Dr Jonathan Carlson and Dr Amanda Beasley

Quality Report

Tothill Surgery
10 Tothill Avenue
St Judes
Plymouth
PL4 8PH
Tel: 01752 315594
Website: N/A

Date of inspection visit: 16/10/2014
Date of publication: 19/03/2015

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

Dr Jonathan Carlson and Dr Amanda Beasley (also known as Tothill Surgery) is a GP practice providing primary care services for people in Plymouth. It provides services from single premises located at Tothill Surgery**,** 10 Tothill Avenue, St Judes**,** Plymouth, PL4 8PH where we carried out an announced inspection on 16 October 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.
- 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.
- Repeat prescriptions were available within 24 hours of being requested.

We saw several areas of outstanding practice including:

- The practice maintained patient registration for its transient population of homeless people and travellers because it recognised these patients were likely to return to the area. Home visits were made to all patients regardless of where they lived including patients with no fixed address who were rough sleeping.
- Patients were able to collect repeat prescriptions within 24 hours of requesting them.

In addition the provider should:

Summary of findings

- Ensure annual checks such as professional body registration (e.g. GMC) and medical insurance are made for locum GPs, who are used regularly for the practice.

We found Tothill Surgery to be a well led practice that was safe, caring, effective and responsive to patients' needs. The practice showed they had an open, fair and transparent manner with the management team showing clear leadership. The patients, clinical and administrative staff we spoke with all told us they felt the practice was well led, approachable and demonstrated good working relations with other health care professionals, organisations and local authorities.

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. Our findings at inspection showed that systems were in place to ensure that all clinicians were up to date with guidance from the National Institute for Health and Care Excellence (NICE) and other locally agreed guidelines, and used it routinely. We also saw evidence to confirm that these guidelines were positively influencing and improving practice and outcomes for patients. The practice was using innovative and proactive methods to improve patient outcomes and it linked with other local providers to share best practice. 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.

Are services caring?

Good

The practice is rated as good for providing caring services. Feedback from patients about their care and treatment was consistently and strongly 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. It reviewed the needs of its local population and engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said

Summary of findings

they found it easy to make an appointment with a named GP and that there was continuity of care. The practice provided an open access service (no bookable appointments) every morning with no time constraints on consultations. Patients reported this service meant they could be seen on the same day. Patients were also able to request a same day call back from a GP.

The practice had good facilities and 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. There was a clear leadership structure and staff felt supported by management. 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 recently formed a virtual patient participation group (PPG) to represent patient views. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Outstanding ☆

Tothill Surgery is rated as outstanding for the care of older people. The practice had a high percentage of its patient population in the 65 and over age group. Overall the older people we spoke with were appreciative of the GPs and nurses. They felt they were treated in a professional and kindly manner. Nursing staff were trained and experienced in providing care and treatment for medical conditions affecting older people. They were able to refer people to local services such as dementia screening clinics and falls assessment clinics. The practice was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. The GPs and nurses were able to book longer appointments if they considered this was appropriate to meet the patient's needs

People with long term conditions

Good

Tothill Surgery is rated as good for the care of people with long-term conditions including asthma, diabetes, and heart disease. Patients were able to book routine appointments with a practice nurse or a GP for monitoring and treatment of their conditions. Nationally reported data showed that some outcomes for patients were below expectation for long term conditions however nursing staff and GPs explained this was due to a high prevalence of patients with a learning disability who also had one or more long term condition and there may be other issues such as difficulty with swallowing or refusal of needles. Nursing staff and GPs were opportunistic about offering health screening checks to patients with long term conditions when they attended the practice. The practice routinely carried out reviews, audits and checks to ensure patients with long term conditions were receiving the correct medicines. The practice followed best practice guidance to ensure it was meeting and protecting patients' medical needs and complying with other statutory guidance issued by, for example, the Department of Health. There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. Longer appointments and home visits were available when needed.

Families, children and young people

Good

Tothill Surgery is rated as good for the care of families, children and young people. Effective systems were in place for GPs to seek advice and support if they had concerns about a child, and to raise a safeguarding alert with a place of safety if they felt the child was in immediate danger of harm. Practice staff were observant for signs of

Summary of findings

neglect. GPs and health visitors monitored these families with escalation to the relevant agencies as needed. They were also aware of the impact of poverty on patients and provided signposting information to various services. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. We saw good examples of joint working with midwives and health visitors. Emergency processes were in place and referrals were made for children and pregnant women whose health deteriorated suddenly and we saw evidence of this.

Working age people (including those recently retired and students)

Good

Tothill Surgery is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Outstanding

Tothill Surgery is rated as outstanding for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including people with dementia and those with a learning disability. It had carried out annual health checks for people with a learning disability. It offered longer appointments for people who were vulnerable. Home visits were made to patients needing this, regardless of where the patient was residing.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff 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)

Outstanding

Tothill Surgery is rated as outstanding for the care of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning

Summary of findings

for patients with dementia. The practice had good access to the local mental health team for support and urgent same day appointments for assessment if these were needed. Staff had received training on how to care for patients with mental health needs and dementia.

The practice provided a daily open access service which had no time constraints on consultations, and the GPs offered longer than average booked consultation periods. The practice did not have a high proportion of missed appointments mainly for these reasons. Afternoon booked appointments were monitored and GPs made follow up calls for missed appointments particularly if they considered the patient was vulnerable and or was known to have mental ill health. The GPs considered longer consultations provided an improvement in patient safety.

The practice offered support and treatment for patients of all ages experiencing mental ill health. The GPs told us they were pleased with the local mental health services which were effective and responsive to referrals for adults and children.

Summary of findings

What people who use the service say

We spoke with five patients. These were patients of all ages including a young person, parents of children registered at the practice, working age and recently retired people and older people. We also spoke with a representative of the Patient Representation Group (PRG) who was a patient and carer of a patient registered at the practice too. We received nine comments cards completed by patients. Patients rated the practice and its staff highly. They said they were treated with respect and appointments were not rushed. Patients who had been with the practice for many years said staff knew their medical history and they felt safe. Patients told us they were given the right medicines for their conditions, they knew what their medicines were for and it was reviewed regularly. Those with complex or long-term conditions said communication between hospital consultants and the practice was good and GPs were prompt in follow-up appointments.

The practice offered an open access service in the mornings. Patients could present at the practice for opening time at 8.30am or telephone the practice at 8.45am to request a time slot to be seen the same morning. Patients could also telephone later in the morning to request a call back by a GP. Some patients expressed frustration about the appointments system. They said it was good because they could be seen on the day however the drawback was the likelihood of a long wait. A minority of patients did not like this system because they considered it was unreliable if they had commitments with pressure on their time.

Patients told us that sometimes it was difficult to get through to the practice in the mornings because the lines were busy. We were also told that if they had called later than 9am, sometimes the reception staff were too rigid and had told patients they would have to telephone again the following day at 8.45am. They could not make a next day appointment. Patients told us this was too inflexible if they had woken up later than 8.30am, not expecting to be unwell.

The practice manager told us that although the afternoon sessions were for booked appointments, some slots were reserved in the event a patient needed to be seen urgently. Receptionists were able to flag up the reason for a request to see a GP.

We received comments that the waiting room was tired and needed redecoration. The practice manager told us that this was planned however there had been a delay due to a leak in the roof. The premises were rented and repair of the roof was the responsibility of the landlord.

Areas for improvement

Action the service SHOULD take to improve

The provider should:

- Ensure annual checks such as professional body registration (e.g. GMC) and medical insurance are made for locum GPs, who are used regularly for the practice.

Outstanding practice

The practice maintained patient registration for its transient population of homeless people and travellers because it recognised these patients were likely to return to the area. Home visits were made to all patients regardless of where they lived including patients with no fixed address who were rough sleeping.

Patients were able to collect repeat prescriptions within 24 hours of requesting them.

Dr Jonathan Carlson and Dr Amanda Beasley

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 advisor.

Background to Dr Jonathan Carlson and Dr Amanda Beasley

Dr Jonathan Carlson and Dr Amanda Beasley (also known as Tothill Surgery) provide care and treatment to approximately 2,300 patients living in Plymouth. They are a two partner practice. One GP works full time at the practice. The other GP works three sessions with additional sessions for DVLA assessments and is also a GP appraiser. There are two practice nurses and one health care assistant who also works some sessions as an administrator. Four reception and administration staff are trained to work in reception and administration roles. They rotate between jobs to ensure all areas are covered.

The practice has 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.

The practice provides services from Tothill Surgery**,** 10 Tothill Avenue, St Judes**,** Plymouth PL4 8PH where we carried out an announced inspection on 16 October 2014.

The practice opening times are 8.30am to 6pm Monday, Tuesday, Thursday and Friday, and 08.30am to 12pm on Wednesdays. The practice closes on Wednesday afternoons from 12pm. Out of hours services are provided by another organisation except Wednesday afternoon when the practice is closed and this is provided by a GP from the practice.

The practice has recently formed a virtual patient representation group (PRG). This is a group that acts as a voice for patients at the practice.

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.

Detailed findings

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 16 October 2014. During our visit we spoke with a range of staff including both GPs, the practice manager, a practice nurse, the healthcare assistant and one of the 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.

Following the inspection we spoke with five patients who used the service, carers and family members of patients by telephone. We reviewed nine 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 used a range of information to identify risks and improve patient safety. For example, National Institute of Health and Care Excellence (NICE) guidance and reminders were cascaded by the GPs to relevant staff. These were also discussed at clinical governance meetings to ensure consistent information was given to patients. One example we were given was an agreed approach to prescribing anti-virals when there were bird flu concerns. National patient safety alerts were also cascaded and discussed with staff. For example an alert for a medicine that was cause for concern if given to patients with a cardiac risk. GPs and staff were aware of the concerns and this informed their future practice when reviewing patients taking this medicine or before prescribing this medicine.

The staff we spoke to were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. Reception staff told us that if they had any concerns about a patient they would immediately contact a GP. A nurse described the action taken and measures put in place by the practice and social services for two different incidents when it was recognised that the patients concerned were at risk of receiving inappropriate care and treatment for their diabetes.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last 12 months. These as well as discussions with individual staff showed the practice had managed patient safety consistently over time and was able to show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice has a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of significant events from July 2013 up to October 2014. The practice manager and both 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 three monthly. The GPs and practice manager considered that as a small team they were able to deal with things very quickly. Communication to the whole practice team was also easy as this too was small. Any verbal information given to staff was followed up by email and staff were given the opportunity to raise questions.

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 of poor communication between secondary care services and the practice. As a result of the incident which was discussed at the clinical governance meeting, the practice policy was changed regarding informing all staff via an internal email alert replacing a more general information sharing method.

Reliable safety systems and processes including safeguarding

Patients said they felt safe at the practice and were confident about raising any concerns. One of the GP's was the lead named GP for safeguarding vulnerable adults and children. Both GPs were trained to the appropriate advanced level. The staff told us they had received safeguarding training. Training records confirmed this. Staff knew who the safeguarding lead was and demonstrated knowledge of how to make a patient referral or escalate a safeguarding concern internally. Details of agencies to contact were displayed where staff could easily find them.

The practice had a chaperone policy in place and the nursing team acted as chaperones when required. One member of the reception team had also undertaken chaperone training. The practice had recognised from this training that as good practice, the chaperone should document what they had witnessed as well as the clinician recording what had happened. The practice manager also recognised that if a staff member acted as an interpreter for a patient, it would be good practice to record this on the patient record.

Quarterly meetings were held at the practice for all staff and other health and social care professionals were invited, for example, health visitors, community nurses, community matron and the palliative care team. The purpose of these meetings was to review and discuss more vulnerable patients and those with complex health care needs. Patient deaths and significant deaths were also discussed at these meetings. The practice staff said they had good working relationships with the community teams who were able to drop in to the practice to speak with the GPs if they particular concerns about a patient and needed a quick

response. The GPs were able to maintain good continuity of care for their patients because they generally knew them when speaking with other health care professionals. The GPs also had a good rapport with the Mental Health Team.

Medicines Management

Medicines were managed at the practice by clear systems of receipt, administration, storage and disposal of medicines, immunisations, emergency medicines and emergency equipment.

We looked at the storage facilities for medicines and immunisations. These were organised, clean and not over stocked. There was a clear system about how vaccines were received at the practice and stored including storage temperatures of vaccines being maintained. This ensured the safe arrival and storage of vaccines. There were systems in place so that checks took place to ensure products were kept within expiry dates. Those medicines which required refrigeration were stored in secure fridges. Fridge temperatures were monitored twice daily to ensure that medicines remained effective.

Emergency medicines were available. These were stored correctly and were easily assessable in an emergency. Medicines were in date. Emergency equipment was also in order and easily accessible. Weekly and monthly checks of the defibrillator and other equipment were recorded.

GPs carried a limited stock of medicines in their bags. These were checked by the nursing team to ensure the medicines were in date.

Patients were supplied their medicines with patient information leaflets and also given specific advice should it be required. Patients were satisfied with the repeat prescription processes. They could use the box in the practice, send an e-mail or telephone the practice in the afternoon to request a repeat prescription. The GPs were responsible for prescribing medicines at the practice. There were no nurse prescribers employed. We saw that prescription pads were stored safely. All prescriptions were authorised by the prescriber. The GPs showed us a system that gave a clear audit trail to identify which GP had prescribed any medicine and if an additional medicine had been added. Nurses could access this however they could not add medicines. If a medicine review was overdue, the patient was initially given a warning. Further action, such as not issuing a repeat prescription until the patient attended for a review, would depend on the medicine.

Cleanliness & Infection Control

The practice had a lead for infection control. This staff member had undertaken further training to enable them to provide advice on the practice infection control policy and disseminate it to other staff. The treatment and consulting rooms appeared clean, tidy and uncluttered. We saw that staff all knew where items were kept and worked in a clean environment. The nurses maintained a policy of cleaning the treatment room twice daily and emptying the bins. They told us this ensured which ever nurse next used the room, they knew they would be coming into a clean working environment. Disposable single-use instruments were used for all clinical examination, tests and minor operations. There was a log for recording when equipment was cleaned and by whom. The clinical rooms were stocked with personal protective equipment (PPE). This included a range of disposable gloves, clinical cleaning wipes, aprons and coverings. This reduced the risk of cross infection between patients. This was checked daily by the healthcare assistant to ensure sufficient supplies were in place. We saw antibacterial gel was available in the reception area for patients to use upon entering the practice.

There was an appropriate system for safely handling, storing and disposing of clinical waste with records to support this. Clinical waste was stored securely in a dedicated secure area within the practice whilst awaiting its weekly collection by a registered waste disposal company. This weekly collection included the sharps bins.

The practice did not carry out Legionella testing. The practice manager confirmed that this required an assessment and if it was necessary, this would be put in place.

There were cleaning schedules in place. A contracted cleaning company was responsible for the non-clinical areas and the nurses cleaned the treatment room. This was overseen by the practice manager There were no recorded audits of cleaning however any issues or concerns were flagged as soon as possible with the cleaning company or nurses. Treatment rooms had hard flooring to simplify the clearance of spillages. Staff were clear about their responsibilities in relation to infection control. For example, staff knew where to find policies and procedures and were aware of good practice guidance. Nursing staff were responsible for managing clinical spillages and had a spillage kit available for use. They told us they had received

updated training in infection control and this was repeated annually. They also attended practice nurse forums where any practice changes such as infection control were disseminated.

All staff said they were offered a vaccination against the risk of Hepatitis B and we saw this was checked and recorded.

Equipment

The practice had systems in place to monitor the safety and effectiveness of equipment. For example, fridge temperatures were taken and recorded to show that correct storage temperatures were maintained for vaccines and medicines. Effective checks were performed on oxygen, gases and the defibrillator. We saw all portable appliance testing, water safety, fire safety and other equipment checks had been undertaken with appropriate certification, calibration and validation checks in place.

Staffing & Recruitment

Staff told us there were suitable numbers of staff however due to long term sickness this was having repercussions for staff with the redistribution of work. Staff felt that nonetheless they maintained a team work approach and helped one another to cover the hours. Only one GP and the healthcare assistant worked full time. Staff and nurses reported that communication was good with an internal messaging system and regular telephone contact with each other to hand over. They said they worked in well-informed teams. They all told us that the GPs were very approachable and preferred issues were brought to them for discussion rather being bottled up causing anxiety and possible friction. We were told that when a staff vacancy arose, the practice took this as an opportunity to review staffing levels and structure. All the staff were invited to contribute ideas. The practice manager explained about plans to share her workload with another member of staff taking responsibility for an overview of the reception team and covering when she was absent.

Recruitment procedures were safe. Staff employed at the practice had undergone the appropriate checks prior to commencing employment. Clinical competence was assessed at interview. Once in post staff completed an induction which consisted of ensuring staff met competencies, understood about the requirements of Caldicott (protecting the confidentiality of patient and service user information and enabling appropriate information sharing) and information governance (confidentiality and data protection), and were aware of emergency procedures.

Criminal records checks were performed for GPs, nursing staff and all administrative staff.

The practice had clear disciplinary procedures to follow should the need arise. Nursing and Midwifery Council (NMC) status was completed and checked annually for the registered nurses to ensure they were on the professional register to enable them to practice as a registered nurse.

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. We found that although appropriate checks were made before the locum's first session at the practice, these checks were not repeated annually for locum GPs who worked at the practice on a regular basis. This left the practice open to risk of financial implications if the locum GP had not renewed their indemnity cover as well as no assurance they were on the professional register to enable them to practice as a GP.

Monitoring Safety & Responding to Risk

The practice had a system in place for reporting, recording and monitoring significant events. There were procedures in place to assess, manage and monitor risks to patient and staff safety. The practice ensured the appropriate checks and risk assessments had been carried out. There was a system in place to inform the practice manager of any concerns staff had about the premises or equipment.

The management team had procedures in place to manage expected absences, such as annual leave, and unexpected absences, for example staff sickness. Annual leave for staff was managed to ensure there were sufficient reception staff on duty each day.

The practice had a suitable business continuity plan that documented the practice's response to any prolonged period of events that may compromise patient safety. For example, this included computer loss and lists of essential equipment. We were told about an unexpected absence of a GP which was logged as a significant event and reported to NHS England. The practice responded efficiently and effectively by putting into action its continuity plan to

Good

Are services safe?

ensure patients requiring urgent consultation were able to see or speak with a GP. We saw an email sent to the practice from NHS England recognising and commending how well the practice had managed the situation.

Arrangements to deal with emergencies and major incidents

Appropriate equipment was available to deal with an emergency, for example if a patient should collapse. One of the GPs was the practice first aider and the first point of call in an emergency. The staff we spoke with all knew where to locate the equipment and emergency medicines. The emergency equipment was well maintained and effective checks were in place to ensure emergency medicines and equipment did not expire. We saw the practice had a small supply of medicines for emergency use. Records showed these were checked regularly to make sure they were safe to use. All staff, including administration staff had received training in emergency procedures.

We were told about a recent incident when a patient had collapsed in the practice. Staff described rapid intervention and care of the patient by the GP whilst awaiting an ambulance.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinical staff were familiar with current best practice guidance accessing guidelines from NICE and from local commissioners. We saw email alerts were sent to staff when new guidelines were disseminated. These were also discussed at clinical governance meetings to ensure consistent information was given to patients. The staff we spoke with and evidence we reviewed confirmed any actions agreed at these meetings were aimed at ensuring that each patient was given support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate.

GPs and nursing staff told us lead roles in specialist clinical areas such as diabetes, heart disease and asthma were agreed. The practice nurses supported this work and this allowed the practice to focus on specific conditions. For example, the GP lead for asthma would see these patients if the lead practice nurse considered they needed a review due to something identified during an appointment with the practice nurse. Generally one practice nurse saw all the patients with respiratory conditions however if there was anything non routine and this practice nurse was not available, the patient would be seen by the other practice nurse.

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 referral rates to secondary and other community care services for all conditions.

There was no evidence of discrimination when making care and treatment decisions. Interviews with GPs and nursing staff showed that the culture in the practice was that patients were referred on need and that age, gender, race and disability were not taken into account in this decision-making. The GPs at the practice were male and female.

Management, monitoring and improving outcomes for people

The practice has a system in place for completing clinical audit cycles. Examples of clinical audits included the use of anti-diabetic medicines in terms of their effectiveness and the use of inhibitors. This had been re-audited and there were plans for a further audit. Another audit looked at an end of life care to see whether patients who had died had had a treatment escalation plan (TEP) in place. This audit had been repeated and found there had been a slight increase in the use of TEPs. Audit results were shared by paper copy with clinical colleagues.

One GP at the practice undertook minor surgical procedures in line with their registration and NICE guidance. These minor surgical procedures included joint injections and simple excisions or incisions. These were not audited however the GP monitored if there was any post-operative infection or complication. Patients were routinely asked to return for a follow up appointment when their histology report was discussed and action taken as appropriate We discussed with both GPs and the practice manager about undertaking clinical audits of minor surgery including complication, infection and histology reports on their results and to use this in their learning.

External referrals were screened by GPs, physiotherapists and consultants. The GPs said they may receive alternative suggestions or advice about things they could do prior to the patient being seen by the clinic where they were being referred. This helped with patients being seen in a timelier manner because for example, up to date recent test results were available to the consultant and the patient did not have to be deferred whilst these were completed.

The practice was part of a pilot for a diabetic virtual service. This had required the practice to complete a review of all its patients diagnosed with diabetes to look at how well patients' needs were meeting, for example, NICE guidelines and prescribing guidance. The review showed that the practice had a high number of patients with very high HbA1c test results. [This is a blood test that measures the amount of glucose being carried by the red blood cells in the body over two to three months.] However a high percentage of the patient population who had diabetes were people with a learning disability. The results were therefore considered with other factors such as patients who had difficulty with swallowing or refused injections. The review found that out of 110 patients, 40 had either very high or very low risk scores. From this group of 40 patients, only one patient's care was not meeting the relevant guidance.

Good

Are services effective?

(for example, treatment is effective)

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support, medical emergencies, infection control and information governance. Staff also attended mandatory updates appropriate to their role, for example, wound care and flu. Both 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). The practice manager kept of record of appraisals and revalidation dates. Both GPs and the practice manager underwent a 360 degree annual appraisal. For one GP this had recently included feedback from clinical colleagues, local GPs, consultants and an undertaker.

All staff underwent an annual appraisal with a GP and the practice manager. These were all completed between October and December and identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example attendance at a study day about diabetes. The practice also paid for the practice nurses to belong to and attend the practice nurse forums which enabled the nurses to receive clinical updates, attend training programmes organised by specialist teams and access the community hospitals' training programme.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, wound care and vascular checks. They also had extended roles for example seeing patients with long-term conditions such as diabetes and respiratory conditions. They were also able to demonstrate that they had appropriate training to fulfil these roles.

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. For example, the GP who reviewed all out of hours contact including 111 calls where patients were given advice then filed these under clinical or administration if there was no clinical detail. We saw there were between 20 to 30 patients who had clinical information uploaded to help manage their care. For example, a frequent caller with chest pain had a protocol in place for an ambulance and a GP assessment. We saw that blood results were checked every morning before surgery and INRs (International normalisation ratio - a way of measuring how fast a patient's blood clots) were checked every Friday evening. If any concerns or a new patient were identified, the out of hours service would be notified. The nurses saw patients for INR blood tests however the GPs chased the blood results and contacted the patient the following day with the results.

Routine referrals were dealt with within two to three days. Anything urgent the GPs contacted the relevant department by telephone. We were told, for example, about an urgent appointment set up for a patient requiring a scan and a subsequent appointment with the GP to review the results of the scan with the patient the following day after the scan. 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.

There were examples of effective working relationships with the rapid access clinic for patients who may need hospital admission. The GPs were able to escalate referrals and in most cases the patient was seen the following day. The GPs told us they were pleased with the mental health services and drug and alcohol support services. They said they were effective and responsive to referrals for adults and children. The nursing team said they had good working relationships with the tissue viability nurse and the diabetes team. The practice had established links with the local safeguarding teams for both children and adults.

The practice was part of a pilot to provide a diabetic virtual service. On initial diagnosis patients were referred to the local hospital to a structured education programme. We were told this had a three to four week referral waiting list.

Good

Are services effective?

(for example, treatment is effective)

Another local practice had set up an evening drop-in session and Tothill Surgery was working with this practice and others to set up groups across the city for patients (these groups were not offered at the hospital). The dietician attended these groups which provided an invaluable source of information for patients about how to manage their diabetes.

The practice held multidisciplinary team meetings every three months to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and health visitors. Minutes of these meetings showed how valuable the meetings were to the sharing of information between all the different teams. We noted that the last meeting was held in February 2014. We were told that this was a city wide matter and no meetings had taken place for six months due to CCG funding being stopped to pay for locum staff cover whilst they attended these meetings. The practice showed us that interaction and processes had continued however bringing the groups all together had stopped. The practice had reached a resolution if funding was not resumed however the CCG had conceded these meetings were important. The next meeting was arranged for November 2014.

The practice had established links with the local safeguarding teams for both children and adults.

Information Sharing

The practice used different electronic systems to communicate with other providers. For example, there was a shared system with the 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, such as the Choose and Book system. (The Choose and Book system 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 referrals were rarely returned as they understood the information they were required to provide when completing the referral form.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record, Microtest, to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice.

Patients felt involved in planning their care and those we spoke with confirmed the GP had explained treatment options so they understood them. One GP told us how they explained the options to the patient and also provided printed leaflets with information for the patient to take away to read. The GP said for less urgent cases, they offered the patient an opportunity to come back or request a telephone consultation if they wanted to discuss treatment options further.

Nursing staff explained how they gave patients verbal information about treatment and choices and they were able to show they had recorded a summary of the issues discussed. Patients were given a printed instruction sheet about medicines they were prescribed. This enabled them to be clear about the dose, particularly when their medicines regime needed frequent adjustment. Nursing staff and GPs were clear about the need to ensure that if the patient lacked mental capacity, decisions were made in the patient's best interest in accordance with the Mental Capacity Act 2005. They were able to give examples and talked knowledgably about the challenges, considerations and process required. The practice had a high prevalence of patients with a learning disability. One of the nursing team told us how they found using familiarisation with patients who had a learning disability was very successful. For example, gaining consent to administer vaccines or to take blood. The nursing staff told us if a patient refused a blood test or a vaccine, they would record this in the patient record but they would not go ahead with the procedure. We were told about examples where they were pressurised by care staff accompanying the patient however they still refused to carry out the procedure without the patient's consent. This was also documented on the patient's record and if there were further concerns for the patient, the patient was referred to the GP.

Good

Are services effective?

(for example, treatment is effective)

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.

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. Both GPs had completed home visits to all these patients to complete a care plan with them, about five percent of the patient population. The care plans included communication, mobility and if aids were needed to move around, and resuscitation. The care plans were reviewed regularly to check if there had been an A&E admission or a hospital admission. The patient also received a three monthly telephone call to check that all was well if the patient had not been seen medically during this period. Recalls were set up on the practice patient record system however as care plan recalls were still in their infancy, this was still being trialled. The practice had also set up a dedicated telephone line in the event of an emergency and other healthcare staff needing to contact the practice.

Patients were able to complete advanced decision forms. Treatment escalation plans (TEP) were considered as part of care reviews, involving the patient's family when possible, as a means of avoiding hospital admission where possible. We saw one example where the GP had arranged for an independent mental capacity advocate (IMCA) to be present with a patient living in a care home who had no family to represent their best interests. On this occasion with an IMCA present, the GP had been able to formalise a TEP with the patient.

Nursing staff requested verbal consent from parents before giving baby immunisations. A practice nurse told us they had recently introduced written consent. Immunisations for babies and children were not given unless a parent was present or the parent had provided written consent for another family member to attend the clinic with the child. The practice nurse said they would still contact the parent to ensure they wanted the immunisation to go ahead, and this was recorded on the child's patient record.

Health Promotion & Prevention

The practice invited certain new patients, for example, patients with a complex health history, registering with the practice 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 Stop Smoking adviser. Her role was to support patients who had a smoking habit by offering help and advice to stop smoking. On the first appointment the HCA completed an assessment with the patient to identify the most suitable product would be best prescribed for the patient to use. This recommendation went directly to the lead GP for review, agreement and to write a prescription. This enabled the patient to leave the practice the same day with a prescription. On subsequent visits, the HCA was able to print repeat prescriptions and these were passed directly to the lead GP again for review with the HCA and to sign if considered appropriate for the patient to continue with the medicine. We were told that the HCA had recently won a competition run in the Plymouth area for the highest success rate.

The practice offered a full range of immunisations for children, travel vaccines 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 caring?

Our findings

Respect, Dignity, Compassion & Empathy

Patients were treated with dignity and respect at Tothill Surgery. Patients told us they felt all conversations with GPs and nursing staff were confidential and told us conversations were always conducted behind a closed door.

The practice reception desk had a sliding glass panel that reduced the likelihood of staff conversation or telephone calls dealt with by the receptionist could be overheard by anyone in the waiting area. Doors were kept closed during consultations. There were curtains in consultation rooms which provided a screen between the treatment couch and door to maintain privacy and dignity. To ensure against interruption, and promote patient confidence during treatment or examination, the treatment room door could be locked from the inside should the patient wish. Within consultation and treatment rooms, windows were obscured with blinds or curtains to ensure patient's privacy.

The feedback we received from patients and carers showed that the staff and GPs knew the majority of their patients. Patients felt able to go to the practice without fear of stigmatisation or prejudice. 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.

The practice registered patients who had no fixed address and examples we were given demonstrated that the GPs were prepared to visit patients regardless of where they were residing. This included patients who were rough sleeping. The practice also had a protocol of retaining homeless patients regardless of where they were in and around Plymouth. The GPs explained that the time to transfer patient records and then to have them transferred back when the patient returned was too long. They recognised these patients were vulnerable and more likely to have patterns of behaviour that would bring them back into the locality. They said they needed to be able to provide continuity of care and, if necessary, quickly.

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. We were shown an example of a report on an incident where there had been a potential breach of confidentiality. The report showed the root cause of how this had happened was identified and the likely impact and potential harm. This was assessed as minimal as the information was not judged to be overly sensitive. However, action was taken to ensure the staff involved were informed. All staff received training and awareness was raised about maintaining confidentiality. There was also evidence of learning taking place as staff meeting minutes showed this has been discussed.

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 and those we spoke with confirmed the GPs and nursing team explained treatment options so they understood them. Patients also felt reassured and had confidence in the clinical teams. 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 if their health need was less urgent, they were given time to take away written information to read and consider options available to them. Patients were able to request a GP telephone call if they had any questions after their consultation and the proposed treatment options.

The nursing team explained how they gave patients verbal information about treatment and choices and they were able to show they had recorded a summary of the issues discussed. They were clear about the need to ensure that if the patient lacked mental capacity, decisions were made in the patient's best interest in accordance with the Mental Capacity Act 2005. They were able to give us several examples and recognised that the practice patient population had the highest prevalence in Plymouth of patients with a learning disability and also older people. Both these groups were patients most likely to have one or more long term condition with often complex and multiple

heath care needs. The nursing team told us they had a challenging role at times however they talked confidently about how they managed the challenges, always keeping the patient at the centre of the care and treatment process and giving due consideration to the patient's circumstances.

The practice held a list of all its patients who were over the age of 75 years. They were allocated to a named GP, although patients could express a preference. Care plans had been written by the GPs with the patient and these were reviewed three monthly or sooner if needed. Patients were able to complete advanced decision forms. Treatment escalation plans (TEP) were considered as part of care reviews, involving the patient's family when possible, as a means of avoiding hospital admission where this was feasible.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke and the comment cards we received were very positive about the emotional support provided by the practice and they rated it highly in this area. All the patients and carers said they had received help to access support services to help them manage their treatment and care when it had been needed.

One patient described how during a particularly difficult time with poor deterioration in their health, no matter how many times they telephoned the practice, a GP always called them back. They told us that the GPs had looked further than the presenting health concern resulting in referrals to secondary care for treatment. Patients also told us results for urgent tests and X-rays were followed up with the hospital straight away.

We were given several examples where action taken was over and above patients' expectations or the expectations of the GP contract. For example, for older patients who were medically deemed to be in crisis, the health and social services operated an intervention team. We were told the GP would drop off the paperwork in person to the team office and speak with the therapist to ensure there was a formal handover of the patient to the team. Another example was helping and supporting patients who were subject to domestic violence and abuse. Referrals were made to the domestic violence team however if there was an answerphone or an unclear response from the team, a referral was also made to the women's refuge. In most cases patients were seeking support to manage their lives. The GPs tried to empower them as well as making referrals to appropriate agencies that could continue the support and enable patients to move forward with their lives. We saw that this care and support applied to both female and male patients in violent relationships. A further example was follow up home visits to patients recently discharged from hospital.

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.

The GPs offered an open door access to community teams as well as their own staff. Macmillan nurses, for example, were able to pop into the practice to discuss any patient about whom they may have concerns. The GPs were able to follow up on these informal discussions as needed. Likewise the nursing team and the reception staff were able to speak with a GP if they were concerned about a patient's well-being both physically and mentally.

Young people were able to see a GP without their parents accompanying them from the age of 14 years. The GPs said this varied according to how well they knew the child and the reason for the consultation. They also said they would telephone the parents if they had any concerns. For any invasive treatment such as vaccinations, a parent or carer was required to be present to give written consent.

Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. We did not speak with any patients who had had bereavement, however the nursing team told us about feedback they had received from patients who had found this positive and helpful.

Prior to Christmas both GPs visited all their older patients living in care homes. On Christmas Eve the senior partner reviewed or contacted vulnerable patients who were considered to be at risk to ensure measures were in place in case help was needed over the Christmas holiday period.

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 received feedback from a few patients that particular reception staff were not always helpful and could be too rigid on occasions. One example was a parent worried about their sick child who telephoned the practice after the allocated time to attend the open access service. Contrary to practice protocol, they were told they were too late to bring the child in to see a GP. We raised this with the practice manager as a matter of concern. We were told that the practice policy was to always see children on the same day and worried parents could call at any time to request for the child to be seen or an urgent telephone consultation. The practice manager agreed this would be brought to the attention of all reception staff to ensure they were aware and followed the practice protocol and policy. Also to ensure that all the reception staff were responsive to patients when they telephoned the practice.

Tackling inequity and promoting equality

The practice had ramped access from the main street to the front door. Inside two GP consultation rooms and the treatment room were on the ground floor, providing level access for patients with limited mobility or using a wheelchair. A room was provided for mothers who wished to breastfeed their baby. This room was also offered to anyone who preferred not to sit in the waiting room, for example, if they became agitated or anxious sitting with people they did not know, and for parents with young children. This room was on the first floor and required people to be able to use stairs. One carer told us the patient was a wheelchair user and they were able to wait with their carer in an area outside the waiting room on the ground floor that was quiet. They said this was an acceptable arrangement.

The practice had patients who were unable to communicate in English. For those where this was the case, arrangements were made with the patient's family who, with consent of the patient, had agreed to interpret and translate. One of the reception staff provided a Polish translation service on request and consent from the patient. This was considered to be a benefit especially for assisting the nursing team with translation about diabetes and vascular conditions, and to gain consent for blood tests. It was recorded in the patient record if a translator was used and who this was. The practice also had access to a language service for other languages if a family member or friend was not suitable or available.

Access to the service

The practice opened from 8.30am to 6pm Monday, Tuesday, Thursday and Friday, and 08.30am to 12pm on Wednesdays. It was closed on Wednesday afternoons from 12pm when an out of hours services was provided by a GP from the practice. On other days and weekends the out of hours service was provided by another organisation. Patients could call between 11.30 am and 12pm to request a GP telephone consultation, after 11am to request a repeat prescription and after 2pm for test results. Every morning was an open access service whereby patients either presented at the practice before 10am and were given a numbered ticket on a first come first served basis. Alternatively patients could telephone between 08:45 and 9.30am. The receptionist was able to give these patients a time slot for when the patient needed to be at the practice based on the number of patients already waiting to be seen. Patients knew that these times were approximate and that because consultations were not a fixed amount of time, they could be waiting for an unknown period of time.

The GPs told us this system had evolved over many years in response to patient feedback and staff suggestions. They told us the telephone consultations had also been running for many years. We received very positive feedback from the patients we spoke with who had requested a call-back. They also all confirmed that they knew they would receive a same day call.

There were also 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.

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 to frail to go into the practice and also to patients who needed to see a GP and who lived in local care homes.

Good

Are services responsive to people's needs?

(for example, to feedback?)

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 either GP. One carer we spoke with told us how they regularly needed an urgent appointment for their relative who had multiple and complex health conditions. They said they knew they could telephone the practice and their relative would usually be seen by a GP within two hours.

We were told that the practice had offered extended opening hours to try to meet the needs of working patients. This had been unsuccessful as it was not used by the patients for whom it was intended. We were told that patients had not objected when it was stopped.

The practice is located in an area close to the university. We were told that the university had its preferred GP practice however students were able to register at Tothill Surgery if this was their preference. Staff said they tended to see more students as temporary residents because they were previous patients and had returned home on a visit.

The practice did not have a high proportion of missed appointments mainly for the above reasons. Afternoon booked appointments were monitored and GPs made follow up calls for missed appointments particularly if they considered the patient was vulnerable and or was known to have mental ill health.

Listening and learning from concerns & 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. It was practice policy that the written permission was required for anyone complaining on behalf of someone else. A notice displayed in the waiting area gave advice about how a concern or complaint should be raised. Reception staff were familiar with the complaints procedure. They confirmed that the practice manager was involved if an issue brought to their attention at the reception desk. The five patients we spoke with felt confident that they could raise any concerns or complaints without fear of victimisation.

We looked at complaints received by the practice over the past 24 months. None had been received since April 2014 and four complaints were received during the period April 2013 to March 2014. These were handled satisfactorily and in a timely manner.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review which had identified that all the complaints were administrative errors. Lessons learned from individual complaints had been acted on and staff concerned were made aware of any issues as well as raising general awareness to all staff.

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. We found details of the vision and practice values were part of the practice's strategy and four year business plan. The practice vision and values included its aim to provide safe and effective continuity of care to all patients registered at the practice in an unbiased manner, and its objectives were to provide accessible services, to provide safe services, to promote health and wellbeing and to empower patients to be involved in managing their own healthcare.

We spoke with four members of staff including the practice manager and they all knew and understood the practice values and their responsibilities in relation to these.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on any computer within the practice. We saw that staff had signed to confirm they had read policies and procedures when they started work at the practice and also any new policy and procedures introduced to the practice.

There was a clear leadership structure with named members of staff in lead roles. For example, the senior partner was the lead for safeguarding and for Caldicott. We spoke with four members of staff including the practice manager 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.

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. They told us that because it was a small team it was possible to manage things quickly. Communication was also easier for the same reason and information given to staff verbally was followed up by email and staff were given the opportunity to raise questions.

The practice nurse told about the nurses' forum run locally and of which both practice nurses were members. 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 an audit of a medicine as part of the medicine optimisation scheme was undertaken in June 2014. This was reviewed in August 2014 which identified there was consistent practice. A further review was planned for early 2015. We also saw previous audits about cost effective and appropriate prescribing, and future agreed audits of asthma inhalers as well as anti-psychosis in patients with dementia. Audit results were shared with colleagues via paper copies.

The practice had robust arrangements for identifying, recording and managing significant events. The practice manager showed us the log, which addressed a range of issues, such as failure of electronic prescribing. We saw these were referred to secondary care, NHS England and other organisations and agencies as needed. They were discussed at clinical governance meetings and used as learning for all staff. Risk assessments were carried out where risks were identified and action plans were produced and implemented. For example, communication about an unexpected death which had been poor. This was discussed at a practice clinical governance meeting and as a consequence policy regarding how staff were informed of a death of a patient was changed.

The practice had identified its most vulnerable groups of patients and had increased patient access to a GP or practice nurse to improve patient safety. This included offering an open access service daily, and longer appointments for booked consultations.

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.

Are services well-led?

Good

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

The practice manager was responsible for human resource policies and procedures which included disciplinary procedures, induction policy and management of sickness. Staff we spoke with knew where to find these policies if required.

Practice seeks and acts on feedback from users, public and staff

The practice had gathered feedback from patients through GPs undertaking Patient and Colleague surveys as part of their appraisal, and from complaints received however there were no other formal methods of collecting patient feedback.

The practice had an active patient representation group (PRG). This had recently been formed and was still in its infancy. The PRG was a virtual group kept together via emails sent from the practice manager.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. One member of staff told us that they had asked for specific training around wound care and this had happened. Staff told us they felt involved and engaged 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 & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at two staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and attendance at learning events.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients. For example an issue relating to a request for a GP to prescribe a medicine usually prescribed by a consultant. Action taken was recorded, NHS England was informed and this was discussed with staff at a clinical governance meeting for future learning.