The Falmouth Health Centre Practice

Inspection report

The Health Centre
Trevaylor Road
Falmouth
Cornwall
TR11 2LH
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Website: www.faldoc.co.uk

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

Ratings

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

Overall summary

This practice is rated as Good overall. (Previous rating October 2016 – Good)

The key questions at this inspection are rated as:

Are services safe? – Good

Are services effective? – Outstanding

Are services caring? – Good

Are services responsive? – Good

Are services well-led? - Good

We carried out an announced comprehensive inspection at The Falmouth Health Centre Practice on 30 October 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.
- Information sharing and co-ordinated care was effective. The practice held daily meetings which were attended by clinical staff at the practice and other health professionals such as community nurses, health visitors and midwives co-located in the same building.
- Risks to patients were assessed and well managed. For example, legionella checks were in place.
- 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 found the appointment system easy to use and reported that they were able to access care when they needed it.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on. All staff we spoke with felt supported by the practice leadership team.
- The practice embraced technology to continuously improve its service to patients. For example, in the use of social media, a website, online appointments and repeat prescriptions.
- The practice sought continuous improvement and shared this with other practices. This included community prescription templates for community nurses (adopted by all the practices in the county) as part of an ongoing improvement programme. Diabetic referral templates and protocols that were shared with all practices in the county. The practice provided technical support to practices to help them integrate these templates into their systems. The benefits to patients included better co-ordinated care and effective, consistent treatment.
- The practice provided a social media page and a website to keep its patients up to date with the latest health guidance and useful healthy lifestyle events taking place at the practice and in the local area.
- On Bank Holidays the practice provided a second duty GP to provide a faster response to patient needs. The practice had a “never say no” policy to providing appointments.

We saw areas of outstanding practice:

- Following a successful pilot, the practice had been amongst the first in the country (and the first in Cornwall) to successfully introduce e-Consult, an innovative online system for patients to access services. E-Consult took the patient through a pathway that altered depending on their enquiry. E-Consult offered a range of self-help solutions for minor illnesses such as consulting with a pharmacist to reduce the need for a visit to the practice. Positive patient feedback about the scheme had been obtained from Healthwatch Kernow. 35 percent of 3,000 users at the practice were able to resolve their health issues without the inconvenience of attending an appointment. E-Consult continued to grow in popularity as more patients adopted new technology.
- GPs at the practice had created a comprehensive range of computer based prompt templates which brought effective care and consistency across the practice. These templates had been created using the latest guidance and enabled accurate and consistent care and treatment to be provided across a range of different areas. Clinical staff used these templates for safeguarding, sepsis, resuscitation, referrals, and bowel screening. The benefits to patients included safer, prompter and more consistent care. The templates had been shared with local practices across Cornwall and adopted as best practice. Thereby improving the health outcomes for the wider population.

Overall summary

- The practice had innovatively reviewed its new patient questionnaire to include new questions which proactively identified military veterans. This was a new development arising from renewed emphasis upon the Armed Forces Covenant enabling priority access to secondary care to be provided to those patients with conditions arising from their service to their country. In an area with strong links to the Royal Navy, there were facilities at the practice to proactively offer health checks including hearing tests in a specialist audio booth to military veterans.

Professor Steve Field CBE FRCP FFPH FRCGPChief Inspector of General Practice

Please refer to the detailed report and the evidence tables for further information.

Population group ratings

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

Our inspection team

Our inspection team was led by a Care Quality Commission (CQC) lead inspector**.** The team included a GP specialist adviser.

Background to The Falmouth Health Centre Practice

This report relates to the regulatory activities being carried out at The Falmouth Health Centre Practice which is situated in Falmouth, Cornwall. The practice is comprised of a single site. The address of the site is The Health Centre, Trevaylor Road, Falmouth, Cornwall TR11 2LH. We visited this site during our inspection. The practice has a website which is located at www.faldoc.co.uk.

The deprivation decile rating for this area is four (with one being the most deprived and 10 being the least deprived). The area had higher than average social and economic deprivation compared to the national average. The practice provides a primary medical service to approximately 9000 patients of a diverse age group. The 2011 census data showed that majority of the local population identified themselves as being White British.

There is a team of six GP partners, three female and three male; the partners supported a GP registrar. The whole-time equivalent is 4.75. The GP team were supported by a practice manager, patient services manager and deputy, a reception manager, four practice nurses, an advanced nurse practitioner, two health care assistants, two phlebotomists, and additional administration staff.

Patients using the practice also have access to health visitors, counsellors, social services carer support workers, district nurses, chiropodists and midwives who are co-located on the same site as the practice. Other health care professionals visited the practice on a regular basis.

The practice is open from 7am to 6.30pm Monday to Friday. Appointments are offered between those times. Extended hours are worked from 7am until 8am daily. Outside of these times 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 (three months in advance) as well as online services such as requesting repeat prescriptions.

The practice is registered for the treatment of disease, disorder or injury, diagnostic or screening procedures, maternity and midwifery, and family planning services.

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. Learning from safeguarding incidents was available to staff. Staff who acted as chaperones were trained for their role and had received an enhanced Disclosure and Barring Service (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.)
- The practice carried out DBS checks for all members of staff. This included administration staff. This was in line with best practice. Clinical staff had received enhanced DBS checks.
- Staff took steps, including working with other agencies, to protect patients from abuse, neglect, 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 and epidemics.
- 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. The practice had devised a prompts template to rapidly identify the symptoms of sepsis and guide staff to appropriate actions.
- 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.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made timely referrals in line with protocols.

Appropriate and safe use of medicines

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

- The systems for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment, minimised risks.
- Staff prescribed and administered or supplied medicines to patients and gave advice on medicines in line with current national guidance. The practice had reviewed its antibiotic prescribing and taken action to support good antimicrobial stewardship in line with local and national guidance.
- There were effective protocols for verifying the identity of patients during remote or online consultations.
- Patients' health was monitored in relation to the use of medicines and followed up on appropriately. Patients were involved in regular reviews of their medicines.
- Effective use of medicines was paramount at the practice. Examples of monthly checks which ensured that patients had up to date advice included adrenaline auto injector guidelines, keppra in children dosage instructions, lithium, thyroxine, topiramate, valproate checks, opiate patches safety advice, checked that

Good

Are services safe?

patients with gout and allopurinol prescriptions had up to date sample tests. As a result of this work, alerts for these patient groups had dropped by 80% in the last two years.

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 safety using information from a range of sources.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice.
- The practice acted on and learned from external safety events as well as patient and medicine safety alerts.

Please refer to the evidence tables for further information.

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- The practice carried out DBS checks for all members of staff. This included administration staff. This was in line with best practice. Clinical staff had received enhanced DBS checks.
- Staff took steps, including working with other agencies, to protect patients from abuse, neglect, discrimination and breaches of their dignity and respect.
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- 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.
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Outstanding ☆

Are services effective?

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

Effective needs assessment, care and treatment

Outcomes for people 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 people who used services. The safe use of pioneering approaches to care and how it was delivered were actively encouraged. New evidence based techniques were used to support the delivery of high quality care.

In almost every clinical domain the practice outscored the local and national averages. For example, the percentage of diabetics having HBA1cs/BP checks. The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c was 64 mmol/mol or less in 2016/17 – 87.7%. This had been improved to 91% in 2017/18. Both years were higher than local and national averages.

The practice was the amongst the first in the country and the first in the clinical commissioning group, Carrick locality, to adopt an innovative IT pilot for online GP consultations. The pilot was being undertaken during our previous inspection and had since been adopted due to its success in improving patient outcomes. The intended outcome was for E-Consult to guide the patient through an online treatment pathway, offer a range of self-help solutions, allow patients to communicate with a GP online, or consult with a pharmacist to reduce the need to make a GP appointment. The practice had delivered this intended outcome and found that approximately 3,000 patients a year used this system. This was the highest rate in the Carrick locality of 10 practices. Positive patient feedback about the scheme had been obtained from Healthwatch Kernow; 35% of users were able to resolve their health issues without the inconvenience of attending an appointment at the practice.

E-Consult provided patients with a new way to contact their GP which was popular both for younger people using new technology and for the working population who could use it at any time of the day or night. The success of eConsult could be demonstrated in the percentage of respondents to the 2018 GP patient survey who responded positively to the overall experience of making an appointment which was 92%, higher than the local clinical commissioning group (CCG) average of 78% and the national average of 67%. The percentage of patients who were very satisfied with their GP practice appointment times was 85% which was higher than the CCG average of 75% and the national average of 65%.

The practice provided a social media page and a website to keep its patients up to date with the latest health guidance and useful healthy lifestyle events taking place at the practice and in the local area. Patients told us they found the other uses of modern technology very useful including the website, email, online appointments and repeat prescriptions. Staff could check test results online and also provided patients with a text reminder service to attend the practice for their results. Innovative use of SMS messaging by GPs and nurses to interact with patients saved the patient's time and anxiety by responding more quickly. In an example week in November, GPs and nurses had contacted patients 121 times by SMS. In conjunction with the practice eConsult service the practice provided an almost immediate response.

GPs at the practice had created a comprehensive range of computer based prompt templates which brought effective care and consistency across the practice. For example, to confirm next steps to take in cases of suspected sepsis, safeguarding and all long-term conditions. These templates had been shared with other practices in the locality and adopted as best practice. There was a positive impact on thousands of patients as the templates brought swift identification of conditions, effective treatment and consistency and continuity of care across the patient population and the locality.

The practice had continued to provide NHS Health Checks although no longer fully funded by the local clinical commissioning group (CCG). The practice had taken the view that these health checks offered real clinical benefits for patients. The practice deployed their health check resources to support hard to reach patients. In the last four months the practice had invited 136 patients in for NHS health checks. 75 had been completed which was a 55% uptake. This was higher than the local CCG average of 30%. The practice continued to follow up non-responders. 21 of the attendees had complex conditions which made them medium risk and two attendees had high risk complex

conditions. One patient had a very high-risk score and previously had been an infrequent attender. All were now receiving appropriate intervention and all were on a follow up regime of future health checks.

Older people:

- 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 medication.
- The practice was already recording patient frailty scores even though this does not go live until 2019/2020 for the QoF. Safety was considered paramount by GPs and important to consider de-escalation of treatment to reduce risks and adjust targets appropriately.
- The practice followed up on older patients discharged from hospital. They ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.

People with long-term conditions:

- The practice had recently set up an online virtual asthma review targeting young adult patients. There were 126 patients aged over 16 years on the asthma register who had not had an annual review. All of these have had multiple reminders and requests, in various forms, asking them to attend for an asthma review. The younger patients in particular were those at highest risk of death from asthma if it was not properly controlled. Two weeks into the campaign, where text messages had been sent to a proportion of these patients asking them to complete an online review that takes two minutes; the practice had achieved a 30% response rate. This is a significant achievement in the first two weeks of a campaign to support an extremely hard to reach group.
- The practice was part of a county wide scheme to receive blood test results electronically to speed up blood test result processes and improve patient safety. This included full details of which kind of blood test was required so that all health professionals involved in the process could clearly see details of the original request. This helped to reduce errors and improve patient outcomes.
- The practice had developed a collaborative programme with local community nurses to support patients with diabetes. This programme reviewed housebound patients by providing them with training on self-administered foot checks and diabetic reviews and support from the practice diabetic specialist nurse and specialist GP who reviewed them twice yearly to ensure they received the same standard of care as ambulatory patients.
- 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.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- Adults with newly diagnosed cardiovascular disease were offered statins for secondary prevention. People with suspected hypertension were offered ambulatory blood pressure monitoring and patients with atrial fibrillation were assessed for stroke risk and treated as appropriate.
- The practice was able to demonstrate how it identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension
- The practice's performance on quality indicators for long term conditions was above local and national averages. For example, the percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control was 88% which was higher than the national average of 76%.

Families, children and young people:

- The practice had consulted with their patient participation group (PPG) prior to arranging their extended hours times. Families and working patients in particular had requested early morning appointments rather than evening or weekend appointments. This feedback had been acted upon. Patient satisfaction was reflected in the percentage of respondents to the 2018

Are services effective?

GP patient survey who responded positively to the overall experience of their GP practice being 98%, which was higher than the CCG average of 89% and the national average of 84%.

- The appointment structure enabled relationships to be developed and maintained as the practice offered on the day, face to face, pre-bookable, telephone appointments, call backs, E-consult appointments. The appointment length of 12 minutes ensured adequate time for most things and the practice also offer double appointments for more complex patients. GPs completed home visits for their own patients on their lists which supported continuity. This was reflected in data including hospital outpatient referrals, prescribing costs and admissions and referral data.

- The practice was part of the SAVVY Kernow scheme to support young people's access to healthcare. SAVVY was not an acronym but a name coined by young people for services aimed at, and accessible by, young people. At this practice, SAVVY included a c-card scheme providing free condoms and sexual health advice to young people and a green card scheme at the neighbouring school. Pupils could obtain a green card from their school office which excused them from class during school time and enabled them to attend the practice for a GP or nurse appointment, in confidence.
- Childhood immunisation uptake rates were 94% which was higher than the target percentage of 90%. The practice had achieved this through child protection training for all of their staff and the following up of any child who did not attend their immunisation or other appointment. This was a recognised achievement in an area of high deprivation.
- The practice also had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation.

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

- A wide variety of face-face, telephone, eConsult, book-ahead and on-the-day appointments were available with all clinicians. Extended hours had been agreed upon in consultation with the patient participation group (PPG).
- The practice's uptake for cervical screening was 80%. The achievement of 80% was in line with expected targets and above the current 75% national average and the 72% Kernow CCG average. The practice had achieved this success through their deputy patient services manager following up every screening appointment where the patient did not attend.
- The practice's uptake for breast and bowel cancer screening was 63% which was above the national average of 55%. The practice achieved this through following up any missed appointments by contacting the patient directly.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice put maximum effort into supporting patients with learning disabilities (LD). Over 90% of LD patients had received a health assessment in the last 12 months. The community LD nurse has commented that this was a significant achievement with what they considered to be a hard to reach patient group.

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

- The practice had dementia friendly signage which was clear, easy to read and helped patients to navigate their way around the practice.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services. There was a system for following up patients who failed to attend for administration of long term medicines.

Outstanding ☆

Are services effective?

- 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.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- The practice offered annual health checks to patients with a learning disability.
- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months was 100%. This was higher than the national average of 90%.
- The practice GP buddy system enabled continuity of care for the most vulnerable patients; mental health; frail elderly and those actively in need of following up whom might not seek follow up when their usual GP was away. This also enabled the practice to ensure that patients near the end of life were fully supported and that families were not left waiting for documents in the event of a patient passing away. A recent Nuffield paper explained why this was crucial to positive health outcomes; and the practice was already meeting many of their recommendations.

Monitoring care and treatment

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

- The practice monitored the care and treatment of its patient population. This was reflected in its achievement of 100% in the Quality Outcomes Framework (QOF) system between April 2017 to March 2018 and 99.5% the previous year. This was above the national average of 96%.
- 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.

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. Cervical screening was above local and national averages, with a dedicated member of staff to target this.
- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with ongoing support. There was an induction programme for new staff. This included one to one meetings, appraisals, coaching and mentoring, clinical supervision and revalidation.
- Two GPs were accredited trainers at this training practice. There was a clear approach for supporting and managing staff when their performance was poor or variable. One GP registrar had recently returned to become a new GP partner at the practice helping provide continuity of patient care.

Coordinating care and treatment

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

- The practice maximised opportunities for networking with the wide range of other health professionals who were co-located in the same building as the practice. We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.
- The practice shared clear and accurate information with relevant professionals when discussing care delivery for people with long term conditions and when coordinating healthcare for care home residents. They shared information with, and liaised, with community services, social services and carers for housebound patients and with health visitors and community services for children who have relocated into the local area.
- For example, GPs at the practice had produced a community prescription template for community nurses

and this had been adopted by all the practices in the county as part of an ongoing improvement program. The practice had devised a diabetic referral template and protocol that was also widely shared through the CCG to all practices. The practice continued to provide technical support to practices to help them integrate it into their systems. The benefits to patients included better co-ordinated care and effective, consistent 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.

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, for example through social prescribing schemes.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.

Consent to care and treatment

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

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

Please refer to the evidence tables for further information.

Good

Are services caring?

We rated the practice as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

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

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment. They were aware of the Accessible Information Standard (a requirement to make sure 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 currently had proactively identified 248 carers. This was 2.7% of the 9,000 patient population.
- Information about support groups was also available on the practice website. There was an information board for carers. The two visual display screens were situated in the waiting room and displayed information relevant to carers. A carer's support group was based at the practice and met at the practice every Wednesday. The carer's lead was employed by Kernow Carers to help promote support and information to carers. A practice receptionist was the practice carer's champion and liaised closely with the carer's lead. Information sheets showing all of the available support services were provided to carers. The carer's lead carried out face to face and telephone appointments together with home visits on behalf of the practice and shared information with them. The practice's computer system alerted GPs if a patient was also a carer.
- The practices GP patient survey results were above local and national averages for questions relating to involvement in decisions about care and treatment.

Privacy and dignity

The practice respected patients' privacy and dignity.

- When patients wanted to discuss sensitive issues or appeared distressed reception staff offered them a private room to discuss their needs.
- Staff recognised the importance of people's dignity and respect. They challenged behaviour that fell short of this.
- GPs contacted patient's family by phone and a face to face visit if desired by family. Sympathy cards were sent with information enclosed how to contact the Bereavement Advice Centre.
- 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 practice had reviewed its new patient questionnaire since our previous inspection. Improvements included new questions which proactively identified military veterans. This was in line with best practice.

Please refer to the evidence tables for further information.

Good

Are services responsive to people's needs?

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

Responding to and meeting people's needs

Services were tailored to meet the needs of individual patients and were delivered in a way to ensure flexibility, choice and continuity of care.

- On Bank Holidays the practice provided a second duty GP to provide a faster response to patient needs. The practice had a "never say no" policy to providing appointments.
- The practice offered early morning appointments from 7am to 8am Monday to Fridays for patients who could not attend during normal opening hours.
- GP appointments were 12 minutes long. Nurse appointments could be a range of different timings to accommodate patient conditions, for example, 40 minutes for lung function testing, contraceptive coil clinics were 50 minutes.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- The practice offered a range of online services including online consultations; appointment booking and requesting repeat prescriptions, change of address and access to medical records.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately. The practice was a nominated yellow fever centre and had a room which could be used as an isolation room.
- There were disabled facilities, a hearing loop and translation services available which staff knew how to use and access.
- The practice had baby changing facilities.
- Reception had a privacy booth to speak confidentially with patients if required.
- There were clear flowcharts, pictures and pictogram charts to assist patients with different communication needs.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GP and practice nurse also accommodated home visits for those who had difficulties getting to the practice due to limited local public transport availability.
- There was a medicines delivery service for housebound patients.

People with long-term conditions:

- There was a proactive approach to understanding and meeting the needs of patients with long term conditions. For example, the practice had enabled nurses to obtain qualifications and training to become specialists in treating long term conditions such as asthma and diabetes. This enabled them to provide the most up to date and consistent care and treatment. Patients with long term conditions told us they felt they were in expert hands when they attended for their regular appointments.
- 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 weekly meetings with the local district nursing team, which was based in the same building as the practice, to discuss and manage the needs of patients with long term conditions.
- Practice GPs had created a diabetic referral template and protocol that had proved so successful it had been widely shared through the CCG to all practices. Practice GPs continued to provide technical support to practices to help them integrate it into their systems. This enabled consistency of care and the sharing of best practice.

Families, children and young people:

- The involvement of other organisations and the local community was integral to how services were planned and delivered for families and young people. For example, the practice had a "never say no" policy to providing appointments. This was often used to support child patients whose parents requested an on the day urgent appointment.

Good

Are services responsive to people's needs?

- We found there were systems to identify and follow up children living in disadvantaged circumstances (and in deprived areas) 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.
- The practice held regular multi-disciplinary meetings which they invited health professionals based at the same location to, such as child safeguarding meetings. This included health visitors and community nurses. This enabled a joined up approach to support patients in a responsive and proactive manner.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.

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.

People whose circumstances 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 in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.

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

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.

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 and treatment.
- 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.
- The practices GP patient survey results were above local and national averages for questions relating to access to care and treatment.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded 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.

Good

Are services well-led?

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

Leadership capacity and capability

The leadership, governance and culture were used to drive and improve the delivery of high-quality patient-centred care. The strategy and supporting objectives were challenging and innovative, whilst remaining achievable.

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them. For example, the successful adoption of E-Consult to manage increasing patient demand.
- Leaders had an inspiring shared purpose and supervisors 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. For example, a former apprentice at the practice had been developed into the role of a deputy patient services manager.

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. Staff we spoked with were all very positive about the practice vision and their roles at the practice.
- The strategy was in line with health and social care priorities across the region. The practice planned its services to meet the needs of the practice population.
- The practice monitored progress against delivery of the strategy.

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. High levels of staff satisfaction were reflected in the extremely high staff retention rate. The majority of staff had worked at the practice for a number of years.
- 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.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams, including teams of other health professionals co-located at the practice, who attended regular meetings.

Governance arrangements

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

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted co-ordinated person-centred care. For example, when referring patients to other services which were co-located in the same building. These services included community nurses, health visitors, podiatrists, dentists, midwives, speech therapists, social services and sexual health services. Practice GPs held a daily meeting which was open to all of these health professionals. This facilitated strong communication between the practice and other health care professionals.

Good

Are services well-led?

- Staff were clear on their roles and accountabilities including in respect of 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.

- The practice had created computer based templates to cover a wide range of issues including safeguarding, sepsis and long-term conditions. These helped to inform 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. Practice leaders had oversight of safety alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.
- The practice had plans in place and had trained staff for major incidents.
- The practice considered and understood the impact on the quality of care of service changes or developments.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients. The practice consistently achieved 99% to 100% in its quality outcomes framework (QOF). This supported appropriate and accurate information to inform patient care.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The practice used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

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

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. There was an active patient participation group.
- The service was transparent, collaborative and open with stakeholders about performance. A wide range of other health professionals co-located in the same building had an open invitation to attend practice meetings.
- The practice had consulted with their patient participation group (PPG) prior to arranging their extended hours times. Families and working patients in particular had requested early morning appointments rather than evening or weekend appointments. The wishes of patients had been acted upon. Patient satisfaction was reflected in the percentage of respondents to the 2018 GP patient survey who responded positively to the overall experience of their GP practice being 98% which was higher than the CCG average of 89% and the national average of 84%.

Continuous improvement and innovation

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

For example, the practice was the amongst the first in the country and the first in the clinical commissioning group, Carrick locality, to adopt an innovative IT pilot for online GP consultations which directly improved patient outcomes. The practice had a track record of sharing its innovations and best practice with other practices in Kernow CCG.

Other examples of continuous improvement included the practice involvement in a scheme to receive blood test results electronically to speed up blood test result processes and improve patient safety and diagnosis. This

Good

Are services well-led?

included full details of which kind of blood test was required so that all health professionals involved in the process could clearly see details of the original request. This helped to reduce the margin of error.

The practice was a teaching and a training practice with one GP registrar and eight medical students having a placement during the previous 12 months. Two GPs at the practice were qualified GP trainers. We spoke with and saw written evidence of positive feedback from these staff. A former GP registrar had recently filled a vacancy at the practice by becoming a new GP partner.

Administration staff were given the opportunity to undertake NVQ training, for example in management skills. The practice provided them with the time and resources to complete these.

Please refer to the evidence tables for further information.