# Drs Hargadon, Atkinson, Thornton, Thinakararajan & Mr D Sheppard

**Inspection report**

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

## Ratings

| **Overall rating for this location** | Outstanding ☆ |
|---|---|
| Are services safe? | **Good** ● |
| Are services effective? | **Good** ● |
| Are services caring? | **Good** ● |
| Are services responsive? | **Outstanding** ☆ |
| Are services well-led? | **Outstanding** ☆ |

# Overall summary

**This practice is rated as Outstanding overall.** (The previous inspection was in September 2015 where we rated the practice as good overall- outstanding in providing responsive services)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Outstanding

Are services well-led? - Outstanding

We carried out an announced comprehensive at Drs Hargadon, Atkinson, Thornton, Thinakararajan & Mr D Sheppard (known as Rosedean Surgery) on Wednesday 6 June 2018 as part of our inspection programme.

At this inspection we found:

- The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.
- Medicines were managed well at the practice with prescribing rates and patterns kept under review to ensure patient safety, effective treatment and cost effectiveness.
- Improvements within the dispensary had taken place since the last inspection and included an extension and additional security measures.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence- based guidelines.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Patients gave strongly positive feedback about the care and treatment they received. Results from the July 2017 national GP patient survey, friends and family test results, independent survey results, comment cards, feedback on NHS Choices and google were all positive. For example, an external survey used each year to benchmark achievements showed the practice exceeded the national average patient satisfaction score in 27 of the 29 criteria.
- Patients found the appointment system easy to use and reported that they were able to access care when they needed it.
- There was a strong focus on continuous learning and improvement at all levels of the organisation. Staff said the practice was a good place to work and added that the leadership team were supportive and encouraged career development and learning to help improve patient safety.
- There was evidence of systems and processes for learning, continuous improvement and innovation. The practice had taken part in local pilots to test new methodology.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.
- The leadership team and staff group were organised, efficient and had effective governance processes.
- The leadership team focused on the needs of patients and morale of staff and proactively and continuously sought feedback about care, treatment and access to services. This feedback and engagement was seen as a positive way to influence change and investigate how to make processes and patient care more streamlined, efficient and improved for patients.

We saw areas of outstanding practice:

There was a proactive approach to understanding the needs of different groups of patients and an awareness to deliver care in a way that meets these needs, promotes equality and ensure individual needs and preferences were central to the planning and delivery of tailored services. This included older patients, those with long term conditions and patients who are in vulnerable circumstances or who have complex needs. This approach continued to improve the healthcare, reduce emergency admissions and reduce the need for journeys to hospital. For example,

- The practice had responded to the needs of the high numbers of frail elderly and completed a restructure of the care pathway by increasing clinical commitment for patients in both nursing and residential homes in the area had contributed in a reduction of emergency admissions by 14% in the last three years.
- The practice shared the care of 101 patients with a local addiction service (Addaction Liskeard). This was a reduction of 13% in the number of patients compared to the previous 12 month period. However, the practice

# Overall summary

had experienced an increase of 18% in Addaction contacts and referrals, reflecting the general increasing complexity of such patients. The practice had also completed a specific piece of work last year where practice staff worked with Addaction to highlight patients on anti-depressive medicines who were also being prescribed Methadone. The exercise resulted in 20 patients having their anti-depressive medicines titrated down and ultimately stopped - in line with best practice.

The leadership team invested and focused on the needs of patients and morale of staff and proactively and continuously sought feedback about care, treatment and access to services. This feedback and engagement was seen as a positive way to influence change and investigate how to make processes and patient care more streamlined, efficient and improved for patients.

**Professor Steve Field** CBE FRCP FFPH FRCGPChief Inspector of General Practice

## Population group ratings

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

## Our inspection team

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

## Background to Drs Hargadon, Atkinson, Thornton, Thinakararajan & Mr D Sheppard

Rosedean surgery is a GP practice which provides services for approximately 9100 patients. The practice is situated in the rural town of Liskeard, Cornwall. The practice provides dispensing services for patients who live further than one mile away from a pharmacy. This is approximately half of its population.

The practice population area is in the fourth decile for deprivation. In a score of one to ten, the lower the decile the more deprived an area is. The practice distribution and life expectancy of male and female patients is equivalent to national average figures. The practice has a significantly higher than average number of patients aged over 75 and 85 years, (10% of the practice list are over the age of 75 years compared to the national average of 8% and 3.3% of the patient list are over the age of 85 compared with the national average of 2%). Average life expectancy for the area is similar to national figures with males living to an average age of 79 years and females living to an average of 83 years.

There is a team of eight GPs (six female and two male). Of the eight GPs four are partners two are salaried GPs and two are retainer GPs. The whole time equivalent (WTE) of GPs is just above 5 WTE. The team also includes a practice manager who is also a partner.

The leadership team are supported by a deputy practice manager, two IT and finance staff, 11 administration and reception staff, three practice nurses, two nurse practitioners and six dispensary staff.

Patients using the practice have access to community staff including community nurses and health visitors. Patients can also access counsellors, depression and anxiety services, alcohol and drug recovery workers, voluntary services and other health care professionals.

The practice is a well established training practice for medical students, foundation doctors (newly qualified doctors) and GP Registrars (doctors training to become a GP). The practice has received positive feedback from students and the medical school.

The GPs provide medical support to residential and nursing care homes in the area and provide weekly 'ward rounds,' end of life care and annual health reviews for these patients.

The practice is registered to provide regulated activities which include:

Treatment of disease, disorder or injury, surgical procedures, family planning, maternity and midwifery services and diagnostic and screening procedures and operates from the location of:

8 Dean Street

Liskeard

Cornwall

PL14 4AQ

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.
- 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, untoward emergencies and epidemics. For example, the partners and team leaders at the practice had recently had an away day, in April 2018, to look at staffing within the practice for a planned change in working patterns. The meeting had resulted in additional staff being recruited to meet the needs of the practice. The patient participation group had been involved in discussing the pressures of staffing and had welcomed the decision to recruit additional staff.
- There was an effective induction system for temporary staff tailored to their role. The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures. 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. Information screens within patient waiting rooms helped patients to recognise the symptoms of sepsis and provided guidance about what actions they should take. Staff had access to written guidance on the practice computer system, at the reception area, and in each treatment and consultation room. 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.

- 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.
- A clinical administration team were in post and had received guidance and additional training in medical terminology. They were able to assist with some of the straightforward administration such as filing test results, hospital discharges that did not require follow up and calling patients back to the practice for follow up appointments and referrals.

### Appropriate and safe use of medicines

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

- The embedded checking systems for managing and storing medicines, including vaccines, emergency medicines and equipment minimised risks.
- The practice had reviewed its antibiotic prescribing and taken action to support good antimicrobial stewardship in line with local and national guidance.
- Patients' health was monitored in relation to the use of medicines and followed up on appropriately. Patients

on high risk medicines and those who required regular monitoring received medicine reviews to reduce these risks due to medicine complexities. Medicine monitoring at the practice was provided by GPs. The practice had a GP prescribing and dispensing lead and a dispensary manager. These staff were responsible for the medicines management in the practice and ensured safe prescribing and routine reviews of medicines took place.
- The practice had clear monitoring systems in place and submitted a quarterly return for any controlled drugs (medicines that require extra checks and special storage because of their potential misuse) concerns. There had been no concerns due to the oversight of the prescribing and dispensing team.

The practice had a dispensary for patients who lived further than one mile away from a pharmacy. There had been a recent expansion and upgrade to the dispensary to offer more space and clearer collection points for patients. Security measures had been introduced following learning from a recent incident. The dispensary was clean, well ordered and the changes appreciated by staff.

There were processes in place within the dispensary on a day to day basis which were led by dispensary staff to keep patients safe.

- The practice had signed up to the Dispensing Services Quality Scheme (DSQS), which rewards practices for providing high quality services to patients of their dispensary
- Practice records demonstrated all members of staff involved in the dispensing process were appropriately qualified and their competence was checked regularly by the lead GP for the dispensary.
- The practice held stocks of controlled drugs (medicines that require extra checks and special storage because of their potential misuse). We checked processes used and saw these were securely managed. There were also safe arrangements for the destruction of controlled drugs.
- Significant events and complaints regarding dispensed medicines were kept and followed significant event processes.
- Standard Operating Procedures were produced and kept under review.

**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 them to understand risks and gave a clear, accurate and current picture that led to safety improvements.

**Lessons learned and improvements made**

The practice learned from and made improvements when things went wrong.

- Staff understood their duty to raise concerns and report incidents and near misses and told us that 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.

**Please refer to the Evidence Tables for further information.**

Good

# Are services effective?

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

Any Quality Outcomes (QOF) data relates to 2016/17. QOF is a system intended to improve the quality of general practice and reward good practice. For this period the practice had obtained 100% of points available. We spoke with the GPs about the higher than average exception reporting rate for diabetic indicators. For example, the percentage of patients with diabetes, on the register, in whom the last blood sugar reading was 64 mmol/mol or less was 23% compared to the CCG average of 20% and national average of 12%. We saw that the practice had a higher than national average of older patients and noted that the practice also cared for older frail patients in two large care homes in the area. Many of the patients had been excluded from the indicators because of the risk associated with maintaining lower blood sugar levels in frail elderly patients.

**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.
- Staff used appropriate tools to assess the level of pain in patients.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- The practice had a higher than local and national prevalence of older patients. (10% of the practice list were over the age of 75 years compared to the national average of 8% and 3.3% of the patient list were over the age of 85 compared with the national average of 2%). These patients often lived in areas of low deprivation. The practice had a low threshold when deciding to do home visits where older patients could not access transport services. This ensured the most vulnerable patients received the treatment and care they required.
- Older patients who are 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 a clinical review including a review of medicines. Patients aged over 75 were invited for a health check. 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.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Since the last inspection, the practice had increased the clinical commitment to the care of patients in both nursing and residential homes in the area. This included a Nurse Practitioner spending two sessions per week visiting the residential homes. This increase in resources had seen emergency admissions reduce by 14%.

People with long-term conditions:

- 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 nursing team worked with other health and care professionals to deliver a coordinated package of care.
- Practice staff worked with a diabetes specialist nurse for assistance in managing patients with complex diabetes.
- Staff who were responsible for reviews of patients with long term conditions had received specific training and educational updates.
- GPs followed up patients who had received treatment in hospital or through Out of Hours services.
- The practice had arrangements for adults with newly diagnosed cardiovascular disease including the offer of medicines to lower cholesterol 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.

Good

# Are services effective?

- The practice was able to demonstrate how they identified patients with commonly undiagnosed conditions such as diabetes, chronic obstructive pulmonary disease (COPD, atrial fibrillation and hypertension).

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Data collected provided by CQC did not match that within the practice.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance. The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation.
- Receptionists were aware of 'red flag' sepsis symptoms that might be reported by patients and knew how to respond if the symptoms were apparent.

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

- The practice's uptake for cervical screening was 72%, which was below the national 80% coverage target for the national screening programme but in line with the current 72% coverage achievement for the national screening programme. The staff recognised the uptake trends matched the lower national rates and were ensuring opportunistic health education took place. There were systems in place to follow up patients that did not attend screening appointments.
- The practices' uptake for breast and bowel cancer screening were in line with the national average. For example, 79% of females between the ages of 50 and 70 had been screened for breast cancer in the last 36 months compared with the national average of 70%. Additionally, 55% of patients between the ages of 60 and 69 had been screened for bowel cancer in last 30 months compared to the national average of 55%.
- 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, patients with addictions 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, 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 monitoring and 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.
- 77% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This was not statistically different to the national average of 84%.
- 91% 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 comparable to 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, 91% of patients experiencing poor mental health had received discussion and advice about alcohol consumption. This was comparable to the national average of 91%.
- 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.

**Monitoring care and treatment**

Good

# Are services effective?

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. For example, the advice in April 2018's MHRA (Medicines and Healthcare products Regulatory Agency) about the risks associated with a medicine used for epilepsy in pregnancy.

- The practice used information about care and treatment to make improvements.
- The practice was actively involved in quality improvement activity. Where appropriate, clinicians took part in local and national improvement initiatives. For example, the practice worked as part of a local community interest company for Kernow health board. The group were looking at ways to provide an 8am-8pm service in the locality through collaborative working and looking at ways to streamline the IT services used by practices.

**Effective staffing**

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 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 said they had received eLearning mandatory training in the last 12 months. Spreadsheets were maintained to monitor this and reminders were included informally, within appraisals and at practice meetings.
- Staff were encouraged and given opportunities to develop.
- The learning and development needs of staff were discussed at appraisal or on an ad hoc basis as required. Staff said there was a culture of education and career development at the practice.
- The practice provided staff with ongoing support both formally and informally. This included an induction process, one-to-one meetings, appraisals, coaching and mentoring and support for revalidation.
- Staff said that the open door approach of the GPs and practice manager helped with this supportive working atmosphere.
- All staff had received an appraisal in the last year.
- The induction and development process for healthcare assistants (HCA) included the requirements of the Care Certificate. However, these had not been required as there had been no new HCAs employed recently.
- 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.

The practice had GPs who hold GPwSI (GPs with a Special Interest) qualifications in Ear nose and throat (ENT) and musculoskeletal medicine. One GP with an interest in aviation medicine and two with interests in sexual health. Another GP had a diploma in menopause management.

**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 deciding 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.

Good

# Are services effective?

**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 own health such as through social schemes and voluntary services.
- 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 such as stop smoking and tackling obesity campaigns.

**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 treated people.
- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.

We saw many forms of positive feedback at the practice. For example;

- Friends and family test up until May 2018 showed that 98% of respondents would be extremely likely or likely to recommend the practice.
- At the time of inspection there were five comments on NHS Choices. All gave five stars. Additionally there were two five star ratings on google review.
- All 32 CQC comment cards were positive about the treatment and care received and about the staff at the practice. Many comment cards contained detailed comments including feedback of the 'helpful' 'considerate' and 'kind' staff who 'take time to listen' and 'help'. Cards also included comments about the 'excellent', 'efficient' and 'compassionate' care. There were no negative comments received.
- We spoke with five patients who reflected the views above. Patients said they never had a problem getting an appointment and parents said their children were always seen on the same day. Patients said staff were kind, friendly and 'helped wherever they could' to provide a 'super' service. Patients appreciated having the dispensary and said getting repeat medicines was not a problem.
- An external patient survey each year to benchmark their achievements showed that in 2017 the practice exceeded the national average patient satisfaction score in 27 of the 29 criteria.

**Involvement in decisions about care and treatment**

Patients told us staff helped and supported them to be involved in decisions about care and treatment. Staff were aware of the Accessible Information Standard (a requirement to make sure that 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.

Results from the national GP patient survey (July 2017) showed patients responded positively and consistently to questions about their involvement in planning and making decisions about their care and treatment. All of the results for GPs and nurses were above local and national averages:

**Privacy and dignity**

The practice respected patients' privacy and dignity.

- 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.
- Staff recognised the importance of people's dignity and respect. They challenged behaviour that fell short of this.

The practice identified patients who were carers. The practice's computer system alerted GPs if a patient was also a carer. 125 (About 1.5%) carers were registered as 'carers' on the practice clinical system.

Patients were identified as carers at the registration or through staff interactions. Patients who were registered as carers were offered flu vaccines by way of written invitation. They were offered home visits for the cared for person when required. Staff at the practice signposted carers to other services and offered help arranging transport when required.

**Please refer to the Evidence Tables for further information.**

Outstanding ☆

# Are services responsive to people's needs?

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

The practice was rated as outstanding for responsive because:

- Patients appreciated the access to appointments and services in a way and at a time that suited them.
- The GP partners had made a conscious decision to ensure GP/patient ratios were kept at manageable levels to ensure 'quality' patient care could be provided.
- The practice had recognised the needs of the population and the difficulty for some patients accessing healthcare and offered additional support and services to reduce the need for long journeys to secondary care and improve access to locally based services.
- Practice staff had developed a visiting service to care homes in the area which had resulted in reduced emergency admissions.

**Responding to and meeting people's needs**

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.
- Patient appointments were 10 minutes long each morning and 15 minutes long in the afternoon to enable more in depth discussions and treatments to take place. Staff also had authority to extend appointment times where necessary.
- Patients were able to book appointments up to six weeks in advance. Extended opening hours were offered on alternate Thursday evenings and alternate Saturdays.
- The practice were working with other local practices to deliver additional evening and weekend appointments in line with the Improving Access to General Practice plans.
- There was an online appointment booking system. 1273 patients had registered to use this service and as a result they could book appointments with a GP up to one month in advance.
- The practice had just started eConsult, an online service enabling patient access to self-help, allowing them to complete administrative tasks such as requesting a sick/fit note remotely, and making it easier for GPs to assess what medical care the patient needed. The number of consultations were being monitored but it was too early to identify benefits or disadvantages of using the system.
- The facilities and premises were appropriate for the services delivered and had appropriate facilities for patients with reduced mobility.
- 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.
- The practice had supported the patient participation group when they had set up a walking group. Indemnity insurance had been funded by the practice.

The leadership had recently introduced an acute care hub in response to a significant event and after acknowledging the acute needs of patients needing to be seen on the same day. Patients were now triaged into the acute clinic and were seen by either a Hub GP or nurse practitioner. This provided increased efficiency and effectiveness in the management of their needs in one place. Previously patients would have been seen by the GP in one part of the building and then sent to the nurses wing for further tests and investigation. The nurses would then wait for an opportunistic moment to interrupt and review the results with the GP. Patients were now seen in one clinic by a named GP or nurse practitioner who would coordinate and review the investigations for continuity. The patient participation group had been involved in setting up this scheme and helped to direct patients to the correct area. Information was being collected to show any impact this had on other parts of the practice or secondary care.

Older people:

- We saw that the practice had a higher than national average of older patients. For example, 14% of the practice population were over the age of 75 years and 37% over 65 years. This compares to the national averages of 10% and 27%.
- 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.

# Are services responsive to people's needs?

- The practice dispensary provided 90 patients with blister packs each week. Most of these older patients had memory problems or had other medicines management needs and benefitted from this type of dispensing of medicines.
- Since the last inspection the practice had continued to recognise the growing number of elderly patients in the practice population and had increased the clinical commitment to the care of patients in both nursing and residential homes in the area. At the last inspection the practice had dedicated one clinical session per week to these patients. A GP now spent two sessions per week visiting the nursing homes to provide this service. This also included medicine reviews, end of life planning and delivery of palliative care. The GP also had a booked telephone call each Monday morning with the largest of the homes to manage any issues that may have arisen over the weekend.
- The Nurse Practitioner, also spent two sessions per week visiting the residential homes. This increase in resources and substantial increase of patient numbers at the care homes had contributed in a reduction of emergency admissions by 14% over the last three years. We saw four written testimonials from these care homes which praised the practice staff and stated that the service provided by the practice had resulted in a reduction of care home staff having to chase appointments, medicines and home visits.
- Pneumococcal, flu and shingles vaccine were provided at the practice, these were administered at home for carers and patients who have problems getting into the practice.
- There were monthly discharge meetings involving the whole multidisciplinary team (MDT) including: GPs, doctors in training, Nurse practitioner, community matron, district nurse. The practice hosted bimonthly mental health MDTs with part of each meeting being set aside for the practices frail or elderly patients.

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 where possible, 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.
- The staff at the practice provided a doppler service for patients with peripheral vascular disease (leg ulcers). A doppler ultrasound is a non-invasive test for patients requiring wound management that can be used to estimate the blood flow through a patients blood vessels. This prevented these patients travelling to the nearest doppler assessment service. The practice nurses had identified equipment which would make this doppler assessment simpler, more effective and quicker and the GPs immediately purchased this equipment.
- The partners had identified that the community nurses did not have access to near patient testing kits so their patients could have their medicine doses adjusted in a more timely way. This equipment was purchased and was now being used by the community nurses for the direct benefit of the practice's patients as well as patients of other local practices.
- The dispensary provided a variety of methods of ordering medicines to suit all patients. This included on-line, face to face, by repeat slip, by email or by being able to leave a telephone message at any time.
- All Lasting Powers of Attorney for health and welfare, treatment escalation plans and Advance Directives were shared with the local district hospital, the ambulance service and out of hours GP service.
- The practice provided rescue medicines and home management plans for asthma and chronic obstructive pulmonary disease exacerbation management as well as for recurrent cellulitis management when appropriate.

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 18 were offered a same day appointment when necessary.
- GPs were involved in a local scheme called TIC TAC- an informal advice, information and resource centre at the local community college. GPs attended the college to provide non judgemental, private consultations where

# Are services responsive to people's needs?

young people could get advice or information including about, smoking, puberty, mental health, alcohol, family concerns, bereavement, drugs, contraception, healthy eating, acne, stress, bullying and much more.
- Practice staff actively promoted Savvy Kernow's sexual health and contraception health services for young people following the withdrawal of the previous service.
- Engagement with social media enabled patients to keep up to date with developments at the practice even if they did not visit regularly.

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, online services and text messaging services.
- The practice had a patient participation group (PPG) which met on a Thursday evening every two months. It had been running since 2008 and by operating outside of normal working hours more patients, including those who work were able to attend.
- The nurse-led travel clinic was also held on Thursday evenings at the same time as the GP extended hours appointments.

People whose circumstances make them vulnerable:

The practice held a register of patients living in vulnerable circumstances including homeless people, patients with drug and alcohol addictions and those with a learning disability and had responded to meet their needs. For example:

- As part of core services the GPs referred patients to a local addiction service for patients with alcohol and drug addictions and cared for a number of patients who were resident at a nearby home for drug and alcohol addiction. For example, the practice shared the care of 101 patients with a local addiction service (Addaction Liskeard). This was a reduction of 13% in the number of patients compared to the previous 12 month period. However, the practice had experienced an increase of 18% in Addaction contacts and referrals, reflecting the general increasing complexity of such patients. The practice had also completed a specific piece of work last year where practice staff worked with Addaction to highlight patients on anti-depressive medicines who were also being prescribed Methadone. The exercise resulted in 20 patients having their anti-depressive medicines titrated down and ultimately stopped - in line with best practice.
- GPs at the practice provide care to six residents in a local care home for people with drug and alcohol abuse. All six patients were registered at the practice and have complex medical requirements. Staff said they enjoyed caring for these patients but acknowledged the additional time and support required to develop appropriate professional relationships compared to the average new patient. Data showed that these patients required on average five times as many contacts per year compared to the average number of contacts for other patients.
- Vulnerable patients and those with mental illness made particular use of the acute GP appointments that were booked on the day that the patient wished to be seen. We were told of examples where staff went above and beyond to ensure patients had their needs met. For example, one patient recently presented with significant leg ulceration and when they failed to keep a pre-booked appointment a nurse practitioner contacted them the next day to discuss their care and subsequently arranged to see them in her clinic despite being already fully committed time-wise.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.
- Staff were able to provide food bank vouchers to those experiencing hardship. In the last 12 months the practice had provided 50 food bank vouchers to patients. This was a 66% increase compared to the number issued during the previous 12 months. The average number of people who benefited from a food bank voucher was 2.2. Therefore in the last 12 months the 50 vouchers would have benefitted 110 people. Feedback from the food bank manager described the practice provision of vouchers as being 'a really valuable service for the vulnerable residents of Liskeard'. The practice issue these to assist with patients experiencing benefit delays/problems, debt, homelessness and ill health resulting in reduced pay.
- The dispensary had a list of all patients who for reasons of mental health or frailty were unable to remember to order their medicines and ordered it on their behalf.

Outstanding ☆

# Are services responsive to people's needs?

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.
- Patients who failed to attend were proactively followed up by a phone call from a GP.
- Patients with an enduring mental illness were offered an annual review with their preferred GP.
- GPs and dispensary staff provide daily and weekly prescriptions for people at high risk.

**Timely access to care and treatment**

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, treatment and dispensary services.
- 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 and added that they were pleased with the appointment service. Patients told us they could always get a same day appointment if necessary, request a telephone call or home visit. Parents and guardians said children were seen as a priority. Other patients told us they could always get an appointment on the same day or within a couple of days if they chose a specific GP.
- Comprehensive information was available for patients about appointments on the practices website and within the practice. This included how to arrange urgent appointments and home visits and how to seek medical assistance when the practice was closed.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment were comparable or slightly better than local and national averages.

- 86% of patients who responded said they could get through easily to the practice by phone; CCG – 79%; national average - 71%.
- 82% 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 - 82%; national average – 76%.
- 99% of patients who responded said their last appointment was convenient; CCG - 87%; national average - 81%.
- 85% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 84% and the national average of 80%.
- 81% of patients who responded described their experience of making an appointment as good; CCG - 81%; national average - 73%.

We spoke with five patients whose views reflected these survey findings.

**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. 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 also from analysis of trends. It acted as a result to improve the quality of care.

**Please refer to the Evidence Tables for further information.**

Outstanding ☆

# Are services well-led?

**We rated the practice and all of the population groups as outstanding for providing a well-led service.**

The practice was rated as outstanding for well led because:

- The leadership, governance and culture were used to drive and improve the delivery of high-quality person-centred care.
- There were high levels of staff satisfaction. Staff were proud of the organisation as a place to work and spoke highly of the culture and morale. There were consistently high levels of constructive staff and patient engagement.
- Innovative approaches were used to gather feedback from patients and rigorous and constructive challenge from patients, the public and stakeholders was welcomed and seen as a vital way of improvement.

**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.
- 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.
- There was strong collaboration and support across all staff and a common focus on improving quality of care and people's experiences.
- There was a clear proactive approach to seeking out and embedding new ways of providing care and treatment to patients in the rural and often isolated community.
- The GP partners had made a conscious decision to ensure appointment times were kept at suitable lengths to ensure 'quality' patient care could be provided.
- Many partners had previously been at the practice as GP trainees and chosen to return because of the leadership style and positive culture of the practice.
- Staff said they felt well led and part of a team.
- The practice manager and GP partners were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. Staff said the practice manager was visible and approachable and provided encouragement and support. Leaders worked closely with staff and others to make sure the team prioritised compassionate and inclusive leadership.
- Staff met daily to discuss any issues or complex cases and to offer and receive support.

**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. The practice had a realistic strategy and supporting business plans to achieve priorities.
- 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 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.

**Culture**

The culture developed at the practice was used to drive and improve the delivery of high-quality person-centred care.

- There were high levels of staff satisfaction. There were consistently high levels of constructive staff engagement and staff were actively encouraged to raise concerns. Staff said they were happy, staff turnover was low and the organisation was a good place to work. Staff said the leadership inspired them to deliver the best care and motivated them to succeed.
- The practice focused on the needs of patients. Staff feedback and suggestions focussed on how to make the processes more streamlined and efficient and improved care for patients. For example, staff had requested additional staff and new patterns of working which had been acted upon. For example, the acute care hub and management of clinical administration.
- The practice staff focused on the needs of patients.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. Staff said there was support given when things went wrong and were involved in the investigations.

Outstanding ☆

# Are services well-led?

- 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. Staff had received regular annual appraisals in the last year and said they had received informal support when the required and could request learning and development at any time. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff 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. Staff said their colleagues and leaders supported them both professionally and personally.
- 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.
- Communication was effective at the practice and organised through structured, minuted meetings. These included partner meetings, clinical meetings, staff meetings, multidisciplinary team meetings, patient participation group meetings, nurses meetings, administration team meetings, notifications on the computer system and an open door policy used by the GPs and practice manager.
- Patients also received a newsletter with updates on practice news, health promotion and staff changes.

**Governance arrangements**

There were clear lines of accountability, responsibilities, roles and systems to support the embedded governance and management systems.

- Structures, processes and systems to support good governance and management were clearly set out, embedded, 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 safe medicines management, safeguarding and infection prevention and control.
- 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 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 national and local 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 implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care. For example, a recent decision to introduce the acute care hub had been discussed with the wider staff group, patients and PPG.

**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 monitored and staff were held to account.

# Are services well-led?

- 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.

The practice had a well-established patient participation group (PPG) group. The group had been running for over ten years and met every two months. There were 47 members and at least 12 members attended each meeting. The leadership team valued the input from the PPG and the members said the practice manger listened to and acted on criticism and feedback. The practice encouraged the PPG to be autonomous and engaged with the wider health community to make improvements for patients in the locality.

Each PPG meeting involved discussing practice matters and also included speakers invited by the PPG. These had included talks from the chief operating officer from the CCG, talks from a pharmacist, physiotherapist, optician, expert patients and the GPs from the practice.

The PPG said they had had been involved in many aspects of the practice. These included input in:

- The refurbishment of the building
- Provision of information TV screens in the waiting room
- Requesting additional staff
- The repeat prescription process
- Sharing views of how discharges are handled at the nearest acute hospital
- Setting up a local 'leg club' in the community
- The eConsult pilot scheme before it was introduced
- Applying for a pilot to introduce a mental health worker for the locality
- Assisting in signposting patients to the new acute care hub.

There were consistently high levels of constructive staff engagement. For example:

Staff said the leadership team proactively asked for their feedback and suggestions about the way the service was delivered. For example feedback from staff had resulted in,

- A restructure of services and introduction of the acute care hub to make the service more efficient for patients.
- Recruitment of additional staff in the dispensary, clinical and administration teams.
- Additional safety measures in the dispensary following an incident.
- Changes to administration systems to prevent home visit requests being missed.
- Changes to the dispensary and dispensary services to meet increased demand and to assist patients more efficiently.
- Installation of staff lockers so staff could securely store their personal belongings.
- Provision of free weekly yoga sessions for staff to support their wellbeing.
- Alteration, increase and reduction in working hours according to need and request.

**Continuous improvement and innovation**

There was evidence of systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement. Staff said they were supported in their education.
- 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.
- A GP and the practice manager represented the practice as a locality lead and were a director of a community interest company for Kernow health board. The staff represented the practice and were involved in any changes in primary care in the area. This included a combined approach to recruitment, extended hours provision and applying for pilot schemes.

Outstanding ☆

# Are services well-led?

**Please refer to the Evidence Tables for further information.**