Pathfields Practice

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

Pathfields Practice is a GP practice providing primary care services for people in and around Plymouth. It provides services from three premises located at Laira Surgery, 95 Pike Road, Plymouth PL3 6HG; Efford Medical Centre, 29-31 Torridge Way, Plymouth PL3 6JG; Plympton Health Centre, Mudge Way, Plympton PL7 1AD. We carried out an announced inspection across the three sites on 11 and 12 December 2014.

When the practice is closed patients are advised to contact the Out of Hours service, which is operated by a different provider.

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

We rated this practice as good.

Our key findings were as follows:

- The practice had a patient-centred focus without judgment or bias.
- Patients felt they were treated with dignity and respect and in a professional manner that showed kindness and care towards them.
- Patients were able to see a GP or have a telephone consultation on the day of requesting an appointment.
- The practice had a clear strategic vision for its future and providing integrated care for its patients based on local needs and within the community.

We saw areas of outstanding practice including:

- One GP partner visited patients in care homes one day a week. This was part of a developing care home project, aiming to be able to provide a GP or nurse practitioner and a prescribing pharmacist, whose work would entirely focus on patients residing in care homes.

However, there were also areas of practice where the provider needs to make improvements. The provider should:

Summary of findings

- Put in place a clear system to check that GPs and nurses have current registrations with their respective professional bodies.
- Set up a comprehensive training plan for non-clinical staff.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed.

Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing patients' mental capacity and promoting good health.

Staff had received training appropriate to their roles and any further training needs had been identified and planned. Staff worked with multidisciplinary teams and aimed to provide holistic and preventative medicine through the promotion of healthy lifestyles.

Are services caring?

Good

The practice is rated as good for providing caring services. Feedback from patients about their care and treatment was consistent and positive. We observed a patient-centred culture. Staff were motivated and inspired to offer kind and compassionate care and put significant effort in to providing care that took account of each patient's physical support needs and individual preferences.

Patients were involved in planning their care and making decisions about their treatment and were given sufficient time to speak with the GP or nurse. Patients were referred appropriately to other support and treatment services. We found many positive examples to demonstrate how patients' choices and preferences were valued and acted on. Patient confidentiality was respected and maintained.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. They reviewed the needs of their local population and engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure

Summary of findings

improvements to services where these were identified. This was also part of the practice strategic vision. Patients said they could make a same day appointment including a telephone consultation. Patients felt there was continuity of care.

The practice was equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand. Evidence showed that the practice responded quickly to issues raised and learned from patients' experiences, concerns and complaints to improve the quality of care.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. The GP partners had a clear leadership structure and staff felt supported by their line managers as well as the GPs. Staff felt able to raise concerns or make suggestions about ideas for improvement for patients and staff.

The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice sought feedback from staff and patients and had formed a virtual patient participation group (PPG) to represent patient views.

Summary of findings

The six population groups and what we found

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

Older people

Good

Pathfields Practice had approximately 9% of its patient population that was over 75 years of age and 2.4% of this group was considered as frail. Staff demonstrated competence in dealing with the health issues associated with old age. GPs had achieved the requirement for practices from April 2014, as part of the GP contract changes for 2014-2015, to ensure that each patient on their practice list aged 75 or over was assigned a named, accountable GP. Annual health checks included a memory question.

The practice was responsive to the needs of older people, offered home visits and participated in hospital admission avoidance schemes aimed at enabling patients to remain at home. Care plans and treatment escalation plans (TEP) were in place for older patients who were care home residents. The practice worked with a domiciliary pharmacist to organise blister packs for older patients who were unable to manage medicines delivered in individual packets.

People with long term conditions

Good

Pathfields Practice worked to a Shared Care protocol to ensure GPs working with relevant health and care professionals delivered a multidisciplinary package of care to patients with long term conditions.

GPs and nurses provided routine appointments for the monitoring and treatment of patients with long term conditions with structured annual reviews to check their health needs were being met. Patients with long term conditions also had six monthly medicines reviews. Longer appointments and home visits were available for those patients who needed this.

Families, children and young people

Good

Pathfields Practice had systems in place to identify and follow up children who were considered to be at risk. All GPs were trained to the relevant level three in safeguarding children and all other staff to level one or two. The practice followed a protocol for documenting A&E attendances and non-attendance for appointments or immunisations. Appointments were available outside school hours for children and young people. There was a responsive working relationship with community midwives and health visitors.

The practice provided family planning and maternity services such as pre and post natal checks for mothers. The practice worked with

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the community midwifery team to ensure expectant mothers had a named midwife and received dual care with their GP. Three GPs and the nurse practitioner had a specialist interest in women's health and contraception.

Men, women and young people had access to a range of contraception services. One of the GP's was undertaking vasectomy training. This would enable the practice to provide a practice based vasectomy service.

Health care information was available in the waiting room on each site for young people and this was actively promoted by GPs and practice nurses during consultations. Young people were able to access sexual health screening, advice and support from the GPs and nurses. The practice website had a section for young people to promote appropriate services and to signpost to other agencies and clinics.

Working age people (including those recently retired and students)

Good

Pathfields Practice offered extended opening hours for pre-booked appointments one evening a week at Laira Surgery from 6.30pm to 8.30pm. Pre-bookable appointments including on the day telephone consultation were available at Laira Surgery and Plympton Health Centre from 8am every morning Monday to Friday. Efford Medical Centre was open from 8am Monday, Wednesday, Thursday and Friday.

Recent flu clinics were offered during half term and on two Saturdays. A repeat prescription service was available online and this was sent directly to a designated pharmacy. Patients were able to self- refer to see a physiotherapist based at Plympton Health Centre, and ultra sounds were offered in-house. The practice offered support for patients returning to work after a period of sickness. Health checks were offered to all patients between 40 to 75 years of age.

People whose circumstances may make them vulnerable

Good

Pathfields Practice offered annual health checks to patients with a learning disability. These were carried out either in care homes or as extended appointments at the practice. The GPs and nurses were able to request support from the learning disability team if needed and they worked collaboratively to meet patients' needs. There were no specific aids such as pictures to assist with communication and visual signage around the three sites was limited. Plympton Health Centre was particularly confusing for anyone with a learning disability or who may be confused, due to the various signage directing patients to several different areas.

Summary of findings

Care plans and treatment escalation plans (for patients nearing the end of their lives) were in place for vulnerable patients who were care home residents.

At the time of this inspection the practice did not have experience of patients who were homeless or rough sleeping. However anyone who found themselves in such a situation, and who was not already registered as a patient at the practice, would be supported to register if this was appropriate.

The practice had a small number of patients who did not communicate in English. These patients attended appointments with a family member who provided translation for them. The practice also had access to language support services.

There was a flag system on patient records to show those patients, including children, who were considered by the practice to be at risk of harm. The practice also held a list of all children who were patients and on the child protection register with a record of family relationships on the patient record. Information and support was available at the three sites for patients (female and male) who were at risk of domestic abuse.

People experiencing poor mental health (including people with dementia)

Good

Pathfields Practice had a Shared Care protocol for the management of patients with dementia, this constituted 2.25% of the patient population. This protocol included shared care management of medicines for these patients. The practice had working relationships with local charities and a befriending service where it was able to signpost patients with dementia care needs.

Patients experiencing poor mental health were involved in decisions about their treatment. If they lacked capacity to understand their choices, then other health care professionals were involved in best interest decisions on behalf of the patient. The practice had working relationships with the community mental health teams.

All the patients who had consented to being included on the mental health register were offered an annual health check and review. A large percentage of these patients were on weekly prescriptions to enable better management of their medicines. Longer appointments were available if these were needed and some patients had appointment alerts on their patient record to ensure they were always booked a longer appointment.

If school counsellors raised concerns about any pupils with mental health issues, the practice offered a responsive service.

Summary of findings

What people who use the service say

We spoke with 13 patients and received 84 comments cards completed by patients. These were patients of all ages including young people, parents of children registered at the practice, working age and recently retired people, older people and people with long term conditions. We also met with the chair person and one representative of the Patient Participation Group (PPG). This is a group that acts as a voice for patients at the practice.

Patients all spoke positively and highly of the GPs. A number of patients commented about two GPs in particular whom they considered made them feel listened to and valued as a person as well as a patient. Patients told us they were always treated respectfully by all the GPs and appointments were not rushed.

We received high praise for the nursing team. Patients and carers said they were caring and they felt able to talk to them.

Overall patients told us the receptionists were polite and courteous both on the telephone and at the reception desk. Some patients said sometimes they experienced a poor attitude and rude manner from some receptionists. A few patients objected to being asked for information about their symptoms by the receptionists that they felt was inappropriate.

Younger people said they felt the practice treated them in an age appropriate manner and they were made to feel welcome.

People told us that sometimes it was difficult to get through to the practice in the mornings by telephone, because the lines were busy. Some older people, carers and people with long term conditions said they struggled with the early morning system of calling the practice for a same day appointment.

The majority of patients knew they could be seen at any of the three practice sites, particularly if they had a preferred GP for continuity of care. Some patients preferred a particular site and were happy to see any GP on the day.

Staff at the practice told us that an online appointment system would be available to patients from January 2015. Text reminders were sent for some appointments, particularly health checks. We were told this was helping to reduce missed appointments. Patients told us they liked this reminder.

Areas for improvement

Action the service SHOULD take to improve

Put in place a clear system to check that GPs and nurses have current registrations with their respective professional bodies.

Set up a comprehensive training plan for non-clinical staff.

Outstanding practice

One GP partner visited patients in care homes one day a week. This was part of a developing care home project, aiming to be able to provide a GP or nurse practitioner and a prescribing pharmacist, whose work would entirely focus on patients residing in care homes.

Pathfields Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist advisor, a practice manager, an expert by experience (this is a person who has personal experience of using or caring for someone who uses this type of care service), a second CQC inspector and a CQC customer services administrator.

Background to Pathfields Practice

Pathfields Practice provided care and treatment to approximately 10, 300 patients living in Plymouth. There were six GP partners, (three female and three male). GP partners hold managerial and financial responsibility for running the business. There were also two GP associates (both male). Three GPs worked full time (eight sessions) and a fourth GP worked eight sessions and six sessions on alternate weeks. The other three GPs worked between four to six sessions. Where possible the GPs worked additional sessions to cover sickness and other absence, although the practice employed locum GPs for this purpose. The GPs worked across at least two sites to maintain the practice ethos and continuity of care for patients.

The practice was a teaching practice and provided placements for a trainee GP, Foundation Year-two doctors (F2) and medical students in years 1, 2 and 5. There was a nurse practitioner, three practice nurses and one health care assistant and two phlebotomists. Ten reception and three administration staff were trained to work in reception and administration roles. The practice also had two reception apprentices.

Pathfields Practice had a Personal Medical Services (PMS) contract. PMS agreements are locally agreed contracts between NHS England and a GP practice, and allow local flexibility in the range of services provided by the practice, the financial arrangements for those services, and the contract holder.

Pathfields Practice provides services from three premises located at:

- Laira Surgery, 95 Pike Road, Plymouth PL3 6HG
- Efford Medical Centre, 29-31 Torridge Way, Plymouth PL3 6JG
- Plympton Health Centre, Mudgeway, Plympton PL7 1AD.

We carried out an announced inspection across the three sites on 11 and 12 December 2014.

Pathfields Practice has planned further expansion to provide services from two more premises later in 2015. This will increase the patient population to approximately 19,000 and offer patients a choice of five sites across Plymouth to see a GP or nurse. One GP partner was working five sessions as a locum at one of the proposed new premises at the time of this inspection as part of the transition to the merger. This GP also worked two sessions and a flexi session one day a week at Pathfields Practice.

Patients were able to see a GP or nurse at any of the three sites during practice opening times :

- Laira Surgery - Monday, Tuesday, Thursday and Friday 08.00am to 6pm. Late opening on Mondays from 6.30pm to 8.30pm. Closed every day between 1pm and 2.30 pm except Wednesday when it was closed all afternoon from 1pm.
- Efford Medical Centre – Monday, Wednesday, Thursday and Friday 08.00am to 6pm. Closed all Tuesday and lunchtimes between 12.30pm to 1.30pm.
- Plympton Health Centre – Monday, Tuesday, Wednesday, Thursday and Friday 08.00am to 6pm.

Detailed findings

A GP was available every morning Monday to Friday for telephone triage. If necessary the GP would arrange for the patient to be seen at the practice. Patients had to call before 10.30am for this service.

Out of hours services was provided by another organisation.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. This provider had not been inspected before and that was why we included them.

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework (QOF) data, this relates to the most recent information available to the CQC at that time.

How we carried out this inspection

Before visiting we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. Organisations included the local Healthwatch, NHS England, the local clinical commissioning group and local voluntary organisations.

We requested information and documentation from the provider which was made available to us either before, during or within 48 hours after the inspection.

We carried out an announced visit on 11 and 12 December 2014. During our visit we spoke with a range of staff including seven GPs, three practice nurses, one phlebotomist, the practice operations manager, the patient services manager, two administrators, the two reception team leaders and three receptionists. We reviewed anonymised personal care or treatment records of patients in order to see the processes followed by the staff. We observed how the practice was run and looked at the facilities and the information available to patients. We looked at documentation that related to the management of the practice. We observed staff interactions with other staff and with patients and made observations throughout the internal and external areas of the building.

During the inspection we spoke with 13 patients who used the service, carers and family members of patients. We reviewed 84 comment cards where patients and members of the public shared their views and experiences of the service.

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

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

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

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

Good

Are services safe?

Our findings

Safe track record

The practice identified that two of their sites were located in areas with risk of deprivation, social exclusion and a higher incidence of domestic abuse. The practice had robust systems in place to ensure that all clinical and reception staff knew how to recognise and report concerns within the practice. The GPs met weekly with the practice operations manager, the patient services manager and the lead practice nurse to discuss all issues that had arisen including any serious and adverse incidents. Any decisions or new arrangements were emailed to all staff. The nursing team met monthly and this information was also discussed at these meetings.

We looked at incident reports and a summary of these for the last year. These showed that the practice took significant events and incidents very seriously and could show a consistent approach to maintaining a safe track record. The practice IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of significant events from December 2013 up to October 2014. The GPs met weekly to discuss all issues that had arisen over the past week. Significant events and incidents were also discussed at the clinical governance meetings held every three months. Information was cascaded to other staff via an internal email system. The nursing team met monthly and discussed any issues as part of these meetings.

There was evidence that the practice had learned from past significant events, incidents and complaints. These were raised appropriately, for example, to the NHS England local area team as well sharing findings with the relevant staff. In cases where it was recognised an incident or complaint required staff training, this was arranged. Records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result of an incident, which had involved a local pharmacy. This was reported to the CCG and a root cause analysis was carried out.

Reliable safety systems and processes including safeguarding

The reception staff we spoke with demonstrated awareness of the safeguarding procedure. They told us they had received training and were able to describe how they would escalate concerns. One reception staff member had undertaken a public services degree and had more detailed knowledge. Two staff were less sure about the whistle blowing procedure although they knew where they could find it. All the reception staff were clear they would not hesitate to report concerns. They had all completed online training for safeguarding children and adults.

All the nursing team we spoke with were familiar with how to report and escalate concerns. One practice nurse provided an example of how they had previously made a referral about a child. Another practice nurse described how after recently seeing a regular patient who was at risk of self-neglect, the practice nurse spoke with the patient and escalated her concerns to a GP. A social services care package was arranged for the patient following a referral by the GP.

The practice had appointed a GP as lead in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke to were aware who the lead was and who to speak to in the practice if they had a safeguarding concern.

GPs and practice nurses told us that one practice site was in an area of high deprivation and across the practice there were a high number of families and individuals at risk on the practice lists. They described how they used the IT flag system which told them about any issues before they saw the patient. They described how they added information to the system and liaised with health visitors as necessary. There was a clear follow up system in place for missed appointments or immunisations for children. We were told that alerts came up for children on the risk register or who were of concern if they missed GP or nurse appointments, hospital appointments or attended the minor injuries unit.

Good

Are services safe?

We were given a recent example of a child not attending for a hospital appointment. The reception staff were tasked with contacting the child's parents to find out why the appointment had been missed.

There was a chaperone policy, which was displayed on each consultation room door. A chaperone's role is to accompany a patient (at the patient's request) during consultation, examination or treatment. Chaperones may also be used by GPs or nurses during examinations of vulnerable adults and of children. All nursing staff, including health care assistants, had been trained to be a chaperone. The receptionist and administration staff were due to attend chaperone training in January 2015 so they could provide this if nursing staff were not available to act as a chaperone.

Medicines management

We saw the emergency medicines at the three sites. All were in date and the practice nurses showed us records of regular checks and prompts for expiry dates. All medicines were stored appropriately and the cold chain was effective for vaccines. There were no recent issues with fridges and regular temperature range checks were completed by the nursing team. At Plympton Health Centre the emergency medicines and equipment were shared with another practice that was located in the same part of the building. We were told these medicines and equipment were checked weekly by the Pathfields lead practice nurse.

Medicines in GP bags were ordered through the practice nurses however, GPs took responsibility to check their bags. Medicines alerts were emailed to clinical staff and any additional information and or action was cascaded to them from the weekly Monday meetings. The practice nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. The health care assistant administered flu and pneumonia vaccinations under Patient Specific Directive (PSDs). The senior practice nurse maintained detailed records listing all the individual vaccines administered and to which patient and this list was countersigned by a GP. Vulnerable patients, older patients and those with long term conditions were prescribed blister packs to enable easier management of their medicines.

All prescriptions were reviewed and signed by a GP before they were given to the patient. There was a protocol for repeat prescribing which was in line with national guidance. Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

We were told about a number of medicines audits. For example, one practice nurse was carrying out a respiratory audit of the use of inhalers. On the day of our inspection, the audit had identified that a patient who was telling nurses that they were fine, had used a larger than expected number of inhalers. The patient had consequently been invited to attend for a review. This audit was on going.

Cleanliness and infection control

The areas we saw of the sites we visited appeared clean, for example, four treatment rooms, four consulting rooms, and waiting areas. Curtains provided for dignity screening had been recently replaced and dates were clearly displayed. There were accessible supplies of gloves, aprons, paper towels and bed roll. A cleaning schedule for the contracted cleaner had been recently introduced and completed. The nursing team told us they had sufficient cleaning and protective equipment.

There had been one infection control audit dated 19 and 20 November 2014 and this had been completed for each site. The infection control lead nurse confirmed that there were no previous audit records. Prompt action had been taken where issues had been identified, for example, removing curtains from a GP consultation room and keeping wipes for baby changing areas at the reception desk. This audit had identified that different cleaning materials needed ordering and these were evident in the cleaner's cupboard. Additional clinical waste bins had been bought as a result of the audit. Other things such as changing to elbow tap handles were passed to the practice operations manager for consideration and discussion with the GPs. The practice operations manager planned to add a column to the checklist to enable the practice nurses to indicate completed actions and further review. It was not clear on the record we were shown that things had been signed off to show actions had been taken.

Reception staff showed awareness of infection control and hand washing. They were able to describe what they would do in specific circumstances to protect patients for

example, if someone vomited or was bleeding heavily in the waiting area. They showed us the spillage kits and procedure and said they had not had any problems using them as necessary.

A Legionella survey had recently been completed at Plympton Health Centre and would be repeated at Laira Surgery and Efford Medical Centre in the near future.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly. We looked at records for each site and found that at Plympton Health Centre the maintenance and calibration schedule included some items that needed updating. Electrocardiogram (ECG) machines were checked annually. The asset register for the practice was under review at the time of this inspection.

Staffing and recruitment

We looked at staff files for clinical and non-clinical staff. We found that appropriate recruitment checks had been completed, for example, references, qualification and criminal records checks. The personnel files were well organised however, for clinical staff the files did not have copies of interview notes. There was also no evidence of checking registrations with professional bodies. The practice operations manager told us she looked at the GMC website to confirm the GPs' registrations were in date. This was not recorded and there was no information to support this had been checked.

The practice used locum GPs when necessary to cover annual leave and other unexpected absence. The practice did not use agency locums, preferring to employ the same locums who were known to and knew the practice and its systems. This also offered better continuity of care to patients. Appropriate checks were repeated annually for locum GPs who worked at the practice on a regular basis.

Monitoring safety and responding to risk

The nursing staff we spoke with told us they provided consistent care to patients and this assisted them to quickly identify changes in condition. We were given an example of a practice nurse walking through a waiting area who saw a patient she saw regularly for a long term condition, waiting for GP appointment. The practice nurse thought the patient had deteriorated greatly and having explained to the reception staff, she carried out an INR test and respiratory test. This picked up an issue that required urgent attention and hospital treatment and was alerted to the patient's GP.

The practice used a particular IT system for communication with the out of hours service. Practice nurses and GPs were able to update this system to inform the out of hours team about patients with long term conditions. They received information about changes to medicines and unplanned hospital admissions electronically. Team leaders in the reception team were able to add information to this system for sharing with the out of hours team, especially for patients who were at end of life.

Arrangements to deal with emergencies and major incidents

We spoke with three practice nurses and three reception staff about numbers of staff on duty. They told us they generally had enough staff to enable flexibility to deal with emergencies such as the impact of adverse weather conditions or sickness. Staff were able to describe the emergency procedures for evacuation of the building in case of fire and their specific responsibilities. For example, reception staff knew that they had to bring the evacuation list and check against it. Reception staff at Laira surgery showed us where to find the disaster plan. It had been reviewed and updated and was due for review again in March 2015.

The plan contained clear instructions on communicating to patients, updating the website, if any of the sites were put out of action. Initial plans were to relocate services to one of the other sites. The disaster plan folder also contained practical details such as full contact list for possible areas of repair (for example, utilities and IT repair). Medical emergency medicines and equipment were kept at each of the three sites. All were in date and the practice nurses showed us records of regular checks and prompts for expiry dates. All medicines were stored appropriately. At Plympton Health Centre staff shared the medical emergency equipment with the other practice located on the premises. The staff of the other practice were solely responsible for checking the nebuliser and resuscitation equipment. Discussion was taking place for Pathfields Practice to hold its own medical emergency equipment.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

GPs and nurses were familiar with current best practice guidance and they accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. This was cascaded to staff by the practice operations manager. Specific issues were discussed at the weekly meeting held by the GPs. The GPs also attended regular update courses and they presented their learning to the other GPs and nurses as part of practice meetings. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs and these were reviewed when appropriate. This was in line with NICE guidelines.

GPs and nursing staff told us they had specialist interests in clinical areas such as diabetes, heart disease and chronic obstructive pulmonary disease (COPD). The practice nurses saw patients with long term conditions for routine appointments. If a practice nurse considered a patient needed a review due to something identified during an appointment, they would refer the patient to a GP. All annual health checks were completed by the GPs. Nursing staff told us the GPs supported all staff to continually review and discuss new best practice guidelines for the management of long term conditions.

National data showed the practice was in line with patient referral rates to hospital, and community care services for all conditions.

There was no evidence of discrimination when making care and treatment decisions. The practice philosophy of care was based on recognising that everyone was different yet equally important, so should be treated without bias or judgment. Interviews with GPs and nursing staff showed that they embraced this philosophy and the culture in the practice was that patients were treated and referred on need and that age, gender, race and disability were not taken into account in this decision-making. There was a balance of male and female GPs at the practice which supported patient choices to see a same sex GP.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management.

The practice has a system in place for completing clinical audit cycles. Examples of clinical audits included the prescribing of an anti-psychotic medicine for patients diagnosed with dementia. Steps had been taken to reduce use of this particular medicine which the audit showed was standard prescribing in secondary care. There was also another audit of anti-psychotic prescribing for patients diagnosed with dementia. This audit met NICE guidelines to review after six weeks and then quarterly for each patient. A minor operations audit had been completed over three months monitoring 50 patients across the three sites for post wound infection. The purpose of the audit was to establish if patients should be prescribed antibiotics as a precaution to prevent post wound infection. Four patients developed infections however, the outcome of the audit showed these infections would not have been prevented if the patient had taken antibiotics following the surgery. This audit was expected to be completed three monthly.

Other examples of practice monitoring and improving outcomes for patients included a routine check every three to six months of smear tests. All the smear tests completed at the practice were collated and these were checked by a practice nurse to identify any patients who had missed a check. A GP had completed first cycle audits of two week wait referrals and the outcome of the correct diagnosis of cancer, and measuring B12 levels after injections to see if patients needed to continue with these injections. Both these audits were due to be repeated. Another audit looked at an end of life care to see whether patients who had died had a treatment escalation plan (TEP) in place. This audit looked at 100 deaths and found that 75% of these patients had a TEP in place. GPs were actively working with patients residing in care homes to achieve 100% completion of TEPs for all these patients. This audit was due to be repeated in January 2015. The practice nurse told us that as part of an insulin study, 1100 patients with diabetes had been audited. The practice was aiming to become part of a structured education programme to offer patients care and support with their diabetes at the practice.

The practice also used the information collected for the quality and outcomes framework (QOF) and performance

Good

Are services effective?

(for example, treatment is effective)

against national screening programmes to monitor outcomes for patients. (QOF is a national performance measurement tool.) The practice met all the minimum standards for QOF and achieved 100% every year since it was introduced. This practice was not an outlier for any QOF (or other national) clinical targets.

The practice had a system to identify more vulnerable patients. It actively sought to support the more vulnerable members of the local community. The GPs were included in a local multi -disciplinary meeting which met every three months to discuss vulnerable patients. The team also included community nurses, a community matron, social workers, occupational therapists and palliative care team. The work undertaken by the GPs and team contributed to the practice's participation in the national initiative to avoid the need to admit patients to hospital.

The GPs and nursing team spoke positively about the innovation of the team. For example, as a part of a hospital admission avoidance scheme, the GPs provided care for temporary patients who were discharged from hospital to a care home for respite prior to returning home, or to patients who were moved into a care home under a rapid response scheme. The practice also had a high percentage of patients residing in care homes. The GPs had recognised that a large amount of time was taken up visiting patients in care homes so had introduced a regular weekly session in each, by one GP exclusively visiting care home patients. This had helped with the out of hours patient referrals from the weekends, as well as reducing overall the amount of time spent by all the GPs visiting care homes, and more patients were seen. As a consequence of this trial, the practice had applied for funding to employ a GP to solely visit care homes. It also planned to introduce working with a local prescribing pharmacist which, with the nurse practitioner, would improve patient care for the 370 patients who were care home residents.

The practice had nominated a staff member as their carers' champion. Health checks were offered annually to patients who were also carers. Patients who were diagnosed with dementia were referred to local befriending and day care services as well as support services in the voluntary sector.

Staff regularly checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice had set up a contract system for patients requiring INRs (International normalisation ratio - a way of measuring how fast a patient's blood clots). The contract and patient care was initially managed by a GP. Subsequently the phlebotomists saw patients for INR blood tests and contacted the patient the following day with the results. The phlebotomists were able to refer back to the GP if they had any concerns or picked up any trends with a patient's INR results. Also if any concerns or a new patient were identified, the out of hours' service would be notified. The practice had a policy of not carrying out these blood tests on a Friday. If necessary, appointments were moved back to Thursday. In the event a patient had this test on a Friday, it was marked as urgent on the pathology laboratory electronic system and reception staff were made aware of the sample. The patient was told not to take any dose at all until they had heard from the GP with their result. We were told that in the rare event the pathology laboratory had not contacted the practice with the test result, the practice would notify the out of hours of service.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records for reception and administration staff and saw that all staff were required to complete mandatory courses. We found that staff had completed three out of seven of these courses. Training was online and staff were expected to complete it during work hours at the practice, although some staff preferred to complete the courses in their own time at home. The practice operations manager told us the plan was for all the other courses to be completed by January 2015. We found there was no formal training plan in place to ensure this happened. All the reception and administration staff we spoke with told us they felt they were well supported. They knew the lines of accountability and were confident if they had any issues they could openly discuss these with their line manager. Two staff told us they were able to request training to improve their working practice. All the reception and administration team received an annual appraisal with a training and development plan.

Good

Are services effective?

(for example, treatment is effective)

The lead nurse managed the phlebotomists and the healthcare assistant (HCA). She also managed the rota for the nursing team. We were told that staff were moved around the three sites according to where they were needed. The lead practice nurse had recently completed an audit over three months to look at the number of unfilled appointments. This had shown that the HCA had too many whereas the practice nurse was over capacity. Consequently the HCA had moved to work at Laira Surgery and the practice nurse had moved to Plympton Health Centre. The nurses all tried to cover each other's absences (such as holidays and sickness). The lead nurse told us that she carried out six monthly competency checks, for example, on confidentiality, hand washing, patient care and computer recording as well as annual appraisals for the HCA and the phlebotomists. The practice nurses we interviewed told us they had regular appraisals and good support. They received appraisal predominantly by a GP. They told us about opportunities for continuing professional development. All the nursing team attended monthly meetings when the lead practice nurse updated them with practice information, concerns and other issues pertinent to nursing. These meetings were also training and update sessions. All the nursing team we spoke with felt the team supported one another and that the team had a good skills mix.

All the GPs were up to date with their yearly continuing professional development requirements and had either been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by NHS England can the GP continue to practise and remain on the performers list with the General Medical Council).

There was a set of policies and procedures for staff to use and additional guidance or policies located on the computer system. All the staff we spoke with knew where to locate these.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage complex cases. It received blood test results, X-ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances within the last year of any results or discharge summaries that were not followed up appropriately.

The practice had collaborative working arrangements in place with midwives, health visitors and school counsellors to ensure vulnerable families and young people were supported. The practice involved local schools in issues relating to young people particularly when mental health issues were identified. This was as a means of ensuring effective communication between different services.

Community nurses and GPs had ad hoc meetings to discuss vulnerable older patients. The GPs also worked with the rapid intervention team (this included social services, older person's mental health team and community nurses) for acute problems to avoid, where possible, hospital admissions for older people. The practice administration team reviewed admissions to hospital and alerted the GPs about admissions to hospital and discharge letters. The GPs either telephoned or visited the patient whichever was most appropriate and also discussed these at their weekly meetings.

Effective communication systems were in place to ensure pertinent information about patients, for example, at end of life, or with a complex long term condition was passed across to the out of hours service. Also for the out of hours service to notify the practice about patients who had had contact with or been seen by the out of hours team.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals through the Choose and Book system (a system that enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was straightforward to use.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient

Good

Are services effective?

(for example, treatment is effective)

record to co-ordinate, document and manage patients' care. All staff were fully trained on the system. The software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

The patients we spoke with and the comments cards were all positive about their involvement in care and treatment. Patients told us they were always asked for their consent and they felt involved in the decision making process about the options for their care and treatment.

Staff had a variety of ways to record when patients gave consent. There were ways of automatically recording when a patient had given consent for procedures including immunisations, injections, ear syringing and minor surgery. Patients told us that nothing was undertaken without their agreement or consent within the practice. This included the disclosure of test results to a third party.

There was a contract system in place for patients requiring INRs; approximately 200 patients, 71% of who were patients with arterial fibrillation. This contract was signed by the patient and they kept as copy as well as a copy being scanned on to their patient record. The contract stated the patient understood about Warfarin therapy and how they would need to have regular checks to monitor their blood clotting.

Where patients did not have the mental capacity to consent to a specific course of care or treatment, the practice acted in accordance with the Mental Capacity Act 2005 to make decisions in the patient's best interest. Staff were knowledgeable and sensitive to this subject, although not all clinical staff and reception staff had received the training.

The reception staff understood that patients needed to give consent. The nursing team described how they recorded consent. They also described the safeguards they would undertake if a person who was not the parent or guardian attended with a child for vaccinations. We discussed specific cases where a young person under 16 years the age had attended for treatment and how they checked understanding. The nursing team showed a clear understanding that individual children's comprehension was different and they had measures to check understanding. We were given examples of young people under 16 who attended for contraception and how checks were made of understanding and consent.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. They were explained the purpose of a care plan, told their point of contact and who was the accountable GP at the practice. The GPs had completed care home visits to all these patients to complete a care plan with them. The care plans included communication, mobility and if aids were needed to move around, and resuscitation. The care plans were reviewed three monthly by a telephone call to the patient to check that all was well if the patient had not been seen medically. Recalls were set up on the practice patient record.

Health promotion and prevention

The practice invited all new patients to have a health check with a practice nurse. It also invited newly diagnosed patient with diabetes or hypertension for a first health check. These were followed subsequently on an annual basis. These appointments were booked to suit patients' needs rather than as set clinics. The nursing team told us this worked well for patients. The nursing team were able to take charge of their lists and appointment times so they could add time to make longer appointments if they knew patients would benefit from extra time. The patient's named GP was informed of all health concerns detected and these were followed up in a timely manner. The GPs used their contact time with patients to be opportunistic and help them maintain or improve mental, physical health and wellbeing by signposting them to support groups or other services.

The healthcare assistant (HCA) was a smoking cessation advisor. Her role was to support patients who had a smoking habit by offering smoking cessation help and advice. She also ran dementia screening clinics and vascular health checks. Pending training the HCA would be responsible for carers' health checks.

The practice offered a full range of immunisations for children and flu vaccinations in line with current national guidance. There was a clear policy for following up non-attenders by the practice nurse.

Good

Are services effective?

(for example, treatment is effective)

The practice offered a full travel vaccination and advice service. It was not registered as a yellow fever centre however patients requiring this were referred to another local GP practice.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients spoke highly of the GPs and nurses. They said they were respectful and maintained patient dignity at all times. A number of patients told us about the compassion and understanding shown to them by GPs and support they had received through difficult periods of personal and family situations. Patients also told us how approachable they found the nursing team who always treated them with kindness and a caring attitude.

Patients of all ages felt able to go to the practice without fear of stigmatisation or prejudice. Young patients told us they found the practice was welcoming and non-judgmental to young people. The nursing team and the GPs were able to make longer appointments for those patients they knew may need longer because, for example, they were anxious or likely to become agitated if they felt they were being rushed. They also made home visits if this better suited patients' needs.

We reviewed the most recent data available for the practice on patient satisfaction from the national patient survey. This showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed patients rated the practice as good or very good.

We also reviewed the action plan for the practice patient survey 2014. This survey focused on reception staff and found that 15% of patients who responded felt that reception staff could be more approachable. During our inspection we received mixed feedback about the reception staff. The majority of patients said the receptionists were polite and courteous both on the telephone and at the reception desk. Our observation of the receptionists at each site found they were generally friendly and helpful. However at Plympton Health Centre, we observed there were occasions when some portrayed a defensive attitude to some patients. Staff told us there was some confusion amongst patients about the reception and waiting areas since a recent merger of another practice that shared the premises with Pathfields Practice.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. We observed that doors were kept closed during consultations. There were disposable curtains in consultation rooms which provided a screen between the treatment couch and door to maintain privacy and dignity. Within consultation and treatment rooms, windows were obscured with blinds or curtains to ensure patient's privacy.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. Each site operated a system that allowed one patient at a time to approach the reception desk. This helped to prevent patients overhearing potentially private conversations between patients and reception staff. At Efford Medical Centre the reception desk had a sliding glass panel that reduced the likelihood of staff conversation or telephone calls dealt with by the receptionist being overheard by anyone in the waiting area. Both Laira Surgery and Plympton Health Centre had an open desk set to one side of the waiting area. At Laira Surgery it was possible to hear the reception staff when they were on the telephone when the waiting area had only a few patients. However, we did not receive any feedback or comments from patients that their confidentiality was compromised by this set up.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager or a GP. The practice manager told us this would be investigated and any learning identified would be shared with staff. For example, we saw in the patient survey action plan that reception staff would receive training and that awareness was raised about maintaining a courteous and polite manner towards patients at all times.

During our inspection the GPs and nursing staff spoke to patients politely. All the patients, carers and family members we spoke with confirmed this was the case on all occasions.

Care planning and involvement in decisions about care and treatment

Patients felt involved in planning their care. The patients we spoke with and comments cards completed by patients, confirmed the GPs and nursing team explained treatment options so they understood them. Patients also felt reassured and had confidence in the GPs and nursing team. They said health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened

to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patients also said they were given written information to take home to read and consider options available to them.

All the staff we spoke with knew how to access additional support, for example, translation services for patients who did not speak English or specialist learning disability support, to help patients be involved in their treatment. We were shown a documented example of how a patient was supported to make decisions. In this instance the practice nurse worked collaboratively with the learning disability team to ensure a patient with a learning disability was able to understand about the purpose and necessity for a test. The nursing team told us that for anyone who was anxious or frightened about any sort of invasive test or examination such as a smear or blood test, the patient would be invited to attend a number of visits. This would give the patient the opportunity to familiarise themselves with the environment and equipment, and to ensure they understood why the process might be necessary and could give consent.

The majority of patients who were care home residents had a completed care plan and a treatment escalation plan (TEP). Care plans and TEPs had been written by the GPs with the patient and involving the patient's family when possible. These were used as a means of avoiding hospital admission where this was feasible. Care plans were reviewed three monthly or sooner by a practice nurse. This was achieved by telephoning patients unless the patient had been seen either in the practice or on a home visit at which point the care plan was updated then. We were told that for the month of December 154 reviews (across the three sites) needed to be completed.

We observed that children and young people were treated in an age appropriate way. They were recognised as individuals with their preferences considered. We observed a GP greet a young child warmly and in a non-threatening manner so the child was content to go into the GP's consultation room. One of the nursing team described situations where reluctant teenagers attended for vaccinations with insistent parents. They said they tried to ensure they spoke directly with the young person but in manner that did not exclude the parent. We saw all the waiting areas had notice boards with information for young people and promoted 'You're Welcome' (The Department Of Health's quality criteria for young people friendly health services).

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day of our inspection and the comment cards we received showed patients were positive about the emotional support provided by the practice. For example, they said that staff responded compassionately when they needed help and provided support when required.

Notices in the waiting areas and patient website informed patients how to access a number of support groups and organisations. We noted that at Efford Medical Centre these were not always displayed in logical groups.

The practice's computer system alerted GPs if a patient was also a carer. We were told that the healthcare assistant would be attending training in February 2015 which would mean the practice could then offer health checks to carers.

The GPs told us they had a good working relationship with the community midwifery team and health visitors. GPs actively screened and monitored for signs of post natal depression and patients were alerted to the midwifery and health visitor teams if this was diagnosed. There was also a good working relationship with schools and school counsellors who identified pupils with mental health issues.

GPs were able to liaise and arrange same day appointments for patients needing a mental health assessment with the local mental health team. They were also able to offer longer consultations to discuss concerns and relay anxieties which helped patients manage their mental health more effectively. GPs were also able to access urgent appointments for patients requiring help and advice for drug and alcohol misuse, and worked collaboratively with a local substance misuse service. Nursing staff told us that patients who misused drugs and or alcohol often lived with anxiety and depression, and had chaotic lifestyles. They said this generally meant these patients were always late for appointments. We were told they were opportunistic and would still see the patient because this avoided a health check or screening being missed altogether.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

We saw written evidence that longer appointment times were offered for particular needs, for example chronic obstructive pulmonary disease (COPD) checks and patients with a learning disability. Reception staff had ready access to a grid guide telling them which appointment times were needed for a variety of nurse or GP consultations or procedures.

We asked how the practice met the needs of patients with conditions not included in QOF outcomes and checks. Examples we were given included an information session about fibromyalgia held for patients by one of the practice nurses. We were told this was well-attended and received good feedback. Another example was that of a practice nurse who had identified that very young mum might need additional health visitor support and had contacted the health visitor team to organise this.

Tackling inequity and promoting equality

The practice had ramped access from the main street to the front door at Efford Health Centre and from the car park to the front door at Laira Surgery. At both sites the front doors were heavy and awkward making access difficult for wheelchair users, parents with prams and buggies, and frailer patients. Hand written signs were posted on each front door advising patients to call out for assistance. There was level access at Plympton Health Centre with an automatic door.

At Efford Medical Centre the wheelchair reception area was not easily visible for wheelchair users. There was a notice adjacent to the area however this also was not easily visible.

There were a number of issues with the accessible toilets at each of the sites. These included at Efford Medical Centre the soap dispenser was positioned too high to reach from a wheelchair. At Laira Surgery the emergency cord in the accessible toilet had been tied up out of reach. In the event of someone falling this would put them at risk of not being able to call for help. There was difficulty with access to the accessible toilet for wheelchair users at Plympton Health Centre. Since our inspection we have been sent copy of minutes of a meeting showing the proposed measures to be taken to address the issues in the accessible toilets identified during the inspection. The practice has confirmed that both soap dispensers and hand towel dispensers have been adjusted since the inspection.

The reception area at Plympton Health Centre was shared with another practice however the signage was unclear. Immediately inside the front door was a separate reception area marked "Prescriptions". This was for the other practice only but this was not obvious. There were two waiting areas of which a section of one was for use by the Pathfields Practice patients. To differentiate each practice waiting area, different coloured stripes had been painted on the walls. Each waiting area was referred to by the colour of the stripe, blue or green. This was confusing as both areas looked the same and the stripes were not obvious (we had to ask and be shown the stripes). Since our inspection the practice management team has met with managers of the other practice sharing the premises. We have seen the minutes of this meeting which showed joint work on signage and adaptations to the entrance and reception area at Plympton Health centre are being considered.

Access to the service

Patients had a range of options for accessing GP or nurse consultations across the three sites. Patients were able to access a GP on the same day, however, this could mean travelling to any of the three sites. The practice staff were mindful this was not always feasible for patients without transport, particularly from Laira and Efford to Plympton. Laira Surgery offered early appointments at 8am four days a week and a late surgery on Mondays from 6.30pm to 8.30pm. One of the reception team leaders said that approximately 30% of patients wanted an initial telephone call with their GP as their first choice rather than going into the practice. Patients preferring this option were asked to contact the practice after 10.30am. The duty GP triaged the patients requesting same day appointments and also call backs. There were slots available in the afternoon to book patients who the GP considered needed to be seen. The duty GP was the same GP all day to provide continuity of care and workflow.

Good

Are services responsive to people's needs?

(for example, to feedback?)

We saw on the appointment system that two slots were reserved at all sites every afternoon for GPs to call patients about blood tests and other test results.

There were arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients on the practice website and on the front door of each site.

Longer appointments were available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to patients too frail to go into the practice and also to patients who needed to see a GP and who lived in local care homes.

Patients were generally satisfied with the appointments system. They confirmed that they could see a GP on the same day if they needed to. They told us this may not be with their GP of choice. However, everyone we spoke with said they were confident about seeing any GP at the practice.

The practice website offered an online translation selection for patients who did not have English as their first language. In the practice staff knew how to access translation services if patients did not have a family member able to provide this for them. We were told it was a small minority of patients who did not speak English and they attended with a family member. This was recorded in the patient record.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice with a nominated person in their absence. Staff knew that they should record and refer all complaints to the lead person for this. A log was kept of both verbal and written complaints. This was password protected and only accessible nominated staff. We saw the log included the date of discussion at the practice weekly meeting and investigation. This was recorded as part of the meeting minutes. We also saw that complaints about staff members were shared with the staff member in a one to one meeting and this was recorded. Any learning from complaints was shared with the GPs, management team and the staff member. The complaints procedure included a six monthly review period. Submission of the last year's complaints had been made to NHS England. There was not a formal annual practice audit of complaints to identify themes or trends. This limited the practice's ability to develop action plans or identify training needs.

We saw six thank you cards to the nursing team thanking them for responding to and meeting patients' individual needs.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The GPs were all supportive and shared the practice vision to provide an equal service without discrimination or judgement. They also fully supported clinical commissioning and their vision and strategy included improving the services available within the community to provide integrated care. The practice promoted healthy living and the delivery of holistic and preventative medicine.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and staff knew where to access these. Policies and procedures were reviewed and we saw a list with dates of review.

There was a clear leadership structure with each partner taking responsibility to be a named lead GP. For example, safeguarding, Caldicott Guardian, clinical research and prescribing. We spoke with thirteen members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns. Everyone also told us how much they enjoyed working at the practice.

The practice had undergone a number of changes that had affected the practice management structure over recent months. This was apparent at times during our inspection, for example, staff training had only partially been completed for subjects identified as mandatory for non-clinical staff and there was no training plan in place. Annual audits of infection control and complaints were not in place. However, all equipment checks and logs were in place.

The GP partners and the management team recognised there were gaps in the existing practice management structure and a need to improve the overview of management across three sites. We discussed with the lead GP for strategic vision about plans for a clear management overview of governance and financial arrangements across potentially five sites by autumn 2015. This GP was aware of challenges and the need to prepare for managing potential future risks. They also understood there were issues of resource and planning implications if the practice was to grow in capacity. The other partner GPs fully supported the practice strategy and we were told that before each decision all the implications were financially evaluated and risk assessed.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was discussed at weekly meetings between the GPs and the practice manager (other staff were able to attend), and action plans were produced to maintain or improve outcomes.

The practice nurse told us that they were members of the local nurses' forum. This provided all the practice nurses with clinical updates and gave them an opportunity to meet monthly for peer review and support.

The practice had an on going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, a minor operation audit was completed over a three month period from August to November 2014. The GPs discussed the audit, infection control and minor operations procedures. The outcome of the audit was for GPs performing minor operations to prescribe prophylactic antibiotics based on the individual patient and the site of operation. This was the first audit, however it was to be repeated six monthly.

The practice had robust arrangements for identifying, recording and managing significant events. The practice operations manager showed us the log, which addressed a range of issues, such as a patient's medicine being stopped in error by a pharmacy. We saw these were referred to secondary care, NHS England and other organisations and agencies as needed. Significant events were discussed at weekly GP meetings if they were considered to be urgent or important. They were also reviewed at quarterly clinical governance meetings. Results of any learning from significant events were disseminated back to all staff via an internal email system. For example, following patient information being recorded on the incorrect patient record, all staff, nurses and GPs were reminded to ensure that they double checked the patient record where they were recording information was the correct patient.

We were given a number of examples where GPs and staff had acted swiftly to assist patients. For example, when a

Are services well-led?

Good

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

patient had collapsed in the waiting room, the reception staff had acted quickly and appropriately. On two different occasions GPs responded quickly and worked together to save the lives of two acutely sick children.

Leadership, openness and transparency

Staff were encouraged to communicate informally and formally through meetings and staff appraisal. All of the staff we spoke with were very positive about the open culture within the practice. They felt they were part of a team and would be listened to and taken seriously if they raised any issues. The reception and administration staff told us they had an open door access to their line manager. They also told us they could attend the weekly meeting with the GPs and take suggestions and ideas for improving systems and methods of working. The nursing team also told us about how they felt supported by their line manager and able to ask for advice or help if there was an area about which they were unsure.

The practice had a lead GP partner who was responsible for practice development and human resources. There were human resource policies and procedures which included disciplinary procedures, induction policy and management of sickness, all available to staff on the practice intranet.

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

The practice had gathered feedback from patients through a patient survey, thank you cards and complaints received. We looked at the results of the annual patient survey and the proposed action in response. We saw, for example, 76% of patients were unaware of the practice website. The practice response was to put up posters and use the display screens in waiting rooms to promote the website. Reception staff were also encouraged to direct patients to the website. We also saw that 66% of patients responded positively to receiving text message reminders for appointments. This system had been recently implemented and we received positive feedback about this from patients during our inspection.

The practice had an active patient participation group (PPG), established in 2011. The PPG included representatives from various population groups although we were told the group was trying to encourage younger people to join it. The PPG also had a higher proportion of patients from Plympton and efforts were being made to attract more patients from Laira and Efford to join. The PPG had met three times in 2013/14 and also communicated via email, telephone and post as needed. The practice was keen to promote the PPG and to keep it as the focus of its patients' voice. For example, the PPG with the practice management team carried out a health survey, given out to patients attending for flu clinics. 120 patients responded to the survey which included questions about alcohol consumption, weight management, smoking, physical activity, employment and financial concerns. As a consequence of the survey a number of patients were invited to attend a health review with their GP to look at ways they could help themselves to improve their health.

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues, their line managers and the GPs. One member of staff told us they were planning to attend the weekly meeting to discuss with the partners an improvement for managing GP dictation. All the staff we asked spoke positively about working at the practice and felt involved in the practice to improve outcomes for both staff and patients.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning and improvement

Nursing staff told us they were supported to maintain their clinical professional development through training and mentoring. Reception and administration staff told us that regular appraisals took place and these included a personal development plan. The practice had protected time for learning and development. This had been four times a year but had been reduced to twice a year in 2014. The next meeting was planned for January 2015 when reception and administration staff were expecting to attend chaperone training. The staff we spoke with about this training were supportive of it. One member of this team told us that it would help both GPs and nurses as reception and administration staff could be more readily available. It also would benefit patients who could be seen at the time of their appointment and not asked to return another day when a chaperone was available.

The practice was a GP training practice and offered placements to a trainee GP, Foundation Year 2 doctors (F2) and medical students in years 1, 2 and 5. Four of the GP

Are services well-led?

Good

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

partners were medical student tutors and another of the partners was a lead for speciality training. All the GPs had specialist interests including acupuncture, cryotherapy, dermatology, joint injections and minor surgery.

The practice was developing a care home project which it was keen to push forward. It planned to set up care home surgeries with a GP and or nurse practitioner and a prescribing pharmacist who could provide all the care home visits. This was being trialled at the time of our inspection with one of the GP partners spending one morning a week seeing only patients in care homes. If the project was successful it would improve prescribing costs. It would also improve patient care because it would reduce the number of call outs, both in and out of hours.

The practice was also developing a website that would enable patients to manage their long term conditions. There was a 14 year disparity in mortality rates for patients who lived nearer the city centre compared with those living in the suburbs and further outside the city. The practice was looking at ways it could reduce this difference. It was hoped that by building a virtual patient support group for integrated care between GP, consultant and patient managing long term conditions could be one way of doing this.