles.

HCAs told us they had been provided with training to do their jobs and to extend their role. For example, they had been trained to use the electrocardiogram (ECG). Staff told us there was good teamwork in the practice. For example, when a clinic was running late, another nurse came to help out.

Bank or locum staff told us there was no induction pack available to them, however, they felt the processes in place were safe and they were happy to come to work at this practice.

Working with colleagues and other services

The practice worked 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. There was a requirement for 24 hour

turnaround for typing of referrals to secondary care. Two week wait referrals were sent same day with a safety net provided for patients by asking them to phone the practice if an appointment was not provided.

GPs met fortnightly with district nurses and monthly for multidisciplinary meetings, to assure care planning and continuity of care for frail and vulnerable patients. However, minutes of these discussions were recorded into patients' notes, and there was no central record for sharing learning or highlighting risk.

GPs met regularly with the community mental health team (CMHT) psychiatrist and community psychiatric nurse (CPN) and counsellors to discuss patients for whom they shared care, planning their care for the months ahead. The local community team had instigated a 'Single Point of Access' for all referrals including access to urgent care on the day using e-mail to the duty Community Psychiatric Nurse team for assessment. The nurse practitioner identified postnatal mothers at risk of depression and informed the practice manager, who made referrals as appropriate to an NHS service for people with emotional or psychological difficulties who want a talking treatment, or for social support and domiciliary care.

GPs provided 20 hours care at the community hospital, on the general ward and the specialised stroke ward, alternating with another practice. There was a fortnightly meeting with Macmillan nurses about palliative care. A health care assistant as well as the GP, visited patients in care homes.

The GP safeguarding lead met with Health Visitors (HVs) regularly and had easy access to them if there were concerns about a child at risk. GPs commented that they did not have such good links with HVs as previously when they were attached to particular GPs the practice. They were no longer able to combine to provide joint baby clinics in the practice at the same time as the baby immunisations.

Kernow CCG were piloting the use of Bodmin Hospital Minor Injuries Unit (MIU), extending their cover to include minor illness such as urine or chest infections, or conjunctivitis, where patients could drop in without an appointment. The lead nurse liaised with the duty GP at the practice if advice or additional treatment was required.

Information sharing

The practice had an admissions protocol and liaised with others including accident and emergency departments (A&E) and medical and surgical units for admissions to hospital. A standard patient profile with medical history was faxed to the relevant clinician together with a medication reconciliation if required for pharmacy use.

There was a standard alert procedure for the out-of-hours service with forms for patient notes to ensure clinicians were aware of on-going patient needs. This was used to identify possible need for admission if a patient's symptoms deteriorated. Out-of-hours services were also informed about patients with 'Allow natural death orders' or advance directives in place.

Consent to care and treatment

We found that although health care professionals had not all received training in the Mental Capacity Act 2005 (MCA) they were aware of their duties in fulfilling it were able to describe how they implemented it in their practice. For example, the nurse practitioner met with the care co-ordinator and relatives at a care home where some patients were due a smear test. The care co-ordinator had books to help explain the procedure. Best interest decisions were made and tests carried out for some of the patients.

During a clinical meeting during September 2014 partners and the nurse practitioner discussed how consent for injections was established. It was noted that this was not always written. A GP undertook to review this and produce a form that would record patients' consent.

Health Promotion and prevention

It was practice policy to offer a health check with the health care assistant / practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. 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 opportunistic chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers.

Diabetic screening was included in screening of new patients over 50 and in health checks offered to patients aged 40 – 75. Participation in a health education programme was available for those at risk with raised blood glucose.

Good

Are services effective?

(for example, treatment is effective)

On the day of inspection a patient attending for their medicines review for hypertension had been given advice with respect to the risks associated with smoking and alcohol. Monitoring for liver function was carried out because of the life style choices described by the patient. Health care professionals were able to refer patients to a smoking advisor who came to the practice.

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

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 national patient survey of 2014, reviews of surveys of patients undertaken by the practice's patient participation group (PPG) from both 2013 and 2014 and the report of December 2014 following an independent patient satisfaction survey commissioned by the practice.

The national patient survey showed when recording patients' overall experience of their GP practice patients reported they had been treated with care and concern. However, there was lower than average satisfaction with privacy in the reception area, and slightly lower than average satisfaction with the GP involving them in decisions about their care.

An on-going patient experience issue reported by the PPG was to highlight patients' difficulties in seeing the practitioner of their choice. During this visit staff were seen helping patients to access GPs and explaining the appointment system.

The independent survey also found that the lowest score recorded was because of patients' inability to see the GP of their choice. The practice did not score highly for telephone access or waiting times. However, there was high scores by patients for satisfaction with their visit, warmth of greeting, ability to listen, explanations, reassurance, confidence in the ability of health care professionals, respect shown, ability to express concerns and having enough time during their appointment to discuss their health concerns.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Screens 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 room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. Treatment doors were locked during treatments, to ensure privacy. A nurse was always present during minor operations and IUCD (coil) fittings.

Conversations with reception staff could be heard by other people in the area. However, we saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments. Reception staff had a good understanding of confidentiality and were aware that they could not disclose anything to carers without patient consent. Carer's information was recorded on clinical system and there was a popup on screen for reception staff indicating if they were entitled to discuss the patients medical records. Reception staff were aware of the need to maintain confidentiality for teenagers and described how they would manage booking an appointment for a 14 year old and any subsequent enquiry from a parent. Staff did not know if there was a policy or how to find it.

Care planning and involvement in decisions about care and treatment

Data from the national patient survey showed that fewer than average practice respondents said the GP involved them in care decisions, however more patients felt they had been involved by nurses in decisions about their treatment. The practice's independent satisfaction survey did not ask the same question but of the 130 respondents, 95 considered that explanations they had been given were excellent, 129 felt they had been shown good or excellent respect and 125 had good or excellent confidence in the ability of the health care practitioners.

Care plans were in place for frail and vulnerable patients. GPs met with district nurses fortnightly to consider the care of end of life patients. There was no central log for monitoring purposes but decisions were entered into patient records. Joint planning reviews took place annually with the community matron, and where there was a social worker involved, they reviewed the care plan. We saw that GPs made home visits and had recorded clear assessments of the terminal phase and the care needed. An 'Allow Natural Death' order had been signed and there were records of contact with the family.

Patients with learning disabilities had a one hour appointment for their annual health plan which included routine health screening and discussion of dentistry needs. The practice nurse had made home visits and had got to know carers in care homes as well as family members. An assistant practitioner made home visits for annual health checks for house bound patients.

Patient/carer support to cope emotionally with care and treatment

Good

Are services caring?

Patients who completed comment cards said that staff responded compassionately when they needed help and provided support when required. GPs visited patients at home for end of life care. They liaised with Macmillan nurses and always visited on the request of the nurse. They left supplies of emergency medicines or a 'just in case' box for the weekend if necessary.

Information about family and informal carers was recorded on the computer system and a message appeared on screen for reception staff if a person other than the patient was entitled to discuss patient medical records. However, reception staff were not aware of any support for carers offered in house. There was no system for referring to carer support services if a patient revealed that they were caring for a sick, frail or disabled person.

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 arranged systems in order to meet the needs of the patient population. The ratio of patients to GPs was high, and there was a higher than average proportion of registered patients with mental health problems, which contributed to the challenging workload. We saw from individual cases that GPs tried to maintain continuity of care although they no longer had personal lists.

For routine appointments the practice booked 100% of routine appointments in advance, up to four weeks ahead. Some GPs were fully booked, three weeks in advance. In order to deal with the demand for on-the-day urgent calls two duty GPs triaged incoming telephone calls from patients. An emergency care practitioner joined the practice team to increase patient access to a health care professional on the day. This was in response to the PPG reporting patients' priorities. The nurse practitioner dealt with 'on the day' appointments, dealing with minor injuries and illness, mostly in children and elderly patients. Under 11s were not triaged, but all given an appointment.

The practice manager said they continued to monitor the appointment system, looking to provide additional cover on days with 'peak demand' to reduce pressure and improve access. Nurses told us they knew reception kept slots for urgent needs, so they told them when their patients needed an urgent appointment to see a GP. Reception staff regularly contacted managers to ask them to book an appointment if they felt the patient needed to see a GP soon. GPs and nurses had been asked to pre-book follow up appointments for patients to avoid the need for the patient to make another call and go through the triage system.

Extended hours were offered on alternate Wednesday and Thursday evenings and Saturday mornings, with a nurse and a duty GP. The pharmacy was open till 6pm for patients to collect their medicines, if they were entitled to use the dispensary. Otherwise prescriptions were passed to the pharmacy the patient chose. Patients told us that anti-malarial medicines they needed had been made available within two hours.

Tackling inequity and promoting equality

Staff had recent equality and diversity training and were able to talk about what they had learnt. If a homeless person arrived needing medical care, the receptionist registered them as a temporary resident and contacted the duty GP.

There was good access for patients who used wheelchairs with level access from the pavement and spacious toilet facilities. Chairs had been provided in the waiting room with arms, to help patients with reduced mobility. There were two wheelchairs which were kept clean but are not serviced. There was no written protocol regarding the use of wheelchairs but they had been used to help members of the public who had suffered a fall in the car park outside.

No part of the reception desk was lowered. Staff said that when patients arrived in wheelchairs, they stood so they could see and speak with them. A hearing loop was available which staff said worked.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the consultation and most treatment rooms. One nurse clinic room was on the first floor. A health care assistant told us they went to the waiting room to collect their patients to make sure they could manage the stairs.

Access to the service

Some patients remained confused and unhappy about appointment system. The on-going patient experience issue reported by the PPG was about patients' difficulties in seeing the practitioner of their choice, since the GPs no longer held personal lists. Demand for on-the day appointments had reduced the availability for booked appointments. The practice changed the booking system to allow for maximum advance booking up to four weeks in advance.

Practice staff identified that there was a need to explain the telephone triage system in more detail to patients and during the triage it was necessary to take a brief medical history to assist GPs in prioritising the calls. The practice had arranged for additional GP appointments for Mondays, to start in April 2015. Some patients expressed dissatisfaction with the appointments system, although most felt secure due to the availability of an urgent response when needed. During this visit staff were seen helping patients to access GPs, and explaining the appointment system

Good

Are services responsive to people's needs?

(for example, to feedback?)

On the day of this inspection there were freezing conditions and snow on the ground. Frailer patients who could not get to their early appointments because of the ice had been fitted in later in the day when the pavements were clear.

Listening and learning from concerns and complaints

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

Next to the reception desk information was displayed about the Patient Advice and Liaison Service, known as PALS, which was introduced to give support to patients, their relatives, carers and friends to get their concerns resolved as quickly as possible.

We saw that complaints had been dealt with in a timely way. A summary had been compiled at our request, showing that 19 complaints had been received in the previous six months. Six of these were in relation to the patient being unhappy either with their appointment or not being able to see their regular GP. Suitable and timely responses had been made to each, with information provided to the patient where appropriate. When the complaint was in respect to a young child we saw the practice had contacted the family the same day. It was not clear how complaints were managed and learning shared, as there was no record of discussion in clinical meetings and no further action agreed.

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 aims of the practice were set out in the practice statement of purpose. Staff gave their vision for the practice as doing the best for patients, to provide further services and further improve integration with external stakeholders.

Decision-making in the practice took place at monthly meetings, when any GP partner could raise an issue or bring a proposal to the meeting. These meetings took three hours on Monday evenings, or occasionally Sunday mornings. Partners told us they had away days in the past, but now found it impossible to get away during the week due to pressure of work with the number of appointments needed by patients. Some partners felt they were unable to make progress with plans for their building, following changes to plans for the town by the local council. They considered it important to work collaboratively with the other practice in Bodmin. This included considering how they managed the work at the hospital, and planning for the health care professionals who were needed to carry out this work.

Governance arrangements

The practice had policies but they were not used for guidance by staff in their work. The staff handbook included guidance to do with employment such as the disciplinary and grievance procedures. Other policies were available on the practice's intranet, but staff said they were not easy to find and not commonly referred to.

The GPs met monthly for a clinical meeting, where significant events and medical reviews of deceased patients were discussed.

Nursing and administrative teams also met monthly. We saw that records were kept but only headings, not action to be taken and these were not shared with other staff via email or the intranet.

Leadership was provided by having named members of staff in lead roles. GPs held wide areas of responsibility, for example, one GP was the prescribing lead and the commissioning representative, another took the lead on diabetes, clinical governance, infection control, QOF management and information technology as well as being the Caldicott Guardian (this is a senior person responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing).

Leadership, openness and transparency

Since the retirement of the last senior partner, the team did not have a designated senior partner but took decisions as a group. The partners held a monthly evening meeting for business discussions and decision making and consideration of anticipated business risks. The practice manager and deputy manager said they were considering ways of delegating and managing work more closely. While succession planning was being considered, no decisions had yet been made about the process for making a new appointment to the senior partner role.

All team members who spoke with us considered that informal communication was good, with staff feeling empowered to express differences of opinion and GPs and staff being supportive of each other. Apart from the dispensary which staff said at times felt rushed, there was an atmosphere of calm confidence and staff told us they felt positive about their work.

Practice seeks and acts on feedback from its patients, the public and staff

There was a box inviting feedback from patients on the reception desk. The practice had commissioned an independent body to survey the patients, an action plan resulting from this was awaited. The appointments system was a continual subject of comments and complaints. Due to the high ratio of patients to GPs this was likely to persist, however, the practice had made some changes to try to accommodate differing needs.

The Patient Participation Group (PPG) had been established for 20 years. It had raised funds for the practice, buying, for example, a defibrillator, a high backed chair, and blood pressure monitors. They held meetings inviting all patients, with speakers on topics of local interest, not necessarily health related. The practice manager always attended meetings and gave an update. GPs occasionally attended to thank the PPG for their support. PPG members who spoke with us were pleased with the support the practice manager gave them. They felt they were consulted and given the information they needed. For example, they had been consulted about the triage system and asked to gather feedback from patients.

Are services well-led?

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

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Nurses told us they found managers to be supportive and they had recently supported them to attend a study day.

A new nurse had been appointed and was being funded for the nurse practitioner course.

Medical students from the Medical School at the University of Exeter came to this practice. Those who spoke with us said they found it a useful and interesting placement, seeing a busy practice, a community hospital, visiting patients in care homes with significant disabilities, home visits with Macmillan nurses and visits to the crematorium.

A practice nurse told us of an opportunity to volunteer to be a pilot practice for a local diabetes consultant to see patients at the practice. This had been discussed with a GP partner and the practice manager, who agreed it would be a good opportunity for further learning and development. The nurse felt the practice culture was very much to encourage staff to continue learning and introduce new ways of working.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision We found that the registered provider had not protected patients against the risks associated with unsafe care or treatment, by means of the effective operation of systems designed to enable the registered person to, where necessary, make changes to reflect information relating to the analysis of incidents that had the potential to result in harm to patients. This was in breach of Regulation 10(2)(c)(i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Records did not demonstrate that relevant staff had been included in discussion and learning from significant event analysis, neither did records show what subsequent actions were taken, or how or with whom any learning was shared.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines We found that the registered provider had not protected service users against the risks associated with unsafe use and management of medicines by means of making the appropriate arrangements for the safe keeping of medicines. This was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Compliance actions

Two of the fridges used to store medicines had not been serviced, thermometers not calibrated and their maximum and minimum temperature could not be continually monitored.