Dr P Taylor and Partners

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

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Hanham Surgery and Oldland Surgery on 21 April 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, well led, caring and responsive services. It was also rated good for providing services for the population groups.

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- The practice used innovative and proactive methods to improve patient outcomes, working with other local providers to share best practice. For example, through the One Care Consortium.
- Patients said they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the Patient Participation Group (PPG).
- The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand
- The practice had a clear vision which had quality and safety as its top priority. A business plan was in place, was monitored and regularly reviewed and discussed with all staff. High standards were promoted and owned by all practice staff with evidence of team working across all roles.

We saw areas of outstanding practice including:

Summary of findings

- The practice had participated in training to access the local scheme Identification and Referral to Improve Safety (IRIS) for domestic violence against women.

However there were areas of practice where the provider needs to make improvements

Importantly the provider should

- Ensure that Drug misuse instalment prescriptions are checked and this is recorded on patient's notes.
- Introduce a system to provide an audit trail for medicines used in the practice.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

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 report incidents and near misses. For example, we were shown the investigations and significant event analysis that had been carried out and the action taken. We found the practice used every opportunity to learn from internal and external incidents, to support improvement. Information about safety was highly valued and was used to promote learning and improvement across the staff team. Risk management was comprehensive, well embedded and recognised as the responsibility of all staff. Staffing levels and skill mix was planned and reviewed so that patients received safe care and treatment at all times. The arrangements in place to safeguard adults and children from abuse reflected relevant legislation and local requirements. The practice had robust arrangements in place to respond to emergencies and other unforeseen situations such as the loss of utilities.

Are services effective?

Good

The practice is rated as good for providing effective services. Our findings at inspection showed systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence guidelines and other locally agreed guidelines. We also saw evidence to confirm that these guidelines were positively influencing and improving practice and outcomes for patients. Information about the outcomes of patients' care and treatment was routinely collected and monitored through auditing and data collection. For example, the practice undertook clinical audits to evaluate the effectiveness of prescribed treatment. We found staff had the skills, knowledge and experience to deliver care and treatment and had undertaken additional training to support this. The practice was using innovative and proactive methods to improve patient outcomes such as accessing the GP Infrastructure Fund for a new telephone system to improve patient access.

Are services caring?

Good

The practice is rated as good for providing caring services. We observed a strong patient-centred culture. Patients' feedback about the practice said they were treated with kindness, dignity, respect and compassion while they received care and treatment. Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieve this. We were told by all the patients we spoke with how much they valued the relationship

Summary of findings

they had with the nurses, GPs and practice. Patients told us they were treated as individuals and partners in their care. We found the practice routinely identified patients with caring responsibilities and supported them in their role. Patients told us their appointment time was always as long as was needed, there was no time pressure, and patients were reassured that their emotional needs were listened to empathetically.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice had initiated positive service improvements for its patients. It acted on suggestions for improvements and changed the way it delivered services in response to feedback from the patient participation group (PPG). It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. We found urgent and routine appointments were available the same day. The practice had good facilities and was equipped to treat patients and meet their needs. We found the practice was involved with providing integrated health services. The practice was responsive to changing risks including deteriorating health and wellbeing or medical emergencies. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly 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 with quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff. There was a clear leadership structure and staff felt supported by management. There were systems in place to monitor and improve quality and identify risk. High standards were promoted and owned by all practice staff and teams worked together across all roles. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. The practice carried out proactive succession planning. There was a high level of constructive engagement with staff and a high level of staff satisfaction. The practice gathered feedback from patients using new technology, and it had a very active patient participation group (PPG).

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. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. Patients over 75 had a named GP. We found integrated working arrangements with community teams and the community nurse for older people who completed frailty assessments which identified risk. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. The practice worked closely with carers and one GP took the lead responsibility for this with specific clinics for carers. All older patients had a six monthly review of their prescribed medicines to ensure that prescribing was effective and met the latest guidance. They had a GP who took lead responsibility for coordinating their work in care homes; each care home had a dedicated GP. In addition, one of their managers was the primary point of contact with carers' organisations .

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management. Patients diagnosed with long term conditions were supported through a range of clinics held for specific conditions such as, asthma, chronic obstructive pulmonary disease (COPD) and heart failure. Weekly nurse led clinics were available to patients diagnosed with diabetes. Patients at risk of hospital admission were identified as a priority for appointments. Longer appointments and home visits were available when needed. All of these patients had a structured annual review to check their health and medicine needs were being met. For those people with the most complex needs, a named GP worked collaboratively with relevant healthcare professionals to deliver a multidisciplinary package of care. Patients receiving palliative care, those with cancer diagnosis and patients likely to require unplanned admissions to hospital were added to the Out of Hours system to share information and patient choice with other service providers.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk,

Summary of findings

for example, children and young people who had a high number of A&E attendances. 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, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses. For example, compliance with the national child immunisation programme was checked regularly by the nursing team. The practice ensured parents were contacted if a child had not attended the practice for immunisations and there were systems to monitor and follow up children when they did not attend hospital appointments. We saw routine audits were carried out by the practice to highlight non-attenders for immunisations and other appointments. The lead GP for children liaised closely with the community health visiting services and provided support with the education of young mothers in dealing with child health issues running 'Poorly Poppets' sessions at local clinics.

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 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. For example, specific treatments were available at any time such as intrauterine device insertion. 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. The practice offered extended hours, weekend appointments and telephone consultations. Immunisation clinics were provided on Saturdays so as to allow working parents to attend with their children

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 and those with a learning disability. It had carried out annual health checks for people with a learning disability, sometimes this took place at their homes. The practice had a high number of patients with a learning disability, some of whom had very complex needs, and had developed innovative ways of working to ensure health needs were met. For example, we heard how the practice and carers worked together on care pathways for patients with epilepsy.

Summary of findings

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. The practice staff had attended training about domestic violence and the practice had participated in the IRIS scheme (Identification and Referral to Improve Safety) for women.

The practice hosted a substance misuse project worker and GPs worked with them to provide shared care for patients who abused substances or alcohol.

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 regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. Patients could access mental health support services at the practice. The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND and SANE. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training about how to care for people with mental health needs and dementia.

The practice undertook an audit of patients with dementia to ensure services and support were appropriate. It carried out advance care planning for patients with dementia and worked with patients and families to ensure any DNAR (do not attempt cardiopulmonary resuscitation) decisions were appropriate and kept under review.

Summary of findings

What people who use the service say

We spoke with patients visiting the practice and we received 1comment card from a patient who visited the practice. We also looked at the practices NHS Choices website to look at comments made by patients. (NHS Choices is a website which provides information about NHS services and allows patients to make comments about the services they received). We also looked at data provided in the most recent NHS GP patient survey and the last Care Quality Commission inspection report about the practice.

The comments made by patients were very positive and praised the care and treatment they received. For example, patients had commented about being involved in the care and treatment provided.

The practice had a patient representation group (PRG), the gender and ethnicity of group was representative of the total practice patient population. Information about the group was available on the website and in the practice. We spoke with patients who had been involved with the patient consultation groups who gave us examples of how closely they worked with the practice for service improvement. For example, we were told how the practice had asked them to 'test drive' on the initiative taken to open (patient) access to medical records. This was trialled at the end of last financial year with a number of members of the PPG.

The practice had also commenced their current 'friends and family' survey.

Areas for improvement

Action the service SHOULD take to improve
Action the provider SHOULD take to improve:

- Ensure that Drug misuse instalment prescriptions are checked and this is recorded on patient's notes.
- Introduce a system to provide an audit trail for medicines used in the practice.

Outstanding practice

- The practice had participated in training to access the local scheme Identification and Referral to Improve Safety (IRIS) for domestic violence against women.

Dr P Taylor and Partners

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included two GPs, a second CQC inspector and a nurse specialist advisor.

Background to Dr P Taylor and Partners

Dr P Taylor and Partners are located in a suburban area of South Gloucestershire between Bath and Bristol. They have approximately 21,000 patients registered who are of a White British ethnicity.

The practice operates from two locations:

Hanham Surgery

33 Whittucks Road

Hanham

Bristol

BS15 3HY

And

Oldland Surgery (branch surgery)192 High StreetOldland CommonBristolBS30 9QQ

The practice is made up of nine GP partners and sixteen salaried GP working alongside three nurse practitioners, eleven qualified nurses and six health care assistants (all female). The practice has a personal medical service contract and also has some additional enhanced services such as unplanned admission avoidance. The practice is open on Monday to Friday 8am – 6.30pm for on the day urgent and pre-booked appointments.

The practice does not provide out of hour's services to its patients, this is provided by Bris Doc. Contact information for this service is available in the practice and on the website.

Patient Age Distribution

0-4 years old: 5.23%

5-14 years old: 10.29%

15-44 years 36%

45-64 years old: 27.21%

65-74 years old: 10.83%

75-84 years old: 7.56%

85+ years old: 2.87%

With 0.67% of patients in a residential or nursing home, the practice holds regular clinics at a local care homes. Practice population ethnicity indicates a population of black and ethnic minorities to be 0.82%.

Information from NHS England indicates the practice is in an area of low deprivation with a lower than national average number so patients with long standing health conditions, caring responsibilities and high levels of employment. The patient gender distribution was male 49.78% and female 50.22%.

The provider has additional contracts for the provision of GP services within secure settings; they also provide occupational GP services for armed forces personnel.

Detailed findings

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme 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 (Regulated Activities) Regulations 2015, 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 data, this relates to the most recent information available to the CQC at that time.

How we carried out this inspection

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 21 April 2015 and visited both sites. During our visit we spoke with a range of staff including GPs, nurse practitioners, nurses, reception and administrative staff and the management team, and spoke with patients who used the service. We observed how people were being cared for and talked with carers and/or family members and reviewed anonymised treatment records of patients.

The team spent time at both sites; we reviewed the premises and observed the day to day running of the sites. We also spoke with the community nurse team based at the Hanham site.

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 whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Good

Are services safe?

Our findings

Safe track record.

The practice had robust systems in place for the safety of patients and staff who worked at the service. For example, we saw that the health and safety issues for the practice were delegated to a trained member of staff who took responsibility to ensure safety audits were carried out. The practice ensured that all staff were trained to a level of competence which kept patients safe. We saw records of training which indicated staff had been updated to understand and implement the latest guidance for treatment such as how to deal with anaphylaxis (a sudden allergic reaction that can result in rapid collapse and death if not treated). We spoke with the GPs and clinical staff at both sites and reviewed information about both clinical and other incidents that had occurred at the practice. We were given information relating to 28 incidents which had occurred during the last 12 months. These had been reviewed under the practice's significant events analysis process. These incidents included a delayed referral and prescribing errors. We read each event was categorised and all were reviewed for any trends; where changes in practice had been highlighted we were able to confirm they had been implemented. When events needed to be raised externally, such as with other providers or other relevant bodies, this was done and appropriate steps were taken, such as providing information to the NHS England in response to a complaint. National patient safety alerts and other safety guidance was checked and circulated to the relevant staff.

The practice manager told us how comments and complaints received from patients were responded to. Staff we spoke to were aware of their responsibilities to raise concerns, and how to report incidents or events. We were told about the open culture in which staff felt they were listened to and responded to in a way which promoted learning rather than blame. We read minutes of meetings which evidenced that the above information was recorded and reviewed by the partners at the practice to prevent recurrence.

Learning and improvement from safety incidents.

There was a range of systems in place for recording incidents and taking appropriate action to improve systems and processes so that further incidents were prevented. For example, the practice had a system in place for reporting, recording and monitoring significant events. The records we reviewed showed that each clinical event or incident was analysed and discussed by the GPs, nursing staff and senior practice management. When we spoke with other staff we were told that the findings from these Significant Events Analysis (SEA) processes were disseminated to other practice staff if relevant to their role. We found the level and quality of incident reporting showed the level of harm and near misses, which ensured a robust picture of safety.

We saw from summaries of the analysis of these events and complaints which had been received that the practice put actions in place in order to minimise or prevent reoccurrence of events. For example, where a prescribing error had occurred, the GPs discussed what actions had been taken, and should the issue arise again what could be done differently.

Staff reiterated to us that promoting and improving the service for patients was their primary concern. We found staff were open and transparent and fully committed to reporting incidents and near misses. We were told how all staff were encouraged to participate in learning and to improve safety as much as possible and this meant they were confident to report concerns when things went wrong. For example, we found significant event and complaints were reported by both administrative and clinical staff.

We also looked at accident and complaint records and saw that incidents had been recorded and if needed escalated to significant events which demonstrated the practice listened and had the intent to learn and make improvements. Safety alerts and information relating to patients was available on the electronic records for staff to readily access.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We asked members of medical, nursing and administrative staff about their most recent training. We were told that all non-clinical staff at the practice had been provided with training for both safeguarding vulnerable adults and children. There was a team of three lead GPs for

safeguarding children and adults at the practice. All of the GPs had been trained to level three for safeguarding children and we saw GPs had completed a range of modules to achieve this.

There were comprehensive systems to keep people safe, which took account of current best practice. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities. Staff knew how to share information, record information about safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible. All staff we spoke to were aware who the leads were for safeguarding adults and children and who to speak to in the practice if they had a safeguarding concern.The practice had participated in the local scheme Identification and Referral to Improve Safety (IRIS) for women.

A proactive approach to anticipating and managing risks to patients was embedded and was recognised as the responsibility of all staff. There was a system to highlight vulnerable patients on the practice's electronic records. Staff were alerted with 'pop ups' when patients records were accessed. This included information to make staff aware of any relevant issues when patients attended appointments for example, children who were subject to child protection plans. We saw the practice produced a list each month of vulnerable adults and children and ensured they were correctly recorded on the electronic record system.

The lead safeguarding GP was aware of the patients who had been assessed as vulnerable children and adults. Information from the GPs demonstrated good liaison with partner agencies such as the police and social services and they participated in multi-agency working. Regular discussions took place with health visitors in regard to children identified as at risk. The community nurses told us they had been invited to attend meetings at the practice on a weekly basis when any 'at risk' adults could be discussed. We were given an example of where staff had acted proactively to prevent potential abuse by reporting unsafe staffing levels to meet resident need, at a care home.

There was a chaperone policy, which was visible on the waiting room and in consulting rooms. There was a chaperone protocol for staff which set out clear steps staff should take and how chaperone support should be recorded in patient's records. Additional training had been provided to some of the staff in order to provide chaperone support to patients. Patients told us they were aware of the availability of chaperones if they required it. Staff told us request for chaperones had increased and so they were able to put their training into action.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. We found the practice staff followed the policy.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of according to waste regulations. We found there was limited evidence in place that the practice could demonstrate a clear audit trail of which medicines had been used, when and for whom. The practice maintained a small supply of controlled drugs which were stored and monitored according to regulation.

The practice had a GP who was the prescribing lead and they were able to describe the processes in place for reviewing prescribing at the practice. We saw records which noted the actions taken in response to a review of prescribing data. For example, audits of older patients with dementia who were prescribed anti-psychotic medicines. The practice had acted on safety warnings about medicines which meant that the patient record system was searched to identify patient who had been prescribed specific medicines and who may be at risk, such as those of child bearing age who were prescribed sodium valproate. The identified patients were reviewed and a decision made about continuation of the medicine. The GP lead also liaised with the CCG pharmacist for the optimisation of medicines and cost effective prescribing. The practice had a dedicated prescription administrator who developed considerable expertise with the processes for repeat medicines and changes following patients discharge from hospital.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses had received

appropriate training to administer vaccines. The nurse practitioners were qualified as independent prescribers and received regular supervision and support in their role as well as updates in the specific clinical areas of expertise for which they prescribed.

There was a system in place for the management of high risk medicines, which included regular monitoring that followed the national guidance. We found appropriate action was taken based on the results.

Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely. There was a protocol for repeat prescribing which followed the national guidance and was implemented in practice. The protocol complied with the legal framework and covered all required areas. For example, how staff who generated prescriptions were trained and how changes to patients' repeat medicines were managed. Staff told us this helped to ensure that patients' repeat prescriptions were still appropriate and necessary. This was overseen by the patient's GP so that they would be aware of any discrepancies and changes to medicines. We were told when patients were discharged from hospital the scanned document was then sent to the appropriate GP for checking and authorisation of any medicine changes.

We looked at the processes for managing prescribing of medicines which required Drug misuse instalment prescription. We saw that one GP took the lead and liaised closely with the drug project worker about prescribing for these patients. However, in the absence of the lead GP, the duty GP took responsibility for signing these prescriptions. We found there was no documented evidence that the prescription, which was generated by the administrator, had been checked against the patient record. This could potentially lead to error made by the administrator being missed. The practice told us their process would be changed immediately in order to mitigate this risk.

Cleanliness and infection control

We observed the premises at Hanham to be clean and tidy. However, it was noted that the cleanliness at the Oldland site was not of the same standard. We saw there were cleaning schedules in place and cleaning records were kept. We found there had been an audit of cleanliness at the Oldland site where it had been noted the level of cleanliness was unsatisfactory and the situation was being monitored to ensure improvement. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a nurse with lead responsibility for infection control who had undertaken training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the practice had carried out audits and that any improvements identified for action were completed on time. For example, cleaning all non-disposable privacy curtains and screens.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, the storage and use of personal protective equipment including disposable gloves, aprons and coverings. We also saw records were kept of staff training and updates, and immunisation status. The policies and protocols were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control guidance. For example, when carrying out intimate patient examinations or taking blood samples. There was also a policy for needle stick injury and staff we spoke with knew the procedure to follow in the event of an injury. We read about an incident of potential cross infection which demonstrated how the procedure had been used. The practice had reviewed the incident and made immediate changes to procedures.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with wall mounted hand soap, hand gel and hand towel dispensers were available in treatment rooms. Taps were elbow operated and work surfaces had sealed and rolled edges to reduce the risk of cross infection accumulating. Waste bins were foot operated in clinical area to maintain hygiene standards.

Staff were able to tell us about and show us the systems for safe disposal of clinical waste. The practice had a suitable contract with a clinical waste company.

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in

contaminated water and can be potentially fatal).We saw records for the practice that confirmed regular checks were carried out according to the policy which reduced the risk of infection to staff and patients.

Equipment

The practice was suitably designed and adequately equipped. The buildings and their fixtures and fittings were owned by the practice who employed specialist contractors as needed. The health and safety manager also had a planned maintenance programme in place. Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records such as certificates that confirmed this.

All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer.

Other equipment such as fire extinguishers were also serviced and tested annually according to fire safety requirements. Fire alarms and emergency lighting were also regularly tested and serviced to meet the recommendations for fire safety. The organisation had 11 trained fire marshals who implemented evacuation procedures in an emergency. The security alarm was also tested annually.

There was a range of appropriate seating in the waiting areas such as lower chairs for children and chairs with arms to aid less mobile patients to stand; all appeared in safe condition. Adjustable examination couches were available in most consultation but all treatment rooms, which had appropriate privacy screening.

Staffing and recruitment

We were able to see evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. We looked at employee files for the most recent recruits and confirmed this had been implemented. When looking at the staff files we saw there was an induction programme appropriate to the role of the staff member. One recently appointed GP told us that their induction had taken two weeks and they were able to learn all about the organisation and visit the sites where services were provided. The senior partner emphasised the importance of investing sufficient time to introduce new employees to the practice and to ensure they were the 'right person', as the demands from a multi- site provision were very different from a normal GP practice. We were told that all new employees were subjected to a probationary period after which time feedback from all department managers was collated for the partners meeting and then considered for a decision.

All staff were given a handbook; we also read the induction information for new GP starters which contained really useful information about who did what in the practice and where to find things such as the GP correspondence trays. We also saw the comprehensive induction for new nursing staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. The clinical manager demonstrated the rota system in place for all the different staffing groups and sites which ensured that the correct staff, in sufficient numbers, were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. The practice had a process in place called 'Doctor Plot' which predicted GP usage over the year. This enabled the practice to book known locum GPs in advance which ensured consistency of care was maintained as far as possible. We found the practice mainly used one agency for GPs because they provided assurance that the required recruitment checks and training had been completed.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. This was reflected in the comments made by patients about the staff at the surgery. The clinical manager showed us records to demonstrate that actual staffing levels and skill mix met with planned staffing requirements.

Monitoring safety and responding to risk

Good

Are services safe?

The practice had comprehensive systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the buildings, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. There was evidence that health and safety was included in the induction of all new staff. The practice held training certificates for staff in a range of health and safety topics such as fire safety. Health and safety information was displayed for staff to see and there was an identified health and safety representative. Cleaning materials were stored in way which met the Control of Substances Harmful to Health (CoSHH) guidelines.

There was a comprehensive range of risk assessments for the operating safety of the staff and environment; for example, there was a risk assessment for the safety of the external environment if there was surface ice in cold weather, with directions how the risk could be minimised.

We saw that any risks were discussed within meetings. There were systems in place for monitoring higher risk patients such as those with long term conditions, in receipt of end of life care and patients being treated for cancer. Welfare, clinical risks and the risks to patient's wellbeing were discussed daily and weekly by the GPs and nursing staff. Patients who were identified as particularly vulnerable had a named GP and a care plan in place which specified potential problems and how the patient, in discussion with their GP, wished to be treated for them.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We were told there was always first aid equipment available on site when the practice was open. We looked at the accident recording log book and found when accidents had occurred at the practice, they were recorded and appropriate action taken to prevent recurrence.

The practice computer based records had an alert system in place which indicated which patients might be at risk of medical emergencies. This enabled practice staff to be alert to possible risks to patients. This information was shared with the reception team if patients were vulnerable. The staff we spoke with told us they knew which patients were vulnerable and how to support them in an emergency until a GP arrived.

Emergency medicines were also available in a secure area of the practice and were routinely audited to ensure all items were in date and fit for use. All staff had completed basic life support training and knew where emergency medicines and equipment were stored and how to use them, for example, for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

Emergency equipment available included oxygen and an automated external defibrillator. The equipment appeared to be in good working order and designated staff members routinely checked this equipment. Equipment was available in a range of sizes for adults and children. We found that equipment and medicines were stored separately which could cause delay in an emergency.

Urgent appointments were available each day both within the practice and for home visits. We were told that the practice prioritised requests for urgent appointments for children. Out of Hours emergency information was provided in the practice, on the practice's website and through their telephone system. The patients we spoke with told us they were able to access emergency treatment if it was required and had not ever been refused access to a GP.

The practice had an alarm system within the computerised patient record system to summon help if needed. A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the buildings. The document also contained relevant contact details for staff to refer to and who was responsible for what needed to be carried out. For example, contact details of the power supplier.

The buildings had a fire system and firefighting equipment, which was in accordance with the fire safety legislation. A fire risk assessment had been undertaken that included

Good

Are services safe?

actions required to maintain fire safety. We saw records that showed the system had been maintained and tested. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with told us about their approaches to providing care, treatment and support to their patients. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The practice used an assessment tool aligned with professional knowledge of patients to identify high risk patients and it participated in joint working with other health and social care professionals and services to avoid any crisis in their health. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were told about the process the practice used to review patients care plans. We saw that the practice provided the emergency admission avoidance enhanced service. This meant patients in this category who were recently discharged from hospital were reviewed within 72 hours. This was monitored by the staff on receipt of discharge summaries, who ensured they were followed up by the most appropriate staff member.

The GPs told us they had lead responsibility for specialist clinical areas and internal referral between clinicians took place for a variety of conditions such as diabetes and heart disease. The practice nurses supported this work and held specialist training qualifications in order to hold nurse led clinics. The nurse practitioners also assessed and treated patients for minor illness. Clinical protocols were in place and had been adapted by the practice to add value to patient care. For example, for the management of chronic obstructive pulmonary disease which linked to the patient self-management plans.

GPs and nursing staff we spoke with were open about asking for and providing colleagues with advice and support. We observed the discussions between GPs and nursing staff about specific patients' concerns during the weekly meeting which allowed discussion and the course of action to be taken.

We saw from the information supplied by the practice during our visit that there was a programme in place which ensured the 88 patients who were registered as having a learning difficulty were offered an annual health check, of which 84 had been seen. Accessible information had been provided to support patient to understand about doctors and the practice. There was also a programme of medication reviews specifically for patients on multiple medicines (polypharmacy).

Discrimination was avoided when making care and treatment decisions. Interviews with GPs and other staff showed that the culture in the practice was in which patients were cared for and treated based on individual need. The practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

We spoke with GPs about how they reviewed and assessed that they were meeting patient's needs. We heard information from Quality Outcomes Framework (QOF), significant events, new guidance and feedback from patients generated clinical audits. QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures. The practice had annually achieved a consistent QOF score of 98.7% which was above the average CCG and higher than the average for England. The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients.

The practice showed us clinical audits that had been undertaken in the last year. These were a range of completed audits from which the practice was able to demonstrate the changes resulting since the initial audit. For example, a completed audit had been undertaken in respect of the assessment of cardiovascular risk in patients presenting with erectile dysfunction. This followed the

Good

Are services effective?

(for example, treatment is effective)

clinical guidance from British Society for Sexual Medicine Guidelines which stated that 'Erectile Dysfunction is an independent marker for cardiovascular risk and can be a presenting feature of diabetes, so serum lipids and fasting plasma glucose (or HbA1c) should be measured in all patients' . We read there had been an initial audit of patients over the period October 2013 to March 2014. This found that not all patients had been tested as per the guidelines. Following the presentation of the information at a clinical meeting the practice set a target of 100% of all patients presenting with erectile dysfunction to have undertaken the additional tests. We found from the re audit from March 2014 to June 2014 there had been a significant increase from 77% to 95% of uptake of recommended testing. This audit was an example of how the practice had improved the patient care.

The team was making use of clinical audit tools, clinical supervision and staff meetings to monitor the performance of the practice. The staff we spoke with discussed how they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice of involvement and how they could contribute to improvements to the service.

There was a protocol for repeat prescribing which followed national guidance. Staff regularly checked that patients who received repeat prescriptions had been reviewed by the GP if necessary. They also checked that all routine health checks were completed for long-term conditions such as diabetes. The patient record system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. The gold standard framework guidance was implemented by the practice. When we spoke with the community nurses they told us that the practice was exceptionally good caring for patients at the end of their lives. We were told there were rarely any issues out of hours as the GPs had been effective in planning and implementing care which supported patients.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that staff were up to date with attending mandatory courses such as annual basic life support. Any gaps in training, particularly e learning, were highlighted and training planned for individual staff. We heard the practice worked collaboratively with other practices and shared training events such as emergency life support training. We noted a good skill mix among the GPs with interest in gynaecology, paediatrics, research and palliative care. One GP had a special interest in drug rehabilitation, another led on women's health. All GPs were up to date with their yearly continuing professional development requirements and all either have 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 the General Medical Council can the GP continue to practise and remain on the performers list with NHS England). The practice had an established pattern of meetings to ensure staff understood the demands of the service.

The nurse practitioner/prescriber and practice nurses had defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, insulin initiation, administration of vaccines, cervical cytology and family planning. We were told by all levels of staff that they were provided with the time, the financial support and the opportunity to undertake training and personal development. Staff told us annual appraisals identified learning needs and from this action plans were developed and documented.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and to work in a coordinated way to manage the needs of patients with complex needs. The practice had attached staff such as health visitors, midwife's and the community nursing team.

There was multidisciplinary team working for patients identified as at risk through age, social circumstances and multiple healthcare needs. The practice had patients in the

Good

Are services effective?

(for example, treatment is effective)

community who were included in the 'virtual ward'. Weekly meetings with other professionals such as the community matron, community nursing teams, health visitors, palliative care team took place. Staff felt this system worked well and there was a team approach to supporting their patients. We obtained positive feedback from the health care professionals who came in contact with the service. We were told that the staff were committed to working collaboratively, people who have complex needs were supported to receive coordinated care and there were innovative and efficient ways to deliver more joined-up care to patients who used services. We heard how the practice worked with other health care providers in the area such as care homes to promote good health and well-being for patients. We were told they were a very friendly and open staff team who never failed to provide support to other professionals.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. The practice also used the Choose and Book for secondary appointments, patient to patient electronic transfer of medical records and summary care records. The practice had systems to provide staff with the information they needed. Staff used an electronic patient record 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. The practice also had an internal system to share documents and records relating to the running of the service, clinical protocols, policies and procedures were all available to staff electronically.

Information was shared with other health care professionals in an appropriate way, for example, we heard from community teams that they were able to link into the practice patient electronic records to add information. The community teams also attended meetings at the practice to share information as well as undertake joint visits with practice staff to patients. Health care professionals also had a telephone direct line to contact the practice.

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 with understood the key parts of the legislation and were able to describe how they implemented it in their practice. We were told that patients were supported to make their own decisions and documented this in the medical notes. Patients with a learning disability and those with a diagnosis of dementia were supported to make decisions through the use of care plans, which they were involved with planning. These care plans were reviewed three monthly or more frequently if changes in clinical circumstances dictated it. The practice had a policy, procedure and information in regard to best interests' decision making processes for those people who lack capacity. We were given the example of patients who lived in residential care for whom 'best interest' decision making meetings were held. The practice confirmed that the GPs involved patients and families in 'Do Not Attempt Cardiopulmonary Resuscitation' decisions. We also read this information was recorded on the care plans of vulnerable patients. One GP took the lead for advanced care planning for patients with dementia.

All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child had the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions including a patient's verbal consent which was recorded in the electronic patient notes and the practice are now obtaining written consent for minor surgical procedures.

We spoke with patients who confirmed that consent was asked routinely by staff when carrying out an examination or treatment. They also told us that staff always waited for consent or agreement to be given before carrying out a task or making personal contact. They also confirmed that if patients declined this was listened to and respected.

Health promotion and prevention

The practice had met with the local authority and the clinical commissioning group in respect of public health and health promotion, to identify and share information about the needs of the practice population. The practice website had information about healthy lifestyles as well as practical guidance about self-treatment for minor illness.

Good

Are services effective?

(for example, treatment is effective)

We noted the culture of the practice was to use their contact with patients to help maintain or improve mental, physical health and wellbeing. This was reflected by the information available to patients in the waiting room which had dedicated notice boards for specific topics. The practice had been successful in achieving its QoF targets for the management of long term health conditions, including patients with mental health conditions.

It was practice policy to offer a health check with the health care assistant or practice nurse to all new patients registering with the practice. New patients' health concerns were identified and arrangements made to add them into any long term health monitoring processes such as the diabetes, asthma or heart conditions clinics or reviews. The practice provided information and signposted patients to services which help maintain or improve their mental, physical health and wellbeing. For example, by offering smoking cessation advice to patients who smoke.

The practice offered NHS Health Checks to all its patients aged 40 to 75 years and had directed patients on to other services when needed. We saw patients had been referred to services such as weight management and physical activity.

The practice identified patients who needed additional support. For example, the practice kept a register of all patients with a learning disability, all of whom were offered an annual physical health check. Similar mechanisms of identifying "at risk" groups were used for patients such as those receiving end of life care, and these patients were offered service support according to their needs. We saw evidence that these lists were reviewed every month.

The practice participated in the national screening programs such as those for cervical cancer, and bowel cancer. There was a process to follow up patients if they had not attended. The practice offered a full range of immunisations for children, travel vaccines and flu vaccines. We were told that flu vaccination clinics were held at weekends to encourage children and families to receive the vaccination.

Advice and information was readily available in the practice about a wide range of topics from health promotion to support and advice. Information was also available on the practice website or patients were directed to links to other providers for specific advice.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the latest national patient survey information for 2014, a survey of 264 patients with a return rate of 48%. The evidence from all this showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed 83% of patients felt that their overall experience was good or very good and 97% had confidence and trust in the last nurse they saw or spoke to.

Patients we spoke with said they felt the practice offered a good service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with the patient participation group on the day of our inspection who told us they were satisfied with the care provided by the practice. Patients stated they felt GPs took an interest in them as a person and overall impression was one of wanting to help patients. We were given examples of the GPs taking additional time to ensure patients received the care they needed such as making contact with patients outside of normal working hours and contacting secondary medical services to ensure referrals were received. All the patients we spoke with said they would recommend the practice. Both patients and staff expressed the service had a holistic approach and a culture which put patients first. This was echoed by the comments received from health care professionals attached to the practice, who rated the practice highly for their professional and caring approach.

The practice had an established history of charitable fundraising, for example, they had been involved in the 'Movember' campaign in 2012 to raise awareness of men's health issues. This had led to the practice initiating a clinical audit in respect of this area of healthcare which had a positive impact on patient health. We were also told about the awareness of social isolation of the frail elderly population and that the practice had worked collaboratively with other practices and the local authority to identify patients who may be at risk.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. In the treatment rooms the nursing staff ran clinics, curtains were provided so patients' privacy was maintained as best as possible when treatment was being carried out. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so confidential information was kept private. The practice switchboard was located away from the reception desk to keep patient information private. The reception desk was not separated from the waiting room. Patients potentially could overhear private conversations between patients and reception staff. However, the practice had introduced a radio to provide background noise and there was the possibility of using unoccupied consultation rooms if patient wished to have a private conversation. We observed mobile screens were also available for use to protect privacy if a patient was unwell in the waiting room.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 97% of respondents had confidence and trust in the last GP they saw or spoke to, and 87% found he receptionists at the practice were helpful both of which were above average compared to Clinical Commissioning Group area.

Patients we spoke with on the day of our inspection told us that 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. We found the practice promoted self- care initiatives such as that for

chronic obstructive pulmonary disease (COPD). Patients were given a short self- assessment guide and a COPD action plan to follow to control periods of abnormal breathlessness including medicines. The practice had achieved all of its QoF targets for COPD including reviewing 93% of all diagnosed patients.

Staff told us that telephone translation services were available for patients who did not have English as a first language. We saw the website had a facility for translation of information. The practice had also installed Wi-Fi for patients to access; the patient newsletter provided additional information about any developments.

We found that more than the required 2% of the patient population identified as vulnerable had their own care plan. We were told that the GPs acted as the care coordinator for a number of patients, all the plans had been reviewed. We found this provided a continuity of care and support for the patient because GPs could recall their patients and the particular circumstances, for example, if there was any local support or care. The care plans included information about end of life planning and choices made by the patient. Similar evidence was seen in regard of patients diagnosed with long-term conditions. Older patients, over 75, had their own named GP.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 88% said the last GP they saw or spoke with was good at treating them with care and concern which was higher than the CCG average. The patients we spoke with on the day of our inspection were also consistent with this patient information.

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them. We were told how access to appointments was flexible to patients who were carers, or had difficulty attending the practice because of their mental health needs. We were told how the GPs and health care staff were flexible to providing home visits to reduce the difficulties carers of patients had attending the practice. An example of this being home visits to patients and their carer for influenza immunisations.

One of the staff acted as a carer's champion for the practice. This meant that all carers were identified and sent relevant information about local carer's organisation. There was a dedicated carer's notice board in the waiting room. This may be benefits advice, carer breaks/holiday, and emergency card scheme, information about voluntary agencies and social services, as well as general support.

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. Information was also available on the website which advised patient of the processes to follow following bereavement.

The information from patients showed patients were positive about the emotional support provided by the practice staff. For example, we were told by one patient how they were supported with a new diagnosis and their long term care was explained to them. They told us they were able to speak to the GPs and nursing staff who answered their questions well and were patient with them when they needed reassurance. The practice had also been proactive in identification of social isolation amongst patients and had worked to ensure that services wherever possible were based at the practice, such as mental health services, and there was access to facilities such as a volunteer driver service.

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 patient's 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. The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. The practice employed staff with a wide range of specialist interests, such as substance misuse, which allowed them to meet a range of patient needs. We found that when the practice had identified a potential shortfall in provision they actively recruited staff in these areas, such as nurse practitioners, or supported current staff with further training. For example, one GP had a specialist interest in palliative care and was completing a master's degree in the subject; they acted as the palliative care lead and point of contact for any clinician with a patient who required this type of treatment.

Patients and staff told us that all patients who requested urgent attention were always seen on the day of their request this included patients requiring home visits. Calls to the practice were triaged so that urgent requests were assessed and requests were prioritised according to need. The practice had provided a responsive service by holding clinics, such as the diabetes ulcer clinic, on a regular day each week for patients who found it difficult to attend variable appointment times. The practice also had access to 'Hot Clinics' at local NHS hospitals which offered access to a consultant at short notice if needed. "Poorly Poppets" was a programme of educational sessions in conjunction with the health visitors to educate parents about common childhood illness, the practice had supported as they were open to supporting innovative ways of working with young people and families.

There was a computerised system for obtaining repeat prescriptions and patients used both the electronic request service, posted or placed their request in a drop box in reception or outside the building. Patients told us these systems worked well for them.

The practice had a Patient Participation Group (PPG) and patients were able to provide feedback about the quality of services at the practice through the PPG. The PPG carried out regular patient surveys and there was evidence that information from these was used to develop services provided by the practice. The representative from the PPG said the practice listened to them about the comments patients made about the service. For example, PPG members agreed with the practice that the priority for 2014-15 was to look at alternatives to the current telephone system. The Executive Manager and Customer Services Manager sit on the PPG, and participate in regular reviews of action plan. Major changes to any process, for example online access, are not enacted without PPG review.

Tackling inequity and promoting equality

The practice had access to online and telephone translation services. The practice had their equality and diversity statement and provided equality and diversity training for all staff. We also saw that the information on the website could be translated.

The premises and services had been designed to meet the needs of patients with disabilities. We saw wheelchair access at the entrance to the practice, an accessible toilet and sufficient space in the waiting room to accommodate patients with wheelchairs and pushchairs which allowed for easy access to the treatment and consultation rooms. The services for patients were on the ground floor; however there was lift access to the first floor.

The practice had recognised the needs of different groups in the planning of its services. The practice provided home visits to patients who were unable to attend the practice and to those living in residential or nursing homes. There was a dedicated 'mobile doctor' who undertook the visits

The practice actively supported patients who had been on long-term sick leave to return to work by referring them to other services such as physiotherapists, counselling services and by providing 'fit notes' for a phased or adapted return to work.

Access to the service

The practice was open 8.00am to 6.30pm Monday to Friday. We saw that patients who called to request same-day appointments after 5.45pm will be asked by the practice to contact the Out of Hours Service via 111. This allowed the practice to appropriately manage the demand for same-day appointment access within their core opening

Good

Are services responsive to people's needs?

(for example, to feedback?)

hours. All patients who contacted the practice were triaged to the most appropriate treatment, for example, the nurse practitioners offered appointments daily for minor illness or patients could be offered a GP telephone consultation. We observed this in action and saw that the receptionist followed a preset script in order to obtain sufficient information to pass to the triage team. The triage GP spoke to us about the effectiveness of the system, for example, 50% of calls resulted in patients being seen, 30% were dealt with as a telephone consultation and 20% were given an appointment at a later date. The executive manager provided us with information which gave a correlation of the reduction in the number of complaints about appointment access and the introduction of telephone triage. We also read from compliments received by the practice from patients that this system had allowed them faster access to treatment.

The practice does not provide out of hours services to its patients, this is provided by Bris Doc information on the out-of-hours service was provided to patients. Appointments were available outside of school hours for children and young people. The practice provided a weekly drop in sexual health clinic. Teenage health checks were undertaken when patients attended for their immunisation boosters. Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed.

Patients told us they were aware that appointment times were not limited to ten minutes but lasted for however long was needed. This system was valued by patients although it meant that they may have had to wait beyond the time they expected. Patients were made also aware when they arrived for appointments if appointment times were late, and that if a child or baby arrived and needed to be seen urgently, then they would be seen by the next available GP. The patients were aware that they could request to see a specific GP otherwise we were told they were happy to see any of the GPs at the practice. For pre-booked appointments patients could choose which GP they saw so there was continuity in their care. The national patient survey results indicated only 41% of respondents found it easy to get through to this surgery by phone, however 86% were able to get an appointment to see or speak to someone the last time they tried and 89% said the last appointment they had was convenient. The practice also had an online booking system for planned appointments.

Longer appointments were also available for patients who requested them, for example, those who may have more than one medical condition. This also included appointments with a named GP or nurse. The patient record system had an alert which to indicate patients who required longer appointments. Home visits were made to a local care homes by named GPs.

The practice had a Customer Services Manager (CUSM) and a lead receptionist. We found the quality of service was promoted through the receptionists' continuous training programme' which focussed on customer care and customer experience. We saw GPs undertook sessions in reception in order to understand the issues and to assist patients wherever needed. In response to patient feedback about telephone access the practice had reviewed the telephone capacity and call-type. This had resulted in the purchase of a new 'intelligent' telephone system which directed patients to the correct person within the practice for their needs. The practice had also planned to install voice recording software in order to be able to monitor for improvement, telephone calls into the practice. As all clinicians participated in the telephone triage of patients, training in this process was included as part of their induction.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice. We found the Executive Manager retained oversight of all complaints and with operational delegation to Customer Services Manager. All complaints received a written reply unless specified otherwise.

As part of the pre-inspection information submission we read the practice had recorded a large number of complaints over a 12 month period. We found the practice had recorded comments and observations made by patients or third parties as complaints, the effect of which portrayed, incorrectly, a practice which received a large number of complaints. We reviewed a selection of the

Good

Are services responsive to people's needs?

(for example, to feedback?)

complaints received in the last 12 months and found these were satisfactorily handled and dealt with in a timely way. An acknowledgement had been sent out, the issues investigated and a response sent to the complainant. There were monthly written and verbal reports to partners; trend analysis was discussed by the practice management team and clinical governance group as appropriate. The practice used the EMIS written 'note of action' system, which the executive manager spot-checked to ensure they had been acted on.

We saw that information was available to help patients understand the complaints system. Information was on display in the patient areas and included on the practice website. There were leaflets provided for patients to take away if they wished to with details of how the complaints process worked and how they could complain outside of the practice if they felt their complaints were not handled appropriately. None of the patients we spoke with had ever needed to make a complaint about the practice but told us they felt the practice would listen and respond to their concerns.

The complaints ranged from a variety of issues, some were in regard to staff attitude at the first point of contact at the reception desk. Others were in regard to patient expectation for treatment or referral to other healthcare providers. We saw that from all complaints the practice had looked at how it could improve and avoid patients raising similar complaints in the future. Where potential serious concerns had been identified these were elevated as a significant event and then reviewed in more depth by the management team. Follow-up actions were on case -by-case basis with compliance monitored by the 'owning' manager, and active executive manager oversight and or intervention.

There were robust procedures for handling, responding to and disseminating compliments which also gave the practice the opportunity of sharing what had gone well with the team. We were given details of the compliments received and read about patient satisfaction with the triage system, the quality of care from the GPs and reception team.

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 vision statement which was to:

- Provide a comprehensive range of high quality services both within the practice and by referral to other agencies.
- Ensure that the services are accessible, efficient and responsive to the needs of patients.
- Provide a professional, pleasant, safe, caring, supportive and efficient working environment for everyone in the practice.
- Include all members of the team in planning and decision-making by encouraging teamwork and good communication.
- Maximise the profitability of the organisation to ensure the best possible service to patients and fair remuneration to all members of the practice team.

We found the leaders within the practice had an inspiring shared purpose; they strove to deliver and motivated staff to succeed. The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We heard from all the staff we spoke with that there was a 'patient first' ethos within the practice. This was corroborated by the patients we talked with. We found that there was strong leadership and strategic vision within the practice. We found the partners in the practice understood their role in leading the organisation and enabling staff to provide good quality care. The practice had a strategic approach to future planning and had put in place succession arrangements to identify and address future risks to personnel leaving or retiring. They had developed a risk tool, Doctor Plot, which predicted staffing requirement for the year.

We found details of the vision and practice values were part of the practice's strategy and business planning. The practice vision and values included, providing the highest quality care which meets the identified needs of patients whilst supporting patients to make decisions to improve and maintain their health. Staff told us that they treated patients with courtesy, dignity and respect at all times by putting patients at the centre of everything the practice does. The practice also participated and engaged with colleagues as part of the South Gloucestershire Clinical Commissioning Group (CCG).

There was a whole team approach to change and innovation which involved the staff and the patient participation group and related agencies such as the CCG. We found examples of involvement in pilot schemes and working collaboratively with four other practices to access funding for innovation, such as having a GPs with specialist interest in older patient care working across the practice group. We found the practice culture was innovative, forward looking and adaptable.

Governance arrangements

Staff were able to demonstrate their understanding and commitment to providing high quality patient centred care. The leadership, governance and culture were used to drive and improve the delivery of high-quality person-centred care. The practice had a number of policies and procedures in place to govern activity and these were available on a shared 'U' drive which staff could access from any computer in the practice. We looked at a number of these policies and procedures and found that they had been reviewed regularly and were up to date. GPs and nursing staff were provided with clinical protocols and pathways to follow for some of the aspects of their work. For example, the prescribing of methadone or ensuring a consistent approach was used for patient referrals. Information on the practice website also informed patients about policies such as confidentiality and how patients could access their own records. Staff we spoke to confirmed their understanding of these topics and would be able to support patients.

There was a clear leadership structure with named members of staff in lead roles. The practice provided us with a list of the areas that each partner GP in the practice led on. We found that for each of the lead roles there was an expectation that the lead GP could provide evidence of how their area of responsibility influenced the practice and patient care. For example the lead GP for coronary disease had recognised their patient population had a low incidence of heart failure, especially given their elderly demographic, at 0.9%. The audit aimed at ensuring they were not under-diagnosing heart failure, as this had implication for patients such as incorrect investigations or risk of suboptimal treatment. This was investigated further the outcome of which resulted in a presentation in the practice to reiterate the importance of specialist diagnosis and treatment pathways for patients who presented with

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'breathlessness'. We saw that buddy arrangements between doctors were clearly documented and staff told us this worked very well in practice and provided a safety network for patients.

We spoke with 25 members of staff and they were all clear about their roles and responsibilities. They told us they felt valued, well supported and knew who to go to in the practice with any concerns. We found that the responsibility for improving outcomes for patients was shared by all staff. The practice gave us examples where both non–clinical and clinical staff had worked together, for example appointment and telephone access was an ongoing issue for the practice. Telephone triage had been introduced and had made significant impact in respect of appointment access for patients. A working party was formed with every team represented; the aim of which party was to ensure that the triage system worked effectively and to keep it under review. We were told the next stage to address the appointment and telephone access was the introduction of a new telecom system. This would allow additional lines and telephone consultations to be monitored or recorded for training and quality assurance purposes.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice was equitable with national standards and was above average for the local Clinical Commissioning Group (CCG) and England average in a number of clinical indicators.

The practice had systems in place to monitor and improve quality. The practice had an ongoing programme of clinical audit which it used to monitor quality and systems to identify where action should be taken. For example, auditing patients who were prescribed medicines which required monitoring through regular blood tests.

The practice had a system of governance meetings to discuss all areas of practice such as quality audits, serious and significant events, complaints, patient feedback, performance data and other information relating to the quality of the service. We saw meeting minutes and reports that demonstrated the practice routinely reviewed data and information to improve quality of service and outcomes for patients. We found the practice approached governance and improvement in a supportive and collaborative way. There was evidence that the practice took the welfare of its staff seriously for example, performance was reviewed in order to enable staff to develop and improve.

The practice ensured risks to the delivery of care were identified and mitigated before they became issues. We found risk assessments had been carried out where risks were identified and action plans had been produced and implemented, for example within the business continuity plan. We discussed how the practice monitored 'at risk' patients to meet the requirements of the enhanced services.For example, the ' Avoiding Unplanned Admissions' enhanced service meant the practice need to be proactive in identifying vulnerable patients and ensuring care plans were in place and were reviewed. We found the practice had systems in place for monitoring, for example, audits, procedures, reviews, monitoring mechanisms, questionnaires and meetings. These individual aspects of governance provided evidence of how the practice functioned and the level of service quality delivered to patients. The practice periodically looked at these as a whole using other indicators such as survey results, other forms of patient feedback, sudden deaths, diagnosis of new cancers and staff appraisals to provide an in depth review of service provision and shape their ongoing business plan.

Leadership, openness and transparency

There was a well-established management structure with clear allocation of responsibilities. We spoke with a number of staff, both clinical and non-clinical, and they were all clear about their own roles and responsibilities. They were able to tell us what was expected of them in their role and how they kept up to date. Staff told us there was an open culture in the practice and they could report any incidents or concerns about the practice. This ensured honesty and transparency was at a high level. We saw evidence of incidents that had been reported by staff, and these had been investigated and actions identified to prevent a recurrence. Staff told us they felt confident about raising any issues and felt that if incidents did occur these would be investigated and dealt with in a proportionate manner. The staff we spoke with were clear about how to report incidents. Staff told us they felt supported by the practice manager and the clinical staff and they worked well together as a team.

The practice had invited the community nurse team to speak with us during the inspection. The team spoke highly

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of the practice and how well the practice worked jointly with their organisation. This demonstrated the practice had an open approach and recognised the value other organisations could provide in quality improvement. The practice had invited the deputy chairperson of the patient participation group and the community nurse team to speak with us during the inspection. This confirmed an open and transparent approach by the practice and demonstrated their commitment to patient involvement.

We heard from staff at all levels that team meetings were held regularly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at meetings. Salaried GPs and trainees were included in meetings and this was reflected in the conversations we had with them where they felt included and valued in the running and development of the service.

The practice employed a practice manager to enable the business and administration of the service. Their responsibilities included the development and implementation of practice policies and procedures. The practice manager provided us with a number of policies, for example the recruitment policy and induction programmes which were in place to support staff. We were shown the online staff information that was available to all staff. Those we spoke with knew where to find these policies if required.

The practice was proactive in planning for future needs; GPs and nurses were being provided the opportunities and access to additional training to develop new services and enhance their skills. For example, we were told about the financial support the practice provided for training examples were for a health care assistant to undertake a nursing qualification, and a nurse practitioner to undertake a specialist qualification in palliative care.

The partners had a formal away day, at which the management team was represented by the Executive Manager. In the future, we aim to have management team away days and an away day conference for all staff at all of the sites Hanham Health supported. The away day which was intended to review, consolidate and plan for the service. The away day was planned to review and develop and celebrate the success of the practice.

A GP partner held lead responsibility within the practice as the Caldicott Guardian and was clear about their role. A Caldicott Guardian is a senior person responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing. Each NHS organisation is required to have a Caldicott Guardian; this was mandated for the NHS by Health Service Circular: HSC 1999/012. The practice had protocols in place for confidentiality, data protection and information sharing.

Seeking and acting on feedback from patients, public and staff

The practice demonstrated a strong commitment to seeking and listening to patient views. They welcomed rigorous and constructive challenge from people who used the service, the public and stakeholders. Throughout the inspection they demonstrated how patient views had influenced improvements in patient care and service. They showed us a range of evidence, such as patient feedback, compliments and complaints they had used to focus improvements on the needs and wishes of patients. This included celebrating what had gone well as well as identifying areas for improvement. For example, the practice had gathered feedback from patients through patient surveys, complaints received and the recently implemented friends and family questionnaire.

The patient participation group (PPG) included representatives from various population groups; patients of working age and recently retired and older patients groups. The PPG had carried out annual surveys and met quarterly. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys are available on the practice website.

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 and this had happened. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. The senior partner reiterated that the staff team and their wellbeing impacted on how well the practice performed and that investment in staff was a priority. We also noted the practice had a social committee which arrange regular social events.

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The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice. There were high levels of staff satisfaction. Staff told us they were proud to work for the practice.

Management lead through learning and improvement

There was a strong focus on improvement and learning shared by all staff. The staff we spoke with demonstrated an understanding of their area of responsibility and each took an active role in ensuring a high level of service was provided on a daily basis. The GPs and nurses we spoke with told us how they conducted routine condition and medicines reviews. GPs and nurses routinely updated their knowledge and skills, for example by attending learning events provided by the South Gloucestershire Clinical Commissioning Group (CCG), completing online learning courses and reading journal articles. Learning also came from clinical audits and complaints. We heard from the GPs that sharing information and cascading learning through the team was an established process and one which kept the staff informed and up to date. The practice had 'Extranet' which allowed staff to access the latest guidance and record and share information in a range of service areas. The practice had completed reviews of significant events, complaints and other incidents. Significant events were a standing item on the practice meeting agenda and were attended by the GPs, the practice management team and practice nurses. Recent significant events were discussed and we were told by GPs they also reviewed actions from past significant events and complaints. There was evidence the practice had learned from these events and that the findings were shared.

The practice was a GP training practice, with two partners taking the lead for GP training. The ethos of the practice was that GPs in training brought new ideas and ways of working to the practice, and challenged established practice. It also provided practical experience for medical and nursing students. The practice offered training placements for medical students, doctors undertaking training to be GPs and student nurse placements. We spoke with the GP currently training at the practice who was appreciative of the support and understanding provided by the practice.

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

The practice took part in research and recruited patients for clinical trials such as the 'Timely diagnosis of dementia' one of the benefits for patients being the ability to access a consultant within two weeks. This contributed to the practice remaining up to date with latest developments in clinical care and linked to the CCG focus on the frail elderly.

The practice participated in joint working for local service developments such as those provided under the Prime Ministers Challenge Fund. The practice are part of a care consortium who successfully bid for some of the fund and are actively involved in development of an IT strategy to introduce a CCG wide intranet to all practices which would allow access to updated guidance, templates and policies from NHS England and the CCG. This meant that any changes, such as in referral templates, would automatically be updated and linked to the practice's electronic records system. The practice had been successful with their bid for funding to extend the practice site at Hanham.

The practice collaborated with other practices in the area for example, the IT manager had supported another local practice with their systems. They also share training sessions which allowed for flexibility for staff and the practices.