Drs. Howe and Hendriksz

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

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

The key questions are rated as:

Are services safe? – Good

Are services effective? – Outstanding

Are services caring? – Good

Are services responsive? – Outstanding

Are services well-led? - Outstanding

As part of our inspection process, we also look at the quality of care for specific population groups. The population groups are rated as:

Older People – Outstanding

People with long-term conditions – Outstanding

Families, children and young people – Outstanding

Working age people (including those recently retired and students – Outstanding

People whose circumstances may make them vulnerable – Outstanding

People experiencing poor mental health (including people with dementia) - Outstanding

We carried out an announced comprehensive inspection at Lostwithiel Medical Practice on 23 January 2018 as part of our planned inspection programme.

At this inspection we found:

- The practice had proven its safeguarding processes were effective and had been commended by the local authority on its use of these processes.
- Outcomes for patients who used services were consistently better than expected when compared with other similar services.
- We saw examples of where practice GPs had provided compassionate care following unexpected bereavements or when a simple act of kindness made a difference. For example, one GP took the elderly husband of a patient fishing at a weekend having arranged care for the patient's wife. GPs considered patient's emotional and social needs as important as their physical needs.
- All staff were actively engaged in activities to monitor and improve quality and outcomes. Opportunities to participate in benchmarking, peer review and accreditation were proactively pursued. High performance was recognised by credible external bodies.
- A systematic approach was taken in working to improve care outcomes, tackle health inequalities and obtain best value for money. The practice performed

Summary of findings

better for antibiotic prescribing compared to the 11 other practices in the mid Cornwall locality, which meant reduced costs for the NHS and reduced risks of antibiotic resistance to patients.

- Patients found the appointment system easy to use and reported that they were able to access care when they needed it, in a way and at a time that suited them.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.
- The practice had a very low emergency admission to hospital rate compared to other practices in the locality. The practice unplanned admission to hospital rate (mid Cornwall locality) was the best rate in the locality of 12 practices. Lostwithiel Med Practice was 26% better than the locality rate and 25% better than the average rate for Cornwall.
- The practice had very low accident and emergency (A&E) attendances, having achieved the second lowest of 12 practices in the locality. NHSE IRIS reporting data showed that in 2016-17 period 1,245 practice patients had attended A&E, and in the 2017-18 period 1,264 attended, which was the second lowest rise in the locality. The practice was 31% lower than the locality and 33% lower than Cornwall averages. The practice told us they were proactive in attending to patients with minor injuries at the practice, in order to achieve this low rate.

We found several examples of outstanding practice. These included:

- The practice employed two specialist consultant orthopaedic surgeons. The practice had developed this service due to the particular difficulties these patient groups had in travelling long distances from this rural area to hospital-based services. The practice also provided secretarial services which ensured patient records were updated in a timely and accurate manner. Kernow CCG paid the practice for providing the service and the practice paid and employed the consultants directly, thereby saving the NHS money. The practice was in the process of extending this successful service to include a rheumatologist, a psychiatrist and ENT (Ear, nose and throat) specialists. Data provided demonstrated an extremely low DNA (did not attend) rate and a very positive patient experience.
- Three key areas of outstanding practice included dementia research, having a cancer champion nurse and an elder care co-ordinator nurse. Practice dementia research had been endorsed by the National Clinical Director for dementia in England. The practice developed specialist dementia nurse services who had provided care as a fully-integrated service by the practice to both the patient and the carers. They had provided home visits and ensured continuity of care for those diagnosed with dementia or mild cognitive impairment. A cancer champion nurse raised awareness across the clinical team in order for cancer to be taken into account when patients attended for other reasons. An elder care co-ordinator nurse specifically supported local care homes. This increased the amount of time practice GPs spent providing a holistic approach to a significant patient population with complex needs. Positive outcomes for patients included reductions in referral rates, low emergency admission rates and patients with deaths at home rather than in hospital, a low referral to consultant rates, thorough care planning and more accurate diagnosis, and increased awareness of the difficulties vulnerable groups of patients faced on a daily basis.
- The practice had gained SAVVY level two, (a county-wide initiative by the council supporting improved access to GP services for young people) approval. This indicated a focus on the emotional health and well-being of young people. Staff encouraged young people to visit the practice and engage with their GP and reassure them that their appointments were entirely confidential. The practice used their SAVVY level two accreditation to maintain the full confidence of its young patients. This was not only about teenage pregnancy rates(total terminations since April 2017 to date numbered three) but about sexual health (participating in chlamydia screening was part of SAVVY level two requirements), providing free condoms, encouraginghealthy living, staying well andbeing safe.Extended opening times with pre-bookable appointments ensured that the target age range of 13 to 19 years could find the practice accessible at all times). The differing levels for SAVVY recognition was an assessment of approachability, accessibility, a variety of services provided in-house, publicising services for young people and included an inspection visit.

Summary of findings

- GPs and nurses had created and regularly updated patient information leaflets (PILS) and public health leaflets (PHILS) which were available on a shared computer drive throughout the building for access by all staff and clinicians. These covered a variety of topics and were given to patients as an adjunct to consultations and explanations for specific medical conditions. The leaflets were based on National Institute for Health and Care Excellence (NICE) guidance and examples include spirometry, blood tests and vaccinations. There was also a handout available giving links to health information sites. Additional information and links were provided on the practice website.

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

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

Drs. Howe and Hendriksz

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 adviser.

Background to Drs. Howe and Hendriksz

Lostwithiel Medical Practice is situated in the semi-rural town of Lostwithiel in Cornwall. The practice provides primary medical services to people living in Lostwithiel and the surrounding areas. The practice provides services to a local population, the vast majority of whom are Cornish.

The deprivation decile rating for this area is six (with one being the most deprived and 10 being the least deprived). The 2011 census data shows that the majority of the local population identify themselves as being White British.

The practice provides a primary medical service to approximately 4,958 patients of a diverse age group. The practice has a team of two male GP partners, together with one female salaried GP and a female GP registrar. The whole time equivalent is two and one third. In addition there is a practice manager, and additional administrative and reception staff. The GP team were supported by a data quality manager, three dispensary staff, three practice nurses (two of which were prescribing nurses), a health care assistant and additional administration staff.

Patients who use the practice have access to community staff including district nurses, community psychiatric nurses, health visitors, physiotherapists, mental health staff, counsellors, visiting consultant outpatient services, the local acute care at home team, an early intervention team and a community matron. Other health care professionals visited the practice on a regular basis.

The practice is open from 8am to 6.30pm Monday to Friday and takes all telephone calls during this time; it does not close at lunchtimes. Appointments are available throughout the working day. Extended hours are provided on Tuesdays and Thursdays from 6.30pm until 8pm. In addition, and in response to winter pressures, GPs had started offering targeted appointments on a Saturday morning from 9am until 12pm, to support patients with identified clinical needs and to support both the local nursing homes, elderly frail still at home and any patient seen recently for whom there is concern that might necessitate urgent admission.

Outside opening times, and including from 6.30pm to 8.00pm, patients are directed to contact the out-of-hour's service and the NHS 111 number; this is in line with local contract arrangements.

The practice offers a range of appointment types including face to face same day appointments, telephone consultations and advance appointments (four to five weeks in advance) as well as online services such as repeat prescriptions.

The practice has a Personal Medical Services (PMS) contract with NHS England.

This report relates to the regulatory activities being carried out at the following location

Lostwithiel Medical Practice

North Street

Lostwithiel

Cornwall

Detailed findings

PL22 0EF

We visited this location during our inspection.

Good

Are services safe?

Our findings

We rated the practice, and all of the population groups, as good for providing safe services.

Safety systems and processes

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

- The practice conducted safety risk assessments. It had a suite of safety policies which were regularly reviewed and communicated to staff. Staff received safety information for the practice as part of their induction and refresher training. The practice had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance.
- The practice worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- In addition to the practice being recognised as a general "safe haven" for anyone in need, it was agreed at a recent multidisciplinary meeting involving police, social workers and GPs that the practice was also deemed a safe haven wherever safeguarding issues arise regarding domestic abuse.
- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks were undertaken where required. (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).
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check.
- The practice had proven its safeguarding processes were effective and had been commended by the local authority on its priority of keeping patients safe and giving them best care.
- There was an effective system to manage infection prevention and control. This was reviewed at least annually. An infection prevention control audit had been completed in June 2017. Action points arising included avoiding needle stick injuries by emptying clinical waste sharps bins on a more regular basis, stopping the overfilling of bins. All staff had been made aware of the outcome of the audit and the recommendations had been implemented.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. The practice had recently employed the services of a specialist Health & Safety advisor to ensure all areas regarding staff and patient safety were addressed and appropriate. There were systems for safely managing healthcare waste.
- All staff had undertaken mandatory health and safety training on an annual basis – any revised policies were circulated at the time of the revision.
- The practice had demonstrated the effectiveness of its Business Continuity Plan when builders next door had cut through the main electricity supply. Steps were taken to inform patients using local radio stations, telephone calls were diverted to a GP personal mobile number to maintain contact with patients and the services continued to be provided throughout a four-hour period without electricity.

Risks to patients

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

- There were arrangements for planning and monitoring the number and mix of staff needed.
- Competencies were routinely assessed and training/ mentoring provided where required
- There was an effective induction system for temporary staff tailored to their role.
- 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, for example, sepsis.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

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

Good

Are services safe?

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Referral letters included all necessary information.

Safe and appropriate use of medicines

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

- The systems for managing medicines, including vaccines, medical gases, and emergency medicines and equipment minimised risks. Since the last inspection, the practice had installed internal thermometers to record fluctuating temperature levels in both the vaccine and medication fridges. The practice kept prescription stationery securely and monitored its use.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. The practice had audited antimicrobial prescribing. (Antibiotics and antimicrobials both inhibit the growth of or kill microorganisms. Antibiotics are produced naturally from moulds or bacteria. Antimicrobials can be also chemically synthesized, but the term encompasses both). There was evidence of actions taken to support good antimicrobial stewardship. The practice was below average for antibiotics prescribing compared to the 11 other practices in the mid Cornwall locality, which meant reduced costs for the NHS and reduced risks of antibiotic resistance to patients.
- Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately. The practice involved patients in regular reviews of their medicines.
- This location was a dispensing practice. Arrangements for dispensing medicines at the practice kept patients safe. Temperatures of medicines were monitored in accordance with national guidance. The refrigerators had external visible thermometers backed up by internal portable thermometers. Written records confirmed these temperature records were monitored. We found that all medicines were within their expiry dates.
- There was a named GP, responsible for the dispensary and all members of staff involved in dispensing medicines had received appropriate training and had opportunities for continuing learning and development. Any medicines incidents or 'near misses' were recorded for learning and the practice had a system in place to monitor the quality of the dispensing process; this process formed part of the significant events monitoring. Dispensary staff showed us standard operating procedures which covered all aspects of the dispensing process (these are written instructions about how to safely dispense medicines). Patients provided us with positive feedback about the service.

Track record on safety

The practice had a good safety record.

- 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 that led to safety improvements.
- All staff were aware of the need to report potential safety issues at the earliest opportunity.
- The lone working policy had recently been in use for a new member of staff visiting a patient at home over the weekend.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents as well as dispensing significant events. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and the manager encouraged staff to do so and supported them when they did.
- 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.
- All significant events were discussed at six weekly clinical meetings and also reviewed on an annual basis with outcomes and/or changes to systems recorded. For

example, a patient attended an appointment with the physiotherapist with the previous patient's details still visible on the computer screen. This could potentially compromise patient confidentiality. It was reported as an event and a review took place. The physiotherapist (and all other staff) now ensured patient notes were closed before calling the next patient into the room. Shared learning ensured that this incident would not reoccur.

- There was a system for receiving and acting on safety alerts. The practice learned from external safety events as well as patient and medicine safety alerts.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Our findings

We rated the practice as outstanding for providing effective services overall and for young people, older people, long term conditions and patients experiencing mental health issues. We rated other population groups as good.

Effective needs assessment, care and treatment

Outcomes for patients who used services were consistently better than expected when compared to other similar services.

There was a truly holistic approach to assessing, planning and delivering care and treatment to patients who used services. New evidence based techniques, equipment and technologies were used to support the delivery of high quality care. We found examples of how the practice used technology and equipment to improve treatment and to support patients' independence. These included 24-hour blood pressure monitoring with all information being downloaded and appropriate measures taken. A full resuscitation trolley had been obtained and equipped since our previous visit. Staff told us how it had been used recently to save the life of a person working locally near to the practice building.

- The low hospital emergency admission rates supported the commitment of the practice to ensure patient care was effective, appropriate and timely. For example, a Saturday morning clinic where one GP saw seven patients, four of whom had acute problems and was able to supply prompt medication. This service potentially reduced demand upon NHS111 which would have no knowledge of these patients.
- Staff, teams and services were committed to working collaboratively, patients who had complex needs were supported to receive co-ordinated care and there were innovative and efficient ways to deliver care. Outpatient clinics were provided with patients being seen by specialist consultants at the practice in order to reduce the inconvenience of travelling long distances (over an hour) to the nearest hospital from this semi-rural location.
- The practice offered minor operations including dermatology, excisions, and joint injections. This meant patients could be saved the inconvenience of a long journey to attend the nearest hospital and receive close-to-home ongoing monitoring of their condition.

Older people:

- Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. Those identified as being frail had a clinical review including a review of their medicines.
- Patients aged over 75 could request a health check if they had not received one in the last 12 months. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.

People with long-term conditions:

- One practice nurse was a recently trained "cancer champion". Cancer was treated as a long term condition by Macmillan nurses and by the practice. 136 patients were currently on the practice cancer register. In addition to the existing advice from palliative care services, the cancer champion provided enhanced advice on diet, health and lifestyle and sign-posted patients to relevant support services such as financial and benefits advice. The practice raised awareness of the provision of five years free prescriptions to patients diagnosed with cancer in recognition of the financial burden such a diagnosis had on patients. Patientsundergoingcancer treatment were exempt from costs aspart of the NHS exemption policy. As a consequence the practice pro-actively identified **patients under the age of 60 years** to ensure they received all that they were entitled to, including free prescriptions.T**his exemption** was valid for up to five years of treatment following diagnosisfor each patient. A recent audit identified 15 patients under the age of 60 years who were contacted to advise them of this exemption.**The register was updated and maintained regularly through the clinical correspondence administrative system to informdiscussion at regular clinical meetings.**

Outstanding ☆

Are services effective?

(for example, treatment is effective)

- 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 worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long term conditions had received specific training for COPD, asthma and diabetes funded by the practice. As a consequence, one specialist nurse had recently been appointed to a post as a facilitator in diabetes on a locality basis, part of a county-wide initiative. Positive benefits to patients included accurate diagnosis of their conditions, effective treatment and sharing of best practice across the county.

Families, children and young people:

- The practice used their SAVVY level two accreditation to**maintainthe full confidence of its young patients.** This was not only about teenage pregnancy rates(total terminations since April 2017 to date numbered three) but about sexual health (participating in chlamydia screening was part of SAVVY level two requirements), providing free condoms, encouraginghealthy living, staying well andbeing safe.Extended opening times with pre-bookable appointments ensured that the target age range of 13 to 19 years could find the practice accessible at all times).**The differing levels for SAVVY recognition was an assessment ofapproachability, accessibility,a variety of services provided in-house, publicising services for young people and included an inspection visit.**
- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were 98% for infants aged one or below and 95% for infants aged two, both of which exceeded the national target percentage of 90%.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines.

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

- The practice's uptake for cervical screening was 83%, which was in line with the 81% coverage target for the national screening programme.
- The practice had systems to inform eligible patients to have the meningitis vaccine, either by telephone or by letter if there was no response, 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. 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.

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

- Research work on dementia completed by practice GPs had been recognised in the BMJ (British Medical Journal) awards and commended by the RCGP (Royal College of General Practitioners) and had led to changes in the model for services to patients with dementia and this had been adopted by others. Subsequent to this, and following the accolades the service received at the time, the shape and structure of the model was adopted and implemented across Cornwall by the Cornwall NHS Foundation Trust.
- The practice specialist dementia nurse had providedcare as a fully-integrated service by the practice to both the patient and the carers. The dementia care nurse undertook regular home visits, provided support to all involved and ensured continuity of care for thosediagnosed with dementia or mild cognitiveimpairment. Tasks included ensuring care plans and admission avoidance planswere in place for each patient, whether on a routine or urgent basis, and accessiblethroughout the working week. Positive benefits to the patients included a low referral to consultant rate as the patients were supported by the dementia care nurse, thorough care planning and more accurate diagnosis. In addition, patient's wishes as to preferred place of death being at home were recorded, known to relevant staff and family members and respected. The practice calculated that the use of a specialist dementia care nurse had saved the NHS

approximately £50,000 per annum. Based on the success of this work, the KCCG revised dementia care as a practice based service across the county and the practice is now included in this service.

- 86% of patients diagnosed with dementia had their care reviewed in a face-to-face meeting in the previous 12 months. This is comparable to the national average of 84%.
- 96% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This was higher than the Kernow CCG (KCCG) average of 94% and the national average of 90%.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example the percentage of patients experiencing poor mental health who had received discussion and advice about alcohol consumption (practice 100%; KCCG 93%; national 91%); and the percentage of patients experiencing poor mental health who had received discussion and advice about smoking cessation (practice 97%; KCCG 95%; national 95%).

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. The practice had a data quality manager to ensure the computer system had pop-up alerts to show specific conditions patients had in order to monitor their care and treatment accurately. Where appropriate, clinicians took part in local and national improvement initiatives. For example, the practice took part in the national CKD (kidney disease audit), occupational medicines audits, and medicines optimisation audits. An example of how this benefitted patients would be in the use of opioids which was well below the national average and significantly lower than county averages as well as the use of antibiotic being consistently the lowest user in the locality. This meant that the risk of addiction to opioids or antibiotic resistance by patients was reduced.

The most recent published Quality Outcome Framework (QOF) results showed the practice had achieved 98% of the total number of points available. (2016/17 https://qof.digital.nhs.uk). This was higher than the both the KCCG average of 94% and the national average of 95%. The overall exception reporting rate was 8% which was comparable with the national average of 10%. (QOF is a system intended to improve the quality of general practice and reward good practice. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.)

- The practice used information about care and treatment to make improvements. For example, by introducing improvements on cancer care nursing, elderly care co-ordination, dementia care, specialist consultants based at the practice and engagement with young people.
- The practice was actively involved in quality improvement activity. Clinical audit had a positive impact on quality of care and outcomes for patients. For example, clinical audits of patients at risk of strokes showed clear evidence of action to improve quality of patient care. A complete cycle audit had been completed on the use of medicines used for blood thinning (to prevent strokes) and omeprazole (patients shouldn't be on both of these medicines together, due to contraindications). The audit found that 31 patients were on both these medicines and immediately took appropriate action. Patients' medicines were changed to appropriate and safe alternatives in order to reduce risks. A re-audit had found that all patients had successfully had their medicines changed and with no side- effects from having received both medicines.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisations and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up-to-date.

- 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 and staff were encouraged and given fully-funded opportunities to develop
- The practice provided staff with on-going support. This included an induction process, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. The induction process for

healthcare assistants included the requirements of the Care Certificate. The practice ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.
- In the last 12 months, staff development enabled one nurse to become a prescriber and one nurse to become a cancer champion.

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, services and organisations, were involved in assessing, planning and delivering care and treatment.
- 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.
- The practice had a very low emergency admission to hospital rate compared to other practices in the locality. The practice unplanned admission to hospital rate (mid Cornwall locality) was the best rate in the locality of 12 practices. Lostwithiel Medical Practice was 26% lower than the locality rate and 25% better than the average rate for Cornwall.
- The practice had very low accident and emergency attendances, having achieved the second lowest of 12 practices in the locality. The practice was 31% lower than the locality and 33% lower than Cornwall averages. The practice told us they were proactive in attending to patients with minor injuries at the practice, in order to achieve this low rate.
- Outpatients services in-house saved patients the inconvenience (and costs) of travelling long distances to hospital, by providing consultants in certain specialties such as gastroenterology and orthopaedics. The gastroenterology consultant had seen 56 new patients and 79 follow up patients in the financial year 2017-18. The orthopaedic specialist had seen 77 new patients and 31 follow-ups between 2017-18. The DNA rates are much lower than in a hospital setting and patient feedback on the service has been extremely positive. A very low “did not attend” rate of 2% had also been achieved.

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.
- Staff encouraged and supported patients to be involved in monitoring and managing their health.
- 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.
- QOF data for the practice demonstrated a consistent approach to targets set by NHS England.
- Participation in local health strategies included The Eden Project’s “Healthy Walking” and the county wide project to identify patients with the potential to develop diabetes and refer them for lifestyle advice.

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.

Good

Are services caring?

Our findings

We rated the practice, and all of the population groups, as outstanding for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs.
- We saw examples of where practice GPs had provided compassionate care following unexpected bereavements, in volatile situations or when a simple act of kindness made a difference. For example, one GP took the elderly husband of a patient with dementia fishing at a weekend having arranged care for the patient's wife. GPs considered patient's emotional and social needs as important as their physical needs.
- The practice gave patients timely support and information.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- All of the 21 patient Care Quality Commission comment cards we received were positive about the service experienced. This was in line with the results of the NHS Friends and Family Test and other feedback received by the practice.
- We saw documented examples of where staff in this semi-rural practice had gone beyond contractual arrangements to provide a caring service. For example, GPs took photographs of unexplained rashes, moles orskin lesions, so that theimage, following patient consent, could be sent quicklyto the dermatology help-line at Treliske for help witha diagnosis or onward referral.
- The practice had voluntarily provided the funding, during an interim two month period, for repairs to a severely disabled patient's suction machine which helped them to breathe. The practice contacted the provider of the equipment and Kernow CCG (KCCG) to resolve this matter. After this interim period the practice successfully requested the KCCG meet these costs.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. 221 surveys were sent out and 124 were returned. This represented about 2.5% of the practice population. The practice was above average for all of its satisfaction scores on consultations with GPs and nurses and in every area of this survey and there were no suggestions from patients where it was felt improvements could be made.

Examples:

- 95% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 92% and the national average of 89%.
- 99% of patients who responded said the GP gave them enough time; CCG - 90%; national average - 86%.
- 99% of patients who responded said they had confidence and trust in the last GP they saw; CCG - 97%; national average - 95%.
- 95% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG– 90%; national average - 86%.
- 96% of patients who responded said the nurse was good at listening to them; (CCG) - 93%; national average - 91%.
- 95% of patients who responded said the nurse gave them enough time; CCG - 94%; national average - 92%.
- 99% of patients who responded said they had confidence and trust in the last nurse they saw; CCG - 98%; national average - 97%.
- 98% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG - 93%; national average - 91%.
- 97% of patients who responded said they found the receptionists at the practice helpful; CCG - 90%; national average - 87%.

NHS Friends and Family survey results from April 2017 to December 2017 showed that of the 36 respondents, 100% were likely or extremely likely to recommend the practice.

Involvement in decisions about care and treatment

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

- Interpretation services were available for patients who did not have English as a first language. We saw notices

in the reception areas, including in languages other than English, informing patients this service was available. Patients were also told about multi-lingual staff who might be able to support them.
- Staff communicated with patients 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 patients who were carers by highlighting them on the computer system. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 116 patients as carers (2% of the practice list).

- The practice supported its carers by identifying them to their GP and other staff and taking into account their responsibilities in their own care and treatment. Staff were able to signpost carers to relevant support services in the local area.
- Staff told us that if families had experienced bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and by giving them advice on how to find a support service. We saw examples of where GPs had provided compassionate care for patients following unexpected bereavement with consideration given to both emotional and social needs as well as physical concerns.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were above local and national averages:

- 96% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 90% and the national average of 86%.
- 97% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG - 87%; national average - 82%.
- 95% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG - 92%; national average - 90%.
- 94% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG - 89%; national average - 85%.

GP Patient Survey results in the caring domain were all significantly better than CCG and national averages, in some cases by as much as 15%. This reflected the positive impact the service provided had on patient care and treatment.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect. For example, the practice monitored the process for seeking consent appropriately. The practice promoted the use of the "Heads Up" form amongst its local care home, nursing home and supported living home. The "Heads Up" form explained the use of informed written consent to support patient and family decisions. Since its instigation in October 2017, eight patients had registered with the practice using the form providing standardised continuity across all involved in patient care and the understanding of informed consent. The form was designed by a GP in training with specialist knowledge of elder care medicine. The RCGP had provided positive feedback on the practice's work on dementia, specifically around the need to collate evidence of consent, and the practice was working to extend this across all vulnerable patient populations to good effect. The "Heads Up" form was therefore used to draw together routine discharge medical and nursing information and add focus to the critical decisions to be taken by the patient's GP. It was tried, tested and amended over a six-month period and from August 2017, used with the nursing home residents in Lostwithiel and has now been shared with the eldercare co-ordinator across the other two practices (Three Harbours Group). Since its inception, there had been 10 new residents to the home in Lostwithiel and no emergency admissions by the practice.
- The practice complied with the Data Protection Act 1998.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

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

Responding to and meeting people's needs

Waiting for and travelling to outpatient appointments had been improved by holding outpatient clinics in-house.

A GP patient survey undertaken by the practice in 2013 identified areas where patients felt the practice needed improving, and the practice had acted upon these areas. These included more appointments including late evenings, more urgent appointment, increased telephoned advice and better access to the practice. In the four complete years since 2013 the practice (several years before extended hours became an enhanced service) the practice extended opening hours from 6.30pm to 8.00pm for two days each week and included appointments with nurses and GPs. The practice had sought and obtained patient feedback which confirmed patient satisfaction.

In addition, a triage system had been introduced, audited and remodelled after the audit and the practice now had an early-morning and daily triage system whereby any patient needing an urgent appointment on the day speaks to a GP and was given an appointment convenient to them wherever possible.

Any child under the age of five years was automatically booked the same day by receptionists without being triaged.

The practice was also responsive to the needs of the more vulnerable patient population to include patients with learning difficulties, safeguarding issues across all population groups, and in particular a local nursing home where external recognition was protracted until a televised Panorama exposé supported the reports submitted by the practice.

The practice identified military veterans in line with the Armed Forces Covenant 2014. This enabled priority access to secondary care to be provided to those patients with conditions arising from their service to their country. The policy had been reviewed in June 2017. The practice had also devised a supplementary protocol to identify military veterans from the armed forces who may be considered vulnerable, in order to offer them additional support.

In response to patient needs, a practice nurse proactively undertook Doppler tests (an ultrasound that uses high-frequency sound waves to measure the amount of blood flow through arteries and veins, usually those that supply blood to your arms and legs) every six months on patients with venous instability or with a previous ulcer, as recommended by NICE. As a consequence the practice leg ulcer rate was extremely low with only two patients currently being treated for active ulcers. A total of 100 patients had had six-monthly Doppler tests in the last 24 months and 76 in the last nine months; this equated to an ulcer rate of 0.02% in the high-risk group of patients. This was expensive in terms of clinical time but offset by the low rate of active ulcers, the costs that would be involved in treating more patients but, more importantly, the excellent healthcare benefits enjoyed by vulnerable patients.

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs. For example extended opening hours, online services such as repeat prescription requests, advanced booking of appointments, advice services for common ailments.
- The practice had trained all three nurses in minor illness/injuries to support and respond quickly to the needs of a rural population.
- This dispensing practice employed two prescribing nurses who also provided asthma, COPD, diabetes and minor illness care. The practice had provided the time and resources for these staff to complete a non-medical prescribing course enabling timely prescribing in a limited range of medications without being referred to a GP.
- The availability of appointments and changing needs of patients is monitored regularly and in particular during holiday periods of doctors. Audit was used as a tool to inform any changes and the practice was flexible in meeting these needs.
- The practice improved services where possible in response to unmet needs.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.
- The practice had provided the time and resources for one of their nurses to attend a Macmillan accredited course and become a trained "cancer champion". Cancer was treated as a long-term condition by Macmillan nurses and by the practice. A register of cancer patients had been maintained for regular review at multidisciplinary meetings in the practice.
- There is a process of recording a pop-up alert on the computer system for appropriate opportunistic consultations and the cancer champion is raising awareness in order for cancer to be taken into account when patients attended for other reasons. This avoided the risk of medicines being prescribed with contraindications to cancer. They also provided advice on diet, health and lifestyle and received signposting to relevant support services. For example, financial and benefits advice. The practice provided five years free prescriptions to patients diagnosed with cancer in recognition of the financial burden this diagnosis had on patients.

Older people:

- Two nursing homes and one supported living home in the area had a high level of need for practice GPs and clinical staff at the practice. In response to this and in collaboration with two neighbouring practices (known as the "Three Harbours" group), the practice applied for project funding for an elder-care nurse co-ordinator from a local trust with the aim of increasing the amount of time GPs and nurses provided for patients both in nursing homes and living at home. The service triaged and co-ordinated the care provided to ensure the most effective practice response and brought together other agencies for a cohesive and co-ordinated approach to health care. Time had also been provided to educate care staff, for example recent work on UTIs (urinary tract infections), working within the nursing homes; this promoted prompt and accurate diagnoses to deliver safe and effective care. This co-ordinator triaged calls from the nursing and supported living homes to ensure the most effective practice response, educated care staff working at those homes and enabled accurate diagnosis and prompt safe care to be delivered. This increased the amount of time practice GPs could spend providing care and treatment to the rest of the patient population in and around Lostwithiel.
- The post of elder care co-ordinator started in November 2017 and the feedback from staff at nursing homes has been exceptionally positive. There has been a demonstrable reduction in the number of GP visit requests on a daily basis. The practice has also provided the staff with better training and an enhanced understanding of patient needs. A named nurse ensured better continuity of care. The co-ordinator provided teaching sessions to nursing staff on microbial resistance and infection prevention and introduced them to the urinary tract infection toolkit to increase awareness of both diagnosis and to encourage early treatment. The co-ordinator promoted the use of a toolkit for general practice in supporting older people living with frailty. The GPs undertook 248 visits between April 2017 and January 2018, a total of 116 were for nursing home residents (47%). Breaking these figures down into pre and post-co-ordinator, from April 2017 to November 2017, the total visits were171 with91 for nursing home residents (54%). The practice calculated that the creation of this role had released at least 16% of GP time to be made available to other patients over a three-month period.
- 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 and practice nurse also accommodated home visits for those who had difficulties getting to the practice due to limited local public transport availability.
- The practice offered extended access for elderly and vulnerable patients on Saturday mornings to ease winter pressures with prompt access to an experienced GP with knowledge of the patient and home circumstances to avoid unnecessary urgent hospital admissions.
- The design and implementation of the "Heads Up" form provided a co-ordinated approach to healthcare from a variety of sources.

People with long-term conditions:

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

- The practice treated cancer as a long term condition and provided specialist services accordingly. One practice nurse was a recently trained cancer champion. Patients were provided with advice on diet, health and lifestyle and signposting to relevant support services. For example, financial and benefits advice. The practice raised awareness of the provision of five years free prescriptions to patients diagnosed with cancer irrespective of age.
- 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 to discuss and manage the needs of patients with complex medical issues.

Families, children and young people:

- 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 five years were offered a same day appointment upon request.
- Eating disorder and anxiety disorders counselling was available to patients up to age 17 years of age ,this was a service provided by Cornwall Foundation Trust, the practice provided a room for this purpose and liaised with clinicians involved about their patients.
- The practice had identified a gap in the service for young people with eating disorders once attaining adult status. There had been numerous occasions whereby there was no service provided by the local authority at the age of 17 and no provision within the adult service. The practice challenged the request by the Cornwall Foundation Partnership Trust for such patients to be monitored in-house and enlisted the support from both the LMC (Local Medical Committee) and the Kernow CIC (Community Interests Company). This resulted in an improvement by the latter providing two specialist nurses in the autumn of 2017, taking over the care of monitoring and supporting young patients with this potentially fatal disorder throughout the county.

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, offering extended opening hours, lunchtime opening and Saturday morning appointments to ease winter pressures.
- Electronic prescription services were widely available for a range of pharmacies depending on patient preference.
- The practice had initiated an outpatients service which reduced the inconvenience (and costs) of travelling long distances to hospital, by providing consultants in certain specialties such as gastroenterology and orthopaedics. The practice was the provider and was responsible for employing the consultants. The practice also provided secretarial services which ensured patient records were updated in a timely and accurate manner. Kernow CCG paid the practice for providing the service and the practice paid and employed the consultants directly. The current cost to Kernow CCG was 63% of tariff, thereby saving the NHS money. The practice was in the process of extending this successful service to include a rheumatologist, a psychiatrist and an ENT (ear nose and throat) specialist. Data provided demonstrated an extremely low DNA (did not attend) rate and very positive patient experience.
- The gastroenterology consultant had seen 56 new patients and 79 follow up patients in the financial year 2017-18. The orthopaedic specialist had seen 77 new patients and 31 follow-ups between 2017-18. The DNA rates are much lower than in a hospital setting and patient feedback on the service has been extremely positive. A very low "did not attend" rate of 2% had also been achieved.

People whose circumstances make them vulnerable:

- Elderly frail, nursing home residents, those with learning disabilities, patients with chronic diseases, patients with epilepsy and patients with a diagnosis of cancer are all classed as "vulnerable". To this cohort the practice included patients with low income, the recently bereaved, those with safeguarding procedures in place (both past and present) as they could all be classed with a potential to attend hospital frequently and perhaps inappropriately. The practice believed that its availability and accessibility (extended opening hours

and triage system) ensured that it maintained very low emergency unplanned admissions to hospital compared to other practices in the locality. The winter pressure scheme of increasing GPs availability to include weekends demonstrated that out of seven patients seen on the first Saturday, four had chest infections requiring prompt treatment; it was likely that without GP access these patients might have involved NHS111 with the potential for delays in treatment resulting in urgent hospital admission. Each nursing home within the practice area had a nominated GP to ease communication and provide a co-ordinated approach to care. The practice unplanned admission to hospital rate was the best rate in the mid Cornwall locality of 12 practices. Lostwithiel Medical Practice was 26% lower than the locality rate and 25% better than the average rate for Cornwall.

- The practice also had very low accident and emergency attendances, having achieved the second lowest of 12 practices in the locality. The practice was 31% lower than the locality and 33% lower than Cornwall averages. The practice told us they were proactive in attending to patients with minor injuries at the practice, in order to achieve this low rate. In the year April 2016 to March 2017 a total of 160 patients with minor injuries had been seen and treated in the practice. In the current year April 2017 to March 2018 the total at the time of our inspection stood at 131.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers, veterans from the armed forces and those with a learning disability. Recent concerns by the practice nurse who had the most contact with the latter group of patients led to a review of the problems encountered and a multidisciplinary meeting with the new manager of the LD (learning disability) supported living home. The outcome was positive and there was now a new protocol and system to make direct contact should the care provided by the home relapse at any stage.
- There was also a protocol to identify military veterans from the armed forces who may be considered vulnerable.
- We found a documented example of when a practice nurse managed to take blood samples from a patient with learning disabilities having gained their trust over time; in the past this patient had always had to have a general anaesthetic for blood tests. This trust had helped improve consultations for this patient and reduced the impact of needing to recover from a general anaesthetic.
- The practice had been recognised by local authorities as a "safe haven" centre for vulnerable patients of any age.

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

- Research work on dementia completed by practice GPs had been commended by the RCGP (Royal College of General Practitioners). This included collating all of their written consent forms, measuring improvements about patient and family satisfaction, urgent hospital admissions and ensuring their wishes such as preferred place of death were complied with. This dementia research conducted by the practice had been endorsed by Professor Alistair Burns, National Clinical Director for dementia in England. The current elder-care co-ordinatorplayed a part in ensuring training and support was widely available for the frail and elderly, including dementia patients.
- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.

Timely access to the service

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- The appointment system was easy to use.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was significantly above local and national averages. This was supported by observations on the day of inspection and completed comment cards.

- 99% of patients who responded said they could get through easily to the practice by phone; CCG – 76%; national average - 71%. This was 23% above the CCG average and 28**%** above the national average. The

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

practice told us they had achieved this by ensuring sufficient staff was rostered on duty during the peak times. The positive benefit to the patients was they were able to speak with a member of staff within four rings of the telephone.

- 94% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 80% and the national average of 76%. This was 14% above the CCG average and 18**%** above the national average. The practice told us they achieved this by remaining open during lunch hours, providing twice weekly evening appointments and Saturday morning opening. The positive benefit to the patients was being able to have an appointment at a time convenient to them.
- 80% of patients who responded said they don't normally have to wait too long to be seen; CCG - 62%; national average - 58%. This was 18% above the CCG average and 22% above the national average. The practice told us they achieved this by maintaining time discipline, offering double appointments and keeping patients up to date on the reasons for delays. The positive benefit to the patients was reducing the amount of time they had to spend waiting at the practice.
- 72% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment; CCG - 62%; national average - 56%.
- 97% of patients who responded said their last appointment was convenient; CCG - 87%; national average - 81%.
- 93% of patients who responded described their experience of making an appointment as good; CCG - 80%; national average - 73%.

Listening and learning from concerns and complaints

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

- Information about how to make a complaint or raise concerns was available and it was easy to do. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. Five complaints were received in the last year. Between April 2016 to March 2017 the practice received and reviewed three written complaints resulting in two being upheld with one of which resulting in a change to practice protocol, the other being human error. This should be taken in the context of the number of written compliments totalling 32. Between April 2017 to January 2018 there had been five written complaints, the outcome of which were still awaited; there were 33 written compliments thus far. We reviewed these complaints and found that they had been satisfactorily handled in a timely way.
- The practice learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care. For example, a complaint had been made that a repeat prescription request made via the website had been incomplete. An email had arrived at the practice with their order but with two items missing. The practice investigated this and found that one of the medicines was up for review and the other medicine required authorisation on every occasion and could not be issued as a matter of routine. This was explained to the patient and the practice manager suggested the patient emailed the practice directly in future to ensure there was an audit trail and avoid future reoccurrence. The patient was satisfied with the outcome.

Are services well-led?

Outstanding ☆

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

Our findings

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

Leadership capacity and capability

The practice had a track record of innovation and had provided creative solutions to common problems in general practice, which had been recognised on a national level.

The leadership, governance and culture were used to drive and improve the delivery of high quality patient centred care. The practice had a consistent record of recognising areas for improvement (outpatients, dementia care, coordination of care for the elderly, telephone triage), designing and improving models and then delivering, and, once proven, sharing the experiences.

- One of the GPs had attended a General Practice Improvement Leaders training programme course led by NHS Improvement in 2016. This complemented existing leadership and enhanced the new collaboration with two neighbouring practices, now known as The Three Harbours group. Leaders had the experience, capacity and skills to deliver the practice strategy and address risks to it.
- Collaborative working by Lostwithiel practice and the Three Harbours group had introduced additional access at weekends to local healthcare for a cohort of nearly 20,000 patients.
- Systems had been devised to link clinical records across the three practices to ensure continuity of care for winter pressures work.
- A systematic approach was taken to working with other organisations to improve care outcomes, tackle health inequalities and obtain best value for money. For example, the senior GP had worked with and on behalf of Kernow CCG to establish an across county dementia service adopted by the commissioners and rolled out across the county.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them. Challenges included the limited amount of space available to the practice. The practice had submitted successive bids in 2015 and again in 2016 to NHS England to improve and expand the premises. Both bids were successful but a change to the rules in accepting funding required the practice to provide a substantial percentage of total costs involved and could not therefore be implemented. This prompted engagement with the community centre to plan a redevelopment.
- Rigorous and constructive challenge was welcomed as a vital way of holding services to account. For example, a GP had written to the head of the local hospital Trust's cardiology department questioning why a patient referred from the practice had not been assessed by that department.
- 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 in the practice. For example, the practice funded both time and course fees for the specialist nurse in chronic diseases to undertake a prescribing course. As a consequence, and in addition to her role within the practice, the nurse was now one of the diabetes trainers for the county teaching and supporting peers in other practices and raising the standards within the practice, ensuring patients received the highest quality and up to date care.
- The practice had a track record of developing and encouraging its staff. For example, in the training of their prescribing nurses, chronic disease specialists and cancer nurse. With both specialist nurses able to prescribe from a limited list of medications, it was proactive in supporting one of the nurses to attend a MacMillan training course to become a cancer champion in the practice. There was a rolling education programme run centrally for Cornwall and the practice subscribed to this annually for a range of updates and extended role training throughout the year. All three nurses were given a minimum of one week's paid study leave to train/update their skills annually.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.

- There was a clear vision and set of values centred on "Right person, right place, right treatment". The practice

Are services well-led?

Outstanding ☆

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

had a realistic strategy and supporting business plans to achieve priorities. Staff were able to tell us that the practice stated it was a centre of excellence and that this was its mission statement.

- The practice developed its vision, values and strategy jointly with patients, staff and external partners.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- Practice GPs had attended and contributed to sustainability and transformation meetings chaired by the LMC and attended by the Chief Executive of the Royal Cornwall Hospital Trust. The practice developed staff in roles considered to be beneficial to its practice population and development was incorporated into the five-year plan for the practice. This was filtered down to staff through regular business and practice meetings.
- The practice strategy had been supported by the national publication of the five-year forward view. Strategically, the practice changed locality groups in Cornwall to build stronger future collaborative work with two neighbouring practices and had developed a shared vision. This realignment had led to recognition by the NAPC (national association of primary care) and reflected the rurality and challenges of the practice population. The strategy was in line with health and social priorities across the region. The practice planned its services to meet the needs of the practice population as well as the wider locality population under the auspices of "The Three Harbours", a collaboration of some 20,000 patients.
- The practice drives continuous improvement and staff had an innovative approach. For example, the practice had achieved very low emergency unplanned admission to hospital rates and very low accident and emergency attendance rates due to constant monitoring of its most at risk patients by staff. Saturday morning opening included both urgent appointments, visits to nursing homes and palliative care for those patients of concern as well as minor procedures to free time up during the working week. Palliative care at weekends had recently become a priority as the partners felt visits at weekends had involved the family as a whole and with the wider social consequences that palliative care involved; the recent positive family response had encouraged the practice to continue the service where appropriate.
- Lostwithiel practice was one of only two practices in the east of the county willing to adopt the extended hour's reform from NHS England and introduce this in an innovative manner to avoid escalating 111 costs and to provide local responsive clinical services.

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.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- 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.
- Clinical staff, including nurses, were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. 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,

Are services well-led?

Outstanding ☆

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

understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control.
- Practice leaders had established proper 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 safety.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Practice leaders had oversight of MHRA alerts, incidents, and complaints.
- Management focus on reducing referrals had been successful. Lostwithiel Medical Practice referral rate was 33% below the Kernow CCG average, which meant reduced cost to the NHS and reduced inconvenience to the patient as their care and treatment could be dealt with at the practice rather than traveling elsewhere. The practice was below average for prescribing which also meant reduced costs for NHS and reducing risks of antibiotic resistance to patients. A senior GP had protected time every weekday to scrutinise all repeat and acute prescription requests and this frequently triggered invites to patients for reviews of all medications and chronic diseases. An experienced dispensing team questioned any prescribing from locums, regular doctors or the GP partners where they felt there were more appropriate options to provide higher quality patient care according to individual patient need.
- Appropriate antibiotic prescribing was targeted as a priority with one lead GP becoming the nominated ambassador. This resulted in discussions in clinical meetings, the provision of local guidance in every clinical room with copies for each prescribing clinician. This was reflected in the antibiotic audit undertaken by the Kernow CCG prescribing team which showed that the practice was the lowest prescriber within the locality over a two-year period. The benefits to patients included lower risk of becoming immune to anti-biotics, more effective use of medicines and lower costs to the NHS.
- Clinical audit had a positive impact on quality of care and outcomes for patients. For example, clinical audits of patients at risk of strokes showed clear evidence of action to improve quality of patient care. A re-audit had found that all patients had successfully had their medicines changed. The number of patients with a diagnosis of transient ischaemic was however too small to demonstrate the effectiveness of this.
- The practice had plans in place for business continuity and had trained staff for major incidents. For example, with regular fire safety checks and drills.
- The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

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

Are services well-led?

Outstanding ☆

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

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

- The changing shape of this practice population and the national challenges had prompted the practice to join the NAPC (National Association of Primary Care) movement. This was an innovative approach to strengthening and redesigning primary care, bringing together a range of health and social care professionals to provide enhanced personalised and preventative care for their local community. This enabled the practice to seek support from the Kernow CIC (Community Interest Company) and Kernow CCG to recognise such local challenges and start to find solutions together.
- 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. The practice provided a quarterly newsletter which contained useful information for patients about key services provided by the practice, numbers of appointments missed and details of any events like flu clinics. In addition, there were articles on topical subjects such as hay fever in spring, bites and stings in summer. Articles were also written by patients, for example an explanation on establishing a Lasting Power of Attorney (LPA).
- The practice has had access to a patient representative group with over 100 members through the website to obtain feedback for the practice. For example on the introduction of specialist consultants being available at the practice. The quarterly newsletter reports on patient questions/suggestions and answers/actions taken by the practice as a consequence, for example new cushions in the waiting room.
- The practice held clinical staff and multidisciplinary meetings every six to eight weeks, practice meetings for all staff quarterly and business meetings weekly. Dispensing meetings took place bi-monthly. All meetings had written agendas and minutes and staff told us they were able to add items to the agenda should they wish to do so.
- Staff had suggested that background music be played in the waiting room. A member of staff was sourcing a licence-free music CD available to be played to create a more relaxed atmosphere in the waiting area and avoid the need for public performance licences.
- The service was transparent, collaborative and open with stakeholders about performance.
- The high regard the service was held in by patients and the public was reflected in its GP Patient survey results, all of which were significantly higher than CCG and national averages. In some areas the practice scored approximately 20% higher than those averages.
- NHS Friends and Family survey results from April 2017 to December 2017 showed that of the 36 respondents, 100% were likely or extremely likely to recommend the practice.
- Involvement with external partners included CCG, NHSE and CIC examples:

1. Locality meetings with GPs and manager
2. Attendance at "shaping our future" workshops
3. NHS Improvement GP leadership participation in Autumn 2016
4. Pilot for elder-care co-ordinator
5. Three Harbours collaboration
6. New structures for winter pressures

Continuous improvement and innovation

Safe innovation was celebrated and there were numerous examples of the practice focus on continuous learning and improvement at all levels. These examples included;

- The practice has provided cardiology, orthopaedics and gastroenterology in-house outpatient clinics for nine years now and from 2016 below tariff; orthopaedic patients were seen post-operatively for physiotherapy in-house introduced in September 2017. The DNA (Did Not Attend) rate was significantly lower than in a secondary care setting and was innovative in Cornwall when first introduced; such services are now approved within the five-year forward view. At the time of our inspection there were two orthopaedic surgeons providing monthly clinics to patients through the "Choose and Book" system. The specialisms were particularly selected due to the range of difficulties patients with these problems encountered in travelling long distances to hospitals. Waiting lists to be seen by the same specialists were shorter in the practice than in hospitals and were provided at 63% of tariff. Patient feedback was extremely positive about the services.
- Dementia research conducted by the practice had been endorsed by the National Clinical Director for dementia in England and won national endorsement in the BMJ Primary Care Team awards in 2013. Ongoing audits updated practice data annually. The service had informed the KCCG in developing a service on a

Are services well-led?

Outstanding ☆

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

county-wide basis for all Cornish practices commencing in 2016. There was now a specialist dementia nurse who provided care as a fully-integrated service for practices, patients and carers.

- The cancer champion nurse was also raising awareness in order for cancer to be taken into account when patients attended for other reasons. The practice ensured all patients on the cancer diagnosis register were receiving five years free prescriptions regardless of age.
- The practice had instigated the provision of an elder care co-ordinator nurse. This increased the amount of time practice GPs could spend providing care and treatment to the rest of the patient population in and around Lostwithiel. This service had also provided training to nursing home staff, for example UTIs (urinary tract infections), to promote timely and informed interventions in patient care as well as increasing continuity of care with staff in an assisted living residential home for patients with learning disabilities.
- The practice had been level two SAVVY improved. Level two indicated a focus on the emotional health and well-being of young people. Staff encouraged young people to visit the practice and engage with their GP and reassure them that their appointments were entirely confidential.
- The practice has also received local authority recognition as a “safe haven” for anyone in need.
- Winter pressures work required IT development and preparation for future integrated/collaborating working. IT solutions had been implemented through meetings with the clinical software supplier and “The Three Harbours” practice group to facilitate this. In addition, the practice was exploring the use of e-consultations and had volunteered for the forthcoming pilot by the CCG for e-consultations.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.