Pathfields Practice

Inspection report

Plympton Health Centre
Mudgeway
Plympton
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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 location	Good
Are services safe?	**Good**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Requires improvement**
Are services well-led?	**Good**

Overall summary

This practice is rated as Good overall. (Previous inspection February 2015 – Good)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Requires improvement

Are services well-led? – Good

We carried out an announced comprehensive inspection at Pathfields Practice, visiting only the location of Plympton Health Centre on 16 October 2018. The branch surgeries will be visited later in the inspection schedule. The inspection was a routine inspection as part of our inspection schedule.

At this inspection we found:

- Pathfields Practice had significantly increased its number of patients registered with the practice after merging with other practices three times since 2015 to create a GP at scale service.
- The practice was strongly focussed on safety and had clear systems to manage risk across the group so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved processes.
- Audit was embedded, with the practice routinely reviewing the effectiveness and appropriateness of the care it provided. Care and treatment was always delivered according to evidence-based guidelines.
- All the feedback from 42 patients at the inspection was positive about staff treating them with compassion, kindness, dignity and respect.
- People's individual needs and preferences were central to the planning and delivery of flexible tailored services. For example, patients could attend any of the practice sites in Plymouth for an appointment at a time to suit them.
- Patient feedback about the appointment system had been listened to. The practice had significantly increased patient access to appointments employing a varied skill mix of staff and increasing the number of appointments available. Extended hours were available across all sites enabling working patients and school children to access a range of services from the multi-disciplinary team. Further improvements were in the process of being introduced.
- There was a strong focus on continuous learning and improvement at all levels of the organisation. Proactive succession planning based on staff development and training of future GPs, doctors and practice nurses was evident at this training practice.
- Pathfields clinicians shared their learning and approach to delivering a safety culture through membership of the South West Academic Heath Science Network and published articles in national Primary Care journals since 2016.
- There was a proactive approach to preventing development of long term health conditions. For example, 786 patients within the pre-diabetic range received support and advice and were reviewed twice a year. Early diagnosis and treatments were put in place for 17 patients identified through these checks reducing the health risks associated with this condition.
- Pathfields practice employed a paediatric advanced nurse practitioner (ANP) partly as a result of learning from a significant event. They worked from two of the sites which was a conscious decision in line with deprivation, patient compliance and public transport facilities. The ANP worked with children up to 14 years of age accounting for nearly 20% of the total patient population. Their role was to triage all calls and requests for an appointment. Patients and parents benefitted from a bespoke and responsive service meeting their needs.
- The practice implemented the recommendations of Cancer Research with GP endorsement to increase eligible patient uptake of bowel screening by 5%. Through audit activities the practice had increased patient uptake of those eligible for bowel cancer screening above the national performance level of 54.6% to 74% at Plympton Health Centre.

We saw two areas of outstanding practice:

- The practice ran a functional disorders and chronic pain clinic for 250 patients aimed at improving their quality of life by using non-medical interventions to reduce pain. The service was evaluated with patients whose feedback was strongly positive and led to significant reduction in pain and risks associated with long-term use of prescribed opiate medicines for 41 patients.

Overall summary

- There was a proactive approach to early identification and support for carers, including young people in this role. The practice had identified 6% of the patient population as a carer or patient being cared for and was constantly monitoring this.

The areas where the provider **should** make improvements are:

- Take action to increase the uptake of reviews of patients with long-term conditions to avoid exception reporting (excluding patients from health reviews) where possible.
- Continue to implement improvements to increase patient access to appointments across Pathfields Practice group.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Population group ratings

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

Our inspection team

Our inspection team was led by a CQC lead inspector**.**The team included a GP specialist adviser, a CQC inspector and manager.

Background to Pathfields Practice

The partnership of GPs registered as Pathfields practice runs one registered location and seven branch surgeries. The practice is developing a GP at scale service, incorporating patient access to a diverse team of clinicians based across all sites. Plympton Health Centre was inspected on 16 October 2018. This was a comprehensive inspection of the registered location and did not include the branch surgeries, which will be inspected at a later date. The practice is located at:

Pathfields Practice

Plympton Health Centre

Mudgeway

Plympton

PL7 1AD

Branch surgeries are situated around Plymouth at:

Laira Surgery, 95 Pike Road, Plymouth PL3 6HG

Efford Medical Centre, 29-31 Torridge Way, Plymouth PL3 6JG

Crownhill Surgery 103 Crownhill road, Plymouth PL5 3BN

Armada Surgery, 28 Oxford Place, Plymouth PL1 5AJ

Beaumont Villa Surgery, 23 Beaumont Road, St Judes, Plymouth PL4 9BL

Tothill Surgery, 10 Tothill Avenue, St Judes, Plymouth PL4 8PH (closing)

University of Plymouth Medical Centre, 27 Endsleigh Place, Plymouth, PL4 6DN (another practice is due to take this medical centre over on 1 November 2018)

The practice group provides primary medical services to 33,150 patients of a diverse age group with the Pathfields location serving about 11,100 patients. The practice population is in the fifth deprivation decile for deprivation. In a score of one to ten the lower the decile the more deprived an area is. The practice area covers a mixed socio-economic demographic, and has a large care home and over 75 population, all with complex health needs. There is a practice age distribution of male and female patient's equivalent to national average figures. Average life expectancy for the area is similar to national figures with males living to an average age of 80 years and females to 84 years.

The partnership at the practice comprises of nine GPs partners and a managing partner (five male and five female). They are supported by five salaried GPs and a retainer GP (two male and four female). The retainer scheme helps support GPs who might otherwise leave general practice to stay practising, for example during periods of parenting. The team are supported by a deputy practice manager, three advanced nurse

practitioners, a trainee advanced nurse practitioner, eight practice nurses, five healthcare assistants, three phlebotomists, a practice based pharmacist and pharmacy technician. There are administrative and reception staff.

Pathfields Practice is an approved training practice providing vocational placements for GPs registrars. Two GP partners are approved to provide vocational training for GPs, second and third year post qualification doctors. Teaching placements are provided for trainee practice nurses, medical students and student nurses. At the time of the inspection there was a GP registrar on placement at the practice.

Patients using the practice also have access to community nurses, mental health teams and health visitors. Other health care professionals visit the practice regularly.

The practice is open between 8am and 6:30pm Monday to Friday. Branch surgery opening times are listed on the practice website. Patients can choose any of the sites under the Pathfields Group practice for appointments and at a time to suit them. Extended hours opening is available across all sites providing early morning and late evening appointments. Extended hours surgeries are pre-bookable only and appointments made between one week and up to 48 hours before the surgery was held, via reception, during normal surgery hours. Outside of these times patients are directed to contact the out of hour's service by using the NHS 111 number.

Flu clinics are held on Saturdays throughout the Autumn and Winter as advertised on the practice website and in waiting rooms.

The practice is registered to provide the following regulated activities: Diagnostic and screening, Surgical procedures, Family planning services, Maternity and midwifery services and Treatment of disease, disorder or injury

Good

Are services safe?

We rated the practice as good for providing safe services.

Safety systems and processes

The practice had clear systems to keep people safe and safeguarded from abuse.

- The practice had appropriate systems to safeguard children and vulnerable adults from abuse. All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Reports and learning from safeguarding incidents were available to staff. Staff who acted as chaperones were trained for their role and had received a DBS check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.)
- Staff took steps, including working with other agencies, to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- We reviewed four files and the locum GP files and found the practice carried out appropriate staff checks at the time of recruitment and on an ongoing basis.
- There was an effective system to manage infection prevention and control.
- The practice had arrangements to ensure that facilities and equipment were safe and in good working order.
- Arrangements for managing waste and clinical specimens kept people safe.

Risks to patients

There were adequate systems to assess, monitor and manage risks to patient safety.

- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness, busy periods and epidemics.
- There was an effective induction system for temporary staff tailored to their role. This included a structured induction and an induction pack should any locum staff work at the practice.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures. Learning from a significant event had led to increased awareness of sepsis, additional paediatric equipment being purchased and the employment of a paediatric advanced nurse practitioner who triaged all children under 14 years.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections including sepsis. Assessment tools were seen to be displayed in all clinical areas and information in the waiting room was available for patients about early symptoms of sepsis.
- When there were changes to services or staff the practice assessed and monitored the impact on safety. Leaders monitored the safety culture and held a daily 'huddle' meeting with staff to handover information about patient safety, including updates from the out of hours service about vulnerable people.

Information to deliver safe care and treatment

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

- The practice used a risk management system, which enabled patient records to be analysed to produce risk profiles to target audit activity, health screening and ongoing monitoring of patients. The care records we saw showed that information needed to deliver safe care and treatment was available to staff. There was a documented approach to managing test results.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made timely referrals in line with protocols.

Appropriate and safe use of medicines

The practice had reliable systems for appropriate and safe handling of medicines.

- The systems for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment, minimised risks.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with current national guidance. The practice had reviewed its antibiotic prescribing and taken action to support good antimicrobial stewardship in line with local and national guidance.

Good

Are services safe?

- Patients' health was monitored in relation to the use of medicines and followed up on appropriately. Patients were involved in regular reviews of their medicines.

Track record on safety

The practice had a good track record on safety.

- There were comprehensive risk assessments in relation to safety issues.
- The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture of safety that led to safety improvements.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice.
- The practice acted on and learned from external safety events as well as patient and medicine safety alerts. An audit was undertaken on receipt of a medicines safety alert in 2017 about the risks of sodium valproate (a medicine for epilepsy). This demonstrated the practice had identified all childbearing female patients who were prescribed sodium valproate, reviewed and altered the prescription where appropriate and advised them of the associated risks during pregnancy. A recent equipment alert regarding blood testing strips had also been appropriately dealt with.

Please refer to the Evidence Tables for further information.

Good

Are services effective?

We rated the practice as good for all of the population groups and good for providing effective services overall.

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- The practice had near patient blood testing for any patients on anticoagulant medicines (warfarin). This enabled patients to receive the result and guidance about dosing before leaving the practice.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- Older patients who were frail or may be vulnerable received a full assessment of their physical, mental and social needs. The practice used an appropriate tool to identify patients aged 65 and over who were living with moderate or severe frailty. Those identified as being frail had regular clinical reviews including a review of medicines. The practice had a monthly meeting to discuss all patients on the frailty register with the multidisciplinary team.
- The practice followed up on older patients discharged from hospital. They ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.

People with long-term conditions:

- The practice's performance on quality indicators for long term conditions was in line with local and national averages with some being exceeded. Performance was above average for quality indicators covering respiratory conditions – asthma and chronic pulmonary disease.
- Patients at risk of developing a long-term condition, for example those classed as being pre-diabetic, were closely monitored with regular blood checks and access to support to promote healthy living. From this monitoring, 17 patients out of 786 were diagnosed with diabetes and treatment was initiated early to reduce the risks associated with this long-term condition.
- Practice nurses visited up to 500 patients who were housebound or in care homes and offered reviews of long term conditions. This had helped reduce the need for hospital admissions and helped improve health outcomes for this group.
- The practice ran a functional disorders and chronic pain clinic for 250 patients aimed at improving their quality of life by using non-medical interventions to reduce pain. The service was evaluated with patients whose feedback was strongly positive and led to significant reductions in pain and risks associated with long-term use of prescribed opiate medicines for 41 patients.

We also found that:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP and clinical pharmacist worked with other health and care professionals to deliver a coordinated package of care.
- Practice nurses were responsible for reviews of patients with long term conditions had received specific training. The nurses held diploma qualifications covering the management of patients with diabetes and respiratory conditions such as asthma and chronic pulmonary disease.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- Adults with newly diagnosed cardiovascular disease were offered statins for secondary prevention. People with suspected hypertension were offered ambulatory blood pressure monitoring and patients with atrial fibrillation were assessed for stroke risk and treated as appropriate.
- The practice was able to demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive

pulmonary disease (COPD), atrial fibrillation and hypertension. Standardised templates were used to assess patients to identify any risks, which prompted specific follow up actions.

Families, children and young people:

- Childhood immunisation uptake rates were above the target percentage of 90%. All the three indicators were above this target ranging from 93.1-96.5% for under and over 2s immunisations. The paediatric advanced nurse practitioner was based at a branch surgery where there was higher social deprivation and a higher percentage of children to ensure higher levels of care and treatment were provided. Parents were actively encouraged to engage in the childhood immunisation programme which had resulted in the higher levels of immunisation.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation.

Working age people (including those recently retired and students):

- The practice's uptake for cervical screening was 76%, which was just below the 80% coverage target for the national screening programme. The practice uptake was in line with the local (76%) and above the national (72%) averages. Staff verified every contact with eligible women was used to encourage and support them to have cervical screening.
- The practice's uptake for breast and bowel cancer screening was slightly above the national average. GP endorsement of this screening had achieved a 74% patient uptake of bowel screening at Plympton Health Centre, which is above the national performance of 54.6%The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74 at least every five years. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.

People experiencing poor mental health (including people with dementia):

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services. There was a system for following up patients who failed to attend for administration of long term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe. All patient or carer contacts from patients in crisis were treated as urgent and referred immediately to the GP.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- The practice offered annual health checks to patients with a learning disability.
- The practices performance on quality indicators for mental health was in line with local and national averages.
- An emergency care practitioner had been appointed to extend the reviews of patients to avoid unplanned admissions. The practice explained they used care home ward rounds and opportunistic reviews during home visits to achieve higher rates of review of people with dementia (98%) compared with the locality and national figures.

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. Where appropriate, clinicians took part in local and national improvement initiatives.

- Data for 2016/17 demonstrated the practice was achieving comparable results compared with local and

national practices. There were some areas where there was a statistically significant positive variation, for example, monitoring patients with respiratory conditions such as asthma and chronic pulmonary disease.

- We looked at the exception reporting rates, for example for patients on the asthma and mental health registers which were higher than the locality and national averages. When we inspected QOF data for 2017/18 had not been published. However, the practice demonstrated monthly QOF performance was closely monitored. Exception reporting (exclusion of a patient for review) was only done at the end of the financial year when all opportunities encouraging eligible patients to attend for a review of their long-term condition had been explored. Clinicians made the decision as to whether to exception report for two reasons, patient dissent or not appropriate due to clinical reasons. The practice used information about care and treatment to make improvements.
- The practice was actively driving quality improvement activity through partnerships with organisations South West Academic Heath Science Network.

Effective staff

Staff had the skills, knowledge and experience to carry out their roles.

- Staff had appropriate knowledge for their role, for example, to carry out reviews for people with long term conditions, older people and people requiring contraceptive reviews.
- Staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date. The practice management team had oversight of all mandatory and specific training via an online system and were able to demonstrate staff had updated or were due to later in the year.
- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with ongoing support. There was an induction programme for new staff. This included one to one meetings, appraisals, coaching and mentoring, clinical supervision and revalidation.
- There was a clear approach for supporting and managing staff when their performance was poor or variable. The practice had a competency framework, which staff were familiar with setting out values and behaviours expected of them.

Coordinating care and treatment

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

- We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.
- The practice shared clear and accurate information with relevant professionals when discussing care delivery for people with long term conditions and when coordinating healthcare for care home residents. They shared information with, and liaised with, community services, social services and carers for housebound patients and with health visitors and community services for children who have relocated into the local area.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- There was a proactive approach to preventing development of long term health conditions. For example, 786 patients within the pre-diabetic range

received support and advice and were reviewed twice a year. Early diagnosis and treatments were put in place for 17 patients identified through these checks reducing the health risks associated with this condition.
- Staff encouraged and supported patients to be involved in monitoring and managing their own health, for example through social prescribing schemes.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately.

Please refer to the evidence tables for further information.

Good

Are services caring?

We rated the practice as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from patients was positive about the way staff treat people.
- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- The practice's GP patient survey results were in line or above local and national averages for questions relating to kindness, respect and compassion. Some indicators were significantly positive.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment. They were aware of the Accessible Information Standard (a requirement to make sure patients and their carers can access and understand the information that they are given.)

- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.
- The practice proactively identified carers and supported them, with over 6% of patients including young carers known to be in this position.
- The practices GP patient survey results were in line local and national averages for questions relating to involvement in decisions about care and treatment. The percentage of respondents to the GP patient survey who answered positively about whether they had confidence in their GP was 93% which was in line with local and national averages.

Privacy and dignity

The practice respected patients' privacy and dignity.

- When patients wanted to discuss sensitive issues or appeared distressed reception staff offered them a private room to discuss their needs.
- Staff recognised the importance of people's dignity and respect. They challenged behaviour that fell short of this.

Please refer to the evidence tables for further information.

Requires improvement

Are services responsive to people's needs?

We rated the practice, and all of the population groups, as requires improvement for providing responsive services.

Responding to and meeting people's needs

- The practice organised and delivered services to meet patients' needs. The practice had 33,150 patients, of which 20% were children under 14 years. Over 31% of patients were over 65, nearly double the national average. They took account of patient needs and preferences.
- The practice understood the needs of its population and tailored services in response to those needs. Patients reported improved access to appointments at Plympton Health Centre and the seven branch surgeries (the university branch surgery was being handed over to another practice on 1 November 2018, and Tothill Surgery closing). The practice had acted on feedback from patients, which included responses from the GP patient survey:
- Measures implemented by the practice included: The addition of a Paediatric Advanced Nurse Practitioner which made services for the practice's children and young people much more accessible; offering pre-bookable appointments up to 6 weeks in advance with staggered release of these appointments over time to improve accessibility and reduce the number of appointments wasted due to patients not attending; the introduction of a prescribing team into the practice as a direct result of patient feedback and complaints regarding delays in receiving timely medication reviews; and the establishment of a 'Duty Team' as opposed a 'hub' model had resulted in more routine appointments being available for non-urgent matters. Specific clinicians were now part of the duty team, whereas previously all clinicians had time out of their clinics to support the hub. Complaints about access to appointments had significantly reduced as a result by the time of the inspection.
- Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.
- The practice provided online services. Repeat prescriptions could be ordered on line and most were sent electronically to the patient choice of pharmacy.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services. The home visiting service was being redesigned with an increased skill mix of staff.
- The practice provided effective care coordination for patients who are more vulnerable or who have complex needs. They supported them to access services both within and outside the practice.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.
- Advanced nurse Practitioners provided appointments for patients with minor illnesses, minor injuries, family planning and paediatric care.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GP, clinical pharmacist and practice nurse also accommodated home visits for those who had difficulties getting to the practice due to frailty or limited access to transport.
- Arrangements were in place with local pharmacies to provide a delivery service of medicines prescribed for housebound patients.
- A weekly ward round was done at a local nursing home, where the majority of residents were registered with the practice. The nursing home provider was strongly positive about this service and the health outcomes for their residents.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- The practice held regular meetings with the local district nursing team and social care representatives to discuss and manage the needs of patients with complex medical issues.

Families, children and young people:

Requires improvement

Are services responsive to people's needs?

- All children under 14 years of age were triaged by the newly appointed paediatric advanced nurse practitioner. Clinics were run for children and young people at the Laira Surgery where there was greatest need. After school and early morning appointments were available to avoid disturbing school attendance.
- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.
- The practice had a well-established recall system with named staff monitoring the childhood immunisation register. On receipt of the hospital discharge letter the practice sent out a congratulations card and an appointment for the baby and parent/s to see the GP and practice nurses. Staff told us they saw this as an important opportunity to engage with parents to explain childhood health, support available and services at the practice.

Working age people (including those recently retired and students):

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, extended opening hours, early mornings and late evening appoints, Saturday flu vaccination clinics throughout the autumn and winter months. Text reminders. Online access to book appointments in advance and request repeat prescriptions.
- The practice provided a travel vaccination service and was a yellow fever centre.

People whose circumstances make them vulnerable:

- Systems were in place for early identification and support of suspected victims of abuse.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- Patient records included details about specific needs such as accessible information requirements.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.

People experiencing poor mental health (including people with dementia):

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia. Data showed the practice achieved 98% performance with reviews and support of patients with dementia.
- Patients in mental health crisis were dealt with as a medical emergency and flagged as urgent to their named or duty GP.
- Named clinical staff were linked to care homes, carrying out regular visits each week to do medicines and frailty reviews.
- The practice had staff who were skilled mental health and dementia practitioners. All staff were 'Dementia Friends' and able to identify if a patient needed assessment or support. Patients who failed to attend were proactively followed up by a phone call from staff who knew them.
- The practice sign posted patients to the local depression and anxiety service.

Timely access to care and treatment

The majority of patients who provided feedback in CQC comment cards reported improved access to care and treatment from the practice within an acceptable timescale for their needs, since the last GP survey results were published in 2018.

- The practice had listened to patient feedback and was improving access to appointments. However, patients told us it was challenging to access appointments at times, particularly those who were in work and couldn't phone the practice early in the day. A new telephone system was being installed providing more lines into the practice to address these issues.
- Data demonstrated there had been an increase in total appointment availability since May 18. Comparative data showed in March 2018 the practice provided between 246 and 372 face to face appointments per week. By September 2018, this had increased to between 388 and 512 face to face appointments.
- Patients had timely access to initial assessment, test results, diagnosis and treatment.

Requires improvement

Are services responsive to people's needs?

- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- Patients reported that the appointment system was easy to use. Working patients told us they tended to use the online services.
- The practices GP patient survey results were comparable with or above local and national averages for questions relating to access to care and treatment.

Listening and learning from concerns and complaints

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

- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. The practice learned lessons from individual concerns and complaints and from analysis of trends. They acted as a result to improve the quality of care.

Please refer to the evidence tables for further information.

Good

Are services well-led?

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

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them in line with the practice business strategy. For example, in recognition of national and local challenges recruiting GPs the practice had focussed on looking at skill mix and diversified roles to develop new pathways of care. The productive general practice programme was being used to review work streams to improve outcomes for patients. There was a whole team approach to reviewing and implementation of changes.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

Vision and strategy

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

- There was a clear vision and set of values based on quality patient care based on: respecting others, working as a team, embracing change, being an effective business, having effective leadership and patient focussed. The practice had a realistic strategy and supporting business plans to achieve priorities.
- The partnership promoted succession within the sector through its development and training placements. As a training and teaching practice, GP registrars, ST 2 & 3 doctors, medical and nursing students were supported. Their feedback demonstrated they were well supported at the practice and found their experiences there valuable.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social care priorities across the region. The practice planned its services to meet the needs of the practice population.
- The practice monitored progress against delivery of the strategy and had an annual away day to plan ahead each year.

Culture

The practice had a culture of high-quality sustainable care.

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- The practice focused on the needs of patients and promoted evidence based care.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values in the practice competency framework.
- The practice worked collaboratively with other practices in the area as well as designing templates which were adopted across the locality.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out,

understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities in respect of prescribing and management, quality improvement, safeguarding and infection prevention and control. Team leaders were accountable for governance of key areas and the partners had oversight of this reviewing performance regularly at meetings.
- Practice leaders had established policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

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

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient and staff safety.
- The practice had processes to manage current and future performance. Practice leaders had oversight of safety alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.
- The practice had plans in place and had trained staff for major incidents.
- The practice considered and understood the impact on the quality of care of service changes or developments.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The practice used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

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

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture.
- There was an active patient participation group which met regularly and a virtual patient group providing feedback. Early consultations and involvement in future plans to improve facilities were taking place.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement. The practice collaborated extensively with the South West Academic Heath Science Network. The learning and Quality Improvement work on morning huddles in general practice had been shared nationally with RCGP Bright Ideas project, RCGP annual meeting and recently published in a clinical magazine.
- Staff knew about improvement methods and had the skills to use them.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance. For example, advanced nurse practitioners met monthly with an advanced nurse practitioner supervisor at Exeter university to develop their competencies and receive support.

Good

Are services well-led?

Please refer to the evidence tables for further information.