Mount Gould GP Practice

Quality Report

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

Ratings

Overall rating for this 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

Mount Gould Medical Centre is operated by Access Health Care, a social enterprise organisation owned by Exeter based Devon Doctors. The practice comprises of three separate medical centres located within three separate areas of the city of Plymouth, Devon. The patient population group of 10,058 was divided as 2795 patients at Mount Gould, 4231 patients at Ernesettle branch and 3032 at the Trelawny branch. (Collectively referred to as sites)

The clinical governance, complaints and human resources management are conducted at the Devon Doctors headquarters in Exeter. There were no GP partners at the practices.

We carried out an announced comprehensive inspection at Mount Gould Medical Centre on 27, 28 and 29 June 2017. Overall the practice is rated as good.

Our key findings across all the areas we inspected were as follows:

- There was an open and transparent approach to safety and a system in place for reporting and recording significant events.
- The practice had clearly defined and embedded systems to minimise risks to patient safety. For example, the practice management teams were open about the shortfalls identified since Access Healthcare had taken over the leadership. Action plans were in place for these issues and timescales had often been met. We saw evidence that action plans demonstrated assessment of risk and priority.
- Staff were aware of current evidence based guidance. Staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment.
- Patients said they were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment.
- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns.
- Not all patients we spoke with said they found it easy to get through on the telephone or make an appointment with a GP and added that there was not

Summary of findings

always continuity of care, but said urgent appointments were available the same day. This had been identified by the management who were in the process of introducing a new telephone system, employing additional staff (clinical pharmacist), and improving ways of how patients could access and cancel routine appointments.

- All three practices had good facilities and were well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. Staff said Access Healthcare were a 'structured' and 'supportive' employer and added that the practices were good places to work. Staff said they had received detailed inductions, supervision, and support and had access to sufficient training and education.
- The practice proactively sought feedback from staff and patients, which it acted on. For example, changes in appointment processes, introduction of additional car park spaces and drinking water dispensers in waiting areas.
- The provider was aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.

The areas where the provider should make improvement are:

- Ensure systems are in place to demonstrate that patients, in addition to an apology, are informed on any delay in response to complaints.
- Ensure systems are in place to ensure the overview and monitoring of clinical roles are consistent and completed across all three sites, and managed by staff with appropriate skills
- Ensure systems continue to ensure the coding (Recording and identification of specific screening tests, conditions and illnesses) are consistently recorded over all three sites to ensure the patient record is accurate and clearly show past and present medical conditions.
- Ensure patient access to GP appointments is monitored following the introduction of new telephone system.
- Continue with the monitoring and audit of the quality of the patient summary record

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.

- From the sample of documented examples we reviewed, we found there was an effective system for reporting and recording significant events; lessons were shared to make sure action was taken to improve safety in the practice. When things went wrong patients were informed as soon as practicable, received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices to minimise risks to patient safety.
- Staff demonstrated that they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role.
- The practice had adequate arrangements to respond to emergencies and major incidents.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework showed patient outcomes were at or above average compared to the national average.
- Staff were aware of current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had the skills and knowledge to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- End of life care was coordinated with other services involved.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care.
- Survey information we reviewed showed that patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.

Summary of findings

- Information for patients about the services available was accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- The practice understood its population profile and had used this understanding to meet the needs of its population.
- The practice took account of the needs and preferences of patients with life-limiting conditions, including patients with a condition other than cancer and patients living with dementia.
- Patients we spoke with said they sometimes found it difficult to make an appointment with a named GP and said continuity of care was not always provided. However, all patients said urgent appointments were available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and evidence from examples reviewed showed the practice usually responded within timescales to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led.

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- The practice management teams were open about the shortfalls identified since Access Healthcare had taken over the leadership. Action plans were in place for these issues and timescales had often been met. We saw evidence that action plans demonstrated assessment of risk and priority.
- There was a clear leadership structure and staff felt supported by management. However, there were no GP partners at the three sites meaning that the overview of clinical responsibility roles were not consistent across all three sites and were sometimes monitored by non-clinical staff.
- Coding of specific screening tests, conditions and illnesses were not always consistently recorded over all three sites meaning

Summary of findings

GPs and nurses often took longer to see a full and accurate patient history. This also meant information capture did not always reflect the care provided by staff and meant that some diagnoses were not always recorded accurately.

- The practice had policies and procedures to govern activity and held regular governance meetings.
- An overarching governance framework supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- Staff had received inductions, annual performance reviews and attended staff meetings and training opportunities.
- The provider was aware of the requirements of the duty of candour.
- The management team and organisation encouraged a culture of openness and honesty. The practice had systems for being aware of notifiable safety incidents and sharing the information with staff and ensuring appropriate action was taken.
- The practice proactively sought feedback from staff and patients and we saw examples where feedback had been acted on. The practice engaged with the patient participation group.
- There was a focus on continuous learning and improvement at all levels. Staff training was a priority and was built into staff rotas.

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

The practice is rated as good for the care of older people.

- Staff were able to recognise and report the signs of abuse in older patients and knew how to escalate any concerns. Staff had received the appropriate level of safeguarding training and any safeguarding incidents were shared in review meetings.
- The practice offered proactive, personalised care to meet the needs of the older patients in its population.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. Elderly frail patients were prioritised for home visits. Patients with mobility issues or hearing impairment were offered support by our reception staff upon arrival.
- The practice identified at an early stage older patients who may need palliative care as they were approaching the end of life.End of life care plans and treatment escalation plans were completed for all palliative care patients. Practice staff, with patient consent, shared details with out of hours (OOH) GP service via special patient messages on Adastra (computer patient record system).Palliative care patients were discussed at clinical meetings which take place weekly or monthly depending on sites.
- The practice followed up on older patients discharged from hospital and ensured that their care plans were updated to reflect any extra needs. Discharge summaries were reviewed by the duty GP who completed medicine reconciliation (updating an accurate list of medicines being taken).Any concerns or changes were raised at the clinical meeting.
- Older patients were provided with health promotional advice and support to help them to maintain their health and independence for as long as possible.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions.

- Nursing staff managed Chronic Disease Management/ Monitoring with support from the GPs and healthcare assistants. This involved interim checks and annual checks. Patients at risk of hospital admission were discussed at clinical meetings.

Summary of findings

- The practice followed up on patients with long-term conditions discharged from hospital and ensured that their care plans were updated to reflect any additional needs. Discharge summaries were reviewed by the duty GP who completed medicine reconciliation. Any concerns or changes were raised at the clinical meetings.
- There were emergency processes for patients with long-term conditions who experienced a sudden deterioration in health. Urgent appointments or home visits could be requested as required. Those under care of long term condition team are discussed at multi-disciplinary team meetings.
- All these patients had a named GP and there was a system to recall patients for a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. All patients had a named GP and were informed by text/letter as well as patients notices in waiting areas. New patients were informed of named GP upon registration.
- Recall processes were in place. Patients were invited in on interim and annual basis by the Business Intelligence Team.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people.

- There were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. All A&E visits were coded on the computer system and regular searches took place to identify any children frequently missing appointments or screening. All emergency department attendances by children were highlighted and discussed at clinical meetings.
- Immunisation rates were average for all standard childhood immunisations. The lead nurse had identified a group of patients who had missed immunisations. A full search of children under the age of 18 years was performed. The cause of the error had been addressed and babies and children recalled for immunisation updates.
- Patients told us, on the day of inspection, that children and young people were treated in an age-appropriate way and were recognised as individuals.

Summary of findings

- The practice provided support for premature babies and their families following discharge from hospital. Any discharge summary involving premature birth of new patients was reviewed and actioned by GP.

Appointments were available outside of school hours and the premises were suitable for children and babies.

Premises were fit for purpose and included a private room for breast feeding and baby change facilities.

- The practice worked with midwives, health visitors and school nurses to support this population group. For example, in the provision of ante-natal, post-natal and child health surveillance clinics. The health visitor worked on site at Mount Gould. Midwives held clinics at all three sites. Midwives, health visitors and school nurses were invited to clinical meetings and received minutes of all clinical meetings held.
- The practice had emergency processes for acutely ill children and young people and for acute pregnancy complications. Urgent appointments were offered and emergency protocols including how to escalate a potentially septic child.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working age people (including those recently retired and students).

- The needs of these populations 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, appointments early and late in the day were offered for working patients. Online booking and prescription ordering was available. Patients were able to book into any of the three practices as one site may be nearer to work than home.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. Online registration was encouraged as part of new patient questionnaire. Patient summary care records, prescription ordering and appointment booking were available online.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those

Summary of findings

with a learning disability (LD). A LD register was held on each site. Homeless patients and traveller patients were coded on the computer system and could be searched to ensure they were receiving the care appropriate to their needs. These patients were discussed at clinical meetings and the lead nurse developed rapport with parents to encourage the uptake of immunisations. The local LD lead met regularly with the nursing team to discuss patient's needs.

- 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 offered longer appointments for patients with a learning disability. Staff made efforts to prioritise appointments for patients with a learning disability at the start of clinics so they did not become anxious in waiting area.
- The practice regularly worked with other health care professionals and invited them to the clinical meetings to discuss the case management of vulnerable patients.
- The practice had information available for vulnerable patients about how to access various support groups and voluntary organisations. There were carer's notice boards with appropriate information signposted and leaflets available.
- Staff interviewed knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. They were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).

- The practice carried out advance care planning for patients living with dementia including patients over the age of 60 years old living in a local care home.
- All patients diagnosed with dementia who had their care reviewed in a face to face meeting in the last 12 months, which is comparable to the national average.
- The practice specifically considered the physical health needs of patients with poor mental health and dementia.

Summary of findings

- The practice had a system for monitoring repeat prescribing for patients receiving medicines for mental health needs. GPs followed a protocol for reviewing repeat prescriptions. This was monitored by the practice manager at each site. Any concerns are raised at the clinical meeting.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia. For example, ward rounds at the local dementia care home were offered by the nurse practitioner and GP. Mental health nurses were invited to attend clinical meetings.
- Patients at risk of dementia were identified and offered an assessment.
- The practice had information available for patients experiencing poor mental health about how they could access various support groups and voluntary organisations.
- The practice had a system to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

The practice had recently gone through an organisational change and was not included in the national patient survey.

All three sites had encouraged patients to complete the friends and family test and liaised with the patient participation group to obtain feedback. We looked at results of the friends and family test conducted over March, April and May 2017. Of the 23 results obtained at Mount Gould 13 said they would be extremely likely or likely to recommend the practice, 3 neither likely nor unlikely, one unlikely and 3 did not know. At Trelawney and Ernesettle, results were identical. Of the 15 results eight said they would be extremely likely or likely to recommend the practice, five were unlikely to recommend and two did not know.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 41 comment cards which were all positive about the staff and the standard of care received. Nine were negative about continuity of care, the telephone system and the ability of getting an appointment.

We spoke with 19 patients during the inspection. All 19 patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. 14 of these patients said they had experienced problems accessing an appointment at a time convenient to them and all said the telephone problem had caused delays speaking with staff to make an appointment.

Areas for improvement

Action the service SHOULD take to improve

- Ensure systems are in place to demonstrate that patients, in addition to an apology, are informed on any delay in response to complaints.
- Ensure systems are in place to ensure the overview and monitoring of clinical roles are consistent and completed across all three sites, and managed by staff with appropriate skills.
- Ensure systems continue to ensure the coding (Recording and identification of specific screening tests, conditions and illnesses) are consistently recorded over all three sites to ensure the patient record is accurate and clearly show past and present medical conditions.
- Ensure patient access to GP appointments is monitored following the introduction of new telephone system.
- Continue with the monitoring and audit of the quality of the patient summary record.

Mount Gould GP 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 adviser and an assistant inspector.

Background to Mount Gould GP Practice

Mount Gould Medical Centre is a GP practice for approximately 10,058 patients.

The practice has an Alternative Provider Medical Services (APMS) contract under a NHS framework agreement. This means NHS England have asked the organisation to manage services for a period of time. This contract had commenced on 1 April 2016. The practice is operated by Access Health Care; a social enterprise organisation owned by Exeter based Devon Doctors. The clinical governance, complaints and human resources management are conducted at this headquarters. This meant there were no GP partners at the practices.

The practice comprises of three separate medical centres located within three separate areas of the city of Plymouth, Devon. The patient population group of 10,058 was divided as 2795 patients at Mount Gould, 4231 patients at Ernesettle branch and 3032 at the Trelawny branch. Although patients could be seen at any of the three sites patients often choose to see GPs and nurses at the practice closest to their home. Staff also occasionally work across all three practices but tended to work at the same practices to improve continuity of care for patients.

The aim at all three sites is to provide 50-54 GP/nurse practitioner sessions per week. Across the three practices there are four salaried GPs (all male) providing 23 sessions. The salaried GPs are supported by one male agency GP providing 10 sessions and five long term locum GPs (three female and two male) providing 18 sessions. The GP received support from two advanced nurse practitioners (one male and one female) providing eight sessions. In total the clinical team provided 59 sessions per week.

There were five practice nurses and three health care assistants across all three sites who together provided 6.23 whole time equivalent.

Each site has an office manager responsible for the 17 business intelligence, administration and reception staff. This team were managed by an overall operations manager and practice manager.

The practice is open Monday to Friday between 8.30am until 1pm and between 2pm until 6pm. There is a contracted agreement that the out of hours provider (NHS 111) responded to calls between 1pm and 2pm and between 6pm and 8.30am.

There was no published collated information regarding the demographics of the practice and two branches. However, neighbourhood demographic information provided by the organisation showed that the majority of patients registered were white British.

The practice is registered to provide regulated activities which include:

Treatment of disease, disorder or injury, surgical procedures, maternity and midwifery services and Diagnostic and screening procedures and operate from the main site of:

Mount Gould Medical Centre based at 200 Mount Gould Road, Plymouth, PL4 7PY

Detailed findings

And from the two other sites at:

Ernesettle branch surgery, Ernesettle green, Plymouth, PL5 2ST

Trelawny branch surgery, 45 Ham Drive, Plymouth, PL2 2NJ

Why we carried out this inspection

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. The 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.

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. We carried out an announced visit on 27, 28 and 29 June 2017.

During our visit we:

- Spoke with a range of staff and spoke with patients who used the service.
- Observed how patients were being cared for in the reception area and talked with carers and/or family members
- Reviewed a sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Visited all practice locations
- Looked at information the practice used to deliver care and treatment plans.

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 were provided for specific groups of people and what good care looked 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 whose circumstances may make them vulnerable
- people experiencing poor mental health (including people living with dementia).

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

Good

Are services safe?

Our findings

Safe track record and learning

There was a system for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system or this could be done by emailing the governance team directly. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).

The management of significant event process was managed centrally at the Access Healthcare headquarters. The governance team followed a standardised process. Any event went to the team for classification into significant or serious events and incidents. Staff were aware of the threshold of these classifications. We looked at minutes of meetings and records to show the discussion that had taken place. We looked at one serious incident report held on the data base within Access Healthcare. The records for this event showed that patients had been informed of the incident as soon as reasonably practicable, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.

Serious incidents were reported externally to the clinical commissioning group (CCG), NHS England and coroner where appropriate. Clinical decisions were discussed at the monthly nurses meetings, fortnightly managers meetings and at the twice yearly clinical governance meetings. Significant events were also reviewed by the board to ensure appropriate actions had been taken.

The practice also monitored trends in significant events and evaluated any action taken.

We saw evidence that lessons had been shared and action taken to improve safety in the practice. For example:

- The organisation had identified trends at Mount Gould and Trelawny where there was no clear audit in place for prescriptions being collected from pharmacies or patients. An audit process had subsequently been introduced to ensure clear records were maintained when a prescription was collected.
- At Ernesettle a trend of significant events had highlighted difficulties in patients trying to contact the practice by phone. It was identified that this was due to the increase in demand for telephone triage appointments as well as reduced numbers of administrative staffing being able to answer the calls due to sickness/holiday absence or resignations. As a result of this the organisation had increased the availability of appointments able to be booked online from a specific "online appointment" slot type to encompass all routine GP appointments and HCA appointments as well as some dressing appointments with practice nurses. Furthermore following an extension to the contract, the telephony system in place was identified as not being fit for general practice and therefore provisions were made to purchase a new, modern system with voice recording that would enable call queuing for patients so that they were not constantly met with an engaged tone.

Practice staff responded promptly when identifying issues at the practice. For example, the organisation had inherited the service with a large number of notes that required summarising. This is where new patients arrive at the practice and need their medical histories and medicine lists added to the patient record used at the practice. Access healthcare had significantly reduced the number of notes that required summarising and had used a system to prioritise higher risk patients (older patients, patients with long term conditions and younger patients). However, there had been some notes identified as containing errors which had been identified and were in the process of being addressed. For example, as this process was taking place the lead nurse had identified a smaller than usual number of children and babies attending for routine immunisations. An immediate investigation and patient search was conducted which highlighted an error in summarisation of patient records The search highlighted a number of children and babies who had missed vaccine boosters and immunisations. At the time of inspection these were in the process of being administered and

scheduled. The issue had also resulted in a further audit of these records to ensure appropriate information for other patients had been summarised correctly. So far the audit had not highlighted any further issues.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to minimise risks to patient safety.

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. We were given examples where staff had raised safeguard alerts with the local safeguarding teams. There was a lead member of staff at each site and within the Access Healthcare organisation for safeguarding.
- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child protection or child safeguarding level three. Nurses were trained to level two and front line staff to level one.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a 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 maintained appropriate standards of cleanliness and hygiene.

- We observed each site to be clean and tidy. Access Healthcare subcontracted cleaning to an external company. There were cleaning schedules in place although completed records to show these had been conducted were not produced. This shortfall had also been highlighted by the recent infection control audits. There were clinical equipment cleaning schedules in place with records maintained to confirm monitoring of this process.
- The lead nurse was the infection prevention and control (IPC) clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an IPC protocol and staff had received up to date training. Annual IPC audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result. For example, at Ernesettle the audit had highlighted that no written records were maintained by the cleaning contractors.

The arrangements at all three sites for managing medicines, including emergency medicines and vaccines, in the practice minimised risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal).

- There were processes for handling repeat prescriptions which included the review of high risk medicines. Repeat prescriptions were signed before being dispensed to patients and there was a reliable process to ensure this occurred. The practice carried out regular medicines audits, with the support of the local clinical commissioning group pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. A practice pharmacist had recently been employed and was due to start work on 4 July 2017 at the practice to assist with these systems and processes. Blank prescription forms and pads were securely stored and there were systems to clearly monitor their use, including for high risk medicines. One of the nurses had qualified as an Independent Prescriber and could therefore prescribe medicines for clinical conditions within their expertise. They received mentorship and support from the medical staff for this extended role. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. Health care assistants were trained to administer vaccines and medicines and patient specific prescriptions or directions from a prescriber were produced appropriately.

There are five GP practices within the Access organisation and we reviewed eight personnel files for staff working across this organisation. Four of these were for the staff at Mount Gould, Ernesettle and Trelawney. We found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.

Good

Are services safe?

Monitoring risks to patients

There were procedures for assessing, monitoring and managing risks to patient and staff safety.

- There was a health and safety policy available.
- The practice had an up to date fire risk assessment and carried out regular fire drills. For Mount Gould, Trelawney the drills had been conducted in June 2017. There were designated fire marshals within the practice. There was a fire evacuation plan which identified how staff could support patients with mobility problems to vacate the premises.

All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order. For example, at all three sitesthe last PAT (Portable electrical testing) had been performed in May 2017. Equipment calibration had been performed. At Mount Gould this had been done in February 2017, Trelawney and Ernesettle October 2016.

The practice had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).

- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system to ensure enough staff were on duty to meet the needs of patients.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- Each site had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines and equipment we checked were in date and stored securely. Records were maintained of these checks.
- The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records. Any updates were communicated through the programme of clinical meetings.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. However, due to the changes in management there were no combined completed QOF figures for 2016/17. (QOF is a system intended to improve the quality of general practice and reward good practice). The practice manager and business intelligence team provided a 'How's my driving' document which showed data collected so far this year. This showed that, performance for diabetes related indicators was lower than the CCG and national averages. For example, the number of patients with a blood pressure recorded within normal ranges was 80% compared with the target of 93%. The practice had recently identified this figure was lower than expected. They had then performed an additional clinical audit at the beginning of June 2017 to identify patients with existing diabetes or at risk of developing diabetes who had not been correctly coded (identified on the computer system) as having appropriate tests in line with NICE guidance performed. It was noted that activity for testing was 'very good' but there were some failures to code for diabetes meaning data was lower than expected and a low uptake of documentation of lifestyle advice on exercise. The action included sharing the audit in the next clinical governance meeting and communication to all the staff group. Letters were written to patients with pre-diabetes with advice on exercise and an offer of seeing the GP about medicines as an option. Staff told us the uptake of these GPs appointments had already been positive.

The team had also reminded locum GPs to code the tests correctly and continued to receive support from the hospital consultant and diabetic specialist nurse. The audit was planned to be repeated in a years' time but data had already indicated significant rise in data capture.

We looked at exception reporting. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). Figures were low across all clinical domains. For example, for dementia outcomes there had been no exceptions. Where exception reporting figures were recorded we noted clear and appropriate reasons for exception reporting.

This practice was not an outlier for any QOF (or other national) clinical targets.

There was evidence of quality improvement including clinical audit:

- We looked at five clinical audits commenced in the last two years, three of these were completed audits where the improvements made were implemented and monitored.

The majority of these audits had involved audits of medicines. A practice pharmacist had recently been employed and was due to start work on 4 July 2017 at the practice to assist with these systems and processes.

We also saw other examples of audits routinely performed by practice staff which included hand washing audits, infection control audits, cervical smear audits, referral audits and contraceptive complication audits.

Effective staffing

Evidence reviewed showed that staff had the skills and knowledge to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff and locum staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.

Good

Are services effective?

(for example, treatment is effective)

- There was a long standing team of nursing staff who told us they received effective support from the lead nurse, GPs and practice management.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions and those performing roles including ear syringing, vaccinations, and minor surgery. For example, the nurse practitioner at Mount Gould performed minor surgery and contraceptive services and demonstrated supervision, education and updates in these additional skills.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- Staff said they had access to the training, education and updates they needed and were supporting in accessing this. The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs and nurses. All staff had received an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- We found that the practice shared relevant information with other services in a timely way, for example when referring patients to other services.
- Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Information was shared between services, with patients' consent, using a shared care record. Patients who were living at the local care home which specialised in dementia care had personal care plans and treatment escalation plans which were jointly reviewed with the care home staff, GPs and Consultant for elderly care from Derriford Hospital.

Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs. For example, the nurse practitioner and GP attended a local care home for patients living with a diagnosis of dementia to ensure care plans and treatment escalation plans reflected the needs of patients.

We spoke with two visiting healthcare professionals who said communication and working relationships with practice staff was positive.

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. End of life care plans and treatment escalation plans were completed for all palliative care patients. Practice staff, with patient consent, shared details with out of hours (OOH) GP service via special patient messages on Adastra (computer patient record system). Palliative care patients were discussed at clinical meetings which take place weekly or monthly depending on sites.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.

Good

Are services effective?

(for example, treatment is effective)

- The process for seeking consent was obtained using in built coding systems on the computer system and using paper documents which were then scanned onto patient records.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and signposted them to relevant services. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation and sexual health.

Staff were consistent in supporting people to live healthier lives through a targeted and proactive approach to health promotion and prevention of ill-health. For example developing an information leaflet and providing an app giving advice, support and guidance for common childhood illnesses including sepsis giving patients greater control and information of when to seek advice.

The overall uptake for the cervical screening programme across all three sites was 71%, which was lower than the national average of 81%. The staff team recognised this percentage was low and had commenced an audit and spot check had highlighted that these women had received appropriate screening but the information had not been correctly captured (coded) on the computer system. For example, a sample of 10% of patient records confirmed that all had either received appropriate screening but had been incorrectly coded or were long term non responders and signed disclaimers.

There was a policy to offer telephone or written reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer. There were failsafe systems to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were comparable to CCG/national averages. For example, rates for the vaccines given to under two year olds ranged from 92% to 93% and 80% for five year olds compared to the national expected coverage of vaccinations which was 90%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

During our inspection we observed that members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Patients could be treated by a clinician of the same sex.

All of the 41 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with a total of 19 patients across all three sites who told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comments highlighted that staff responded compassionately when they needed help and provided support when required. Patients added that additional rooms were available for when more privacy was required.

The views of external stakeholders were positive and in line with our findings. For example, we spoke with two visiting health care professionals who said the feedback from patients was good about the practice and added that they had not heard any complaints about the care and treatment, apart from getting through on the telephone.

Care planning and involvement in decisions about care and treatment

Patients told us 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 available to them. Patients told us there was sometimes a wait to see the GP but added that this was not usually a problem because they too were given sufficient time and not rushed. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

We spoke with two young people were treated in an age-appropriate way and recognised as individuals.

Because of changes in organisation there were no results from the national GP patient survey. However, we saw that the practice provided facilities to help patients be involved in decisions about their care:

- Staff told us that interpretation services were available for patients who did not have English as a first language.
- The Choose and Book service was used with patients as appropriate. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website. Support for isolated or house-bound patients included signposting to relevant support and volunteer services.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 220 patients as carers. This was divided up as this was reflective of 58 patients at Mount Gould, 95 patients at Ernesettle and 67 at Trelawny (approximately 2% of the combined practice list). Written information was available to direct carers to the various avenues of support available to them and included on carers notice boards at each site.

Staff told us that if families had experienced bereavement, their usual GP contacted them to offer advice on how to find a support service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood its population profile and had used this understanding to meet the needs of its population:

- The practice offered longer appointments for those that needed them.
- Home visits were available for patients and patients who had clinical needs which resulted in difficulty attending the practice.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions. There were early and ongoing conversations with these patients about their end of life care as part of their wider treatment and care planning.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- The practice sent text message reminders of appointments, screening and test results. The text also gave information about how patients could cancel appointments in an attempt to reduce the DNA (did not attend) rate.
- Patients were able to receive travel vaccines available on the NHS. Those only available privately/were referred to other clinics for vaccines available privately.
- There were accessible facilities, which included a hearing loop, and interpretation services available. All three sites had level access and automatic doors at the main entrances.
- The practices at Mount Gould and Ernesettle had passenger lifts which improved access for patients and staff. The site at Trelawny was on one level.
- Other reasonable adjustments were made and action was taken to remove barriers when patients find it hard to use or access services. For example, hearing loops were in place for hearing impaired patients.

Access to the service

The practice was open between 8.30am and 1pm and 2pm and 6pm. Outside of these times calls were transferred to the out of hours provider via NHS 111 as an agreed contract. There was a designated bypass telephone line for professionals to use between 8am and 6pm. In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments on the same day with either the duty GP or nurse practitioner were available for patients that needed them.

There were no results from the national GP patient survey for this practice. However, we spoke with 19 patients and read 41comment cards which showed a mixed response in regard to patient's satisfaction with how they could access care and treatment. For example:

- At Mount Gould we spoke with six patients and received 29 comment cards. All six patients and seven of the comment cards expressed dissatisfaction with the telephone system and getting to see the same GP or GP of the patients choice.
- At Ernesettle we spoke with eight patients and received four comment cards. Two of the comment cards expressed dissatisfaction with the telephone system and access to getting appointments with the GPs. Of the eight patients we spoke with all said they had experienced difficulties getting through on the telephone and had not been able to access an appointment with the same GP. Staff explained this situation had been identified and a new telephone system was in the process of being installed. The Patient Participation Group had also suggested that the surgery advertise the number of no shows (DNA) as the number at its peak was 500 in one month. As a result of implementing this request, as well as a dedicated DNA cancellation line (due to difficulties accessing the practice by telephone during busy periods) the number had reduced down to 150. Staff added that the dedicated line for cancelling appointments had been crucial to the success of this decreasing figure and was included on all appointment text message reminders sent to patients at the point of booking.
- At Trelawny we spoke with five patients and received eight comment cards. All patients were complimentary about getting an appointment and access to the GP and nursing team.

The practice had a system to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- We saw that information was available to help patients understand the complaints system. For example, posters within the waiting areas, patient leaflets and information on the practice website.

We looked at two complaints received in the last 12 months from the Access Health Care group. All complaints had been managed centrally at the Access Health Care headquarters. Both had been dealt with in an open and transparent way, although one did not contain evidence that patients had been contacted when a delay in response occurred. Lessons were learned from individual concerns and complaints and also from analysis of trends and action was taken to as a result to improve the quality of care. For example, a complaint had been received about clinical care and attitude of the GP. This had been investigated by a doctor within the organisation to ensure clinical care and treatment had been appropriate. The patient had received an apology, explanation of the investigation findings.

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 practice had a mission statement which was displayed in the waiting areas and staff knew and understood the values.
- The practice had a clear strategy and supporting business plans which reflected the vision and values and were regularly monitored.

There had been a period of uncertainty over the last year causing staff to feel unsettled and the recruitment of more permanent staff GPs an issue. All staff spoken with said the leadership over this time had been supportive and informative. Staff said Access Healthcare staff had been supportive and sympathetic to these changes. Representatives from the Patient participation group (PPG) at Ernesettle confirmed that in recent times there had been problems regarding who would be running the practice but at all times the patients had been kept informed as much as possible of the changes.

Governance arrangements

The practice management teams were open about the shortfalls identified since Access Healthcare had taken over the leadership. Action plans were in place for these issues and timescales had often been met. We saw evidence that action plans demonstrated assessment of risk and priority: For example:

- Identification of shortfall of childhood immunisations and subsequent prompt investigation, audit and action taken to ensure all children had received up to date immunisations and boosters
- Ongoing backlog of patient record summarisation which had reduced over the last 15 months and managed according to risk.

However, there was still a level of risk present. For example;

- There were no GP partners at the three sites meaning that the overview of clinical responsibility roles were not consistent across all three sites and were sometimes monitored by non-clinical staff.
- Coding of specific screening tests, conditions and illnesses were not always consistently recorded over all three sites meaning GPs and nurses often took longer to see a full accurate patient history. This also meant information capture did not always reflect the care provided by staff.

The overarching governance framework supported the delivery of the strategy and good quality care. This outlined the structures and procedures and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. GPs and nurses had lead roles in key areas. For example, staff were aware of who the safeguarding leads were in the organisation.
- Practice specific policies were implemented and were available to all staff on the organisation intranet site. These were updated and reviewed regularly. Any updates were communicated through clinical newsletters, staff meetings and clinical meetings.
- A comprehensive understanding of the performance of the practice was maintained. Practice meetings, clinical meetings and governance meetings were held which provided an opportunity for staff to learn about the performance of the practice.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were appropriate arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.
- We saw evidence from minutes of a meetings structure that allowed for lessons to be learned and shared following significant events and complaints.

Leadership and culture

Staff explained that the organisation provided clear leadership and were accessible when needed. On the day of inspection the practice leadership demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. Staff told us they prioritised safe, high quality and compassionate care and told us the GPs and practice manager were approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).This included support

Are services well-led?

Good

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

training for all staff on communicating with patients about notifiable safety incidents. The management team and organisation encouraged a culture of openness and honesty. We found that the practice had systems to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.
- The practice kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure and staff felt supported by management.

- The practice held and minuted a range of multi-disciplinary meetings including meetings with district nurses and social workers to monitor vulnerable patients. GPs, where required, met with health visitors to monitor vulnerable families and safeguarding concerns.
- Staff told us there was an open culture within the practices and organisation and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- Staff said they felt respected, valued and supported, particularly by the practice management staff and organisation management team. All staff were involved in discussions about how to run and develop the practice, and the management team and organisation encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients and staff. It proactively sought feedback from patients through the patient participation group (PPG) and through surveys and complaints received. The PPG met regularly, carried out patient surveys and submitted proposals for improvements to the practice management team. For example:

- At Mount Gould feedback from the PPG had resulted in additional car parking spaces being secured for patients and the introduction of a drinking water dispenser in the waiting area.
- At Ernesettle the PPG suggested that the practice advertise the number of no shows (DNA) and introduce a dedicated DNA cancellation telephone line resulting in the number of DNAs reducing to 150. This information had been rolled out across all three sites.
- At Trelawney the PPG chair had suggested changes in the front desk and reception function as they felt there was a confidentiality issue. The staff trialled it and had good feedback from staff and patients. The PPG had also suggested that in winter evenings the pathway was very dark this had resulted in a new light being erected as requested.

Feedback from the NHS Friends and Family test, complaints and compliments received had also resulted in changes which included the introduction of a new telephone system which was in the process of being installed.

Feedback from staff had also resulted in changes. For example, the appointment system at Ernesettle was changed following consultation with the clinical and administration teams to include a duty GP system to ensure that a minimum of two GPs were working at all times with additional provision at peak times. At Mount Gould feedback from staff about the prescribing process was unclear. This was raised at a team meeting. A medicines management course was provided and the repeat prescription process reviewed and rolled out to all staff.

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management and said the practice management staff and management team within Access Healthcare were approachable and supportive. Staff told us they felt involved and engaged to improve how the practice was run and said there was a sense of mutual respect shared across the practices and teams.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. Staff were aware of the organisational situation but added that there had not been any restrictions on the educational development of staff or services. Staff said they were in the process of discussing how to extend services in the future including the development and further identification of carers and military veterans.