The Medical Centre, Ridingleaze

Quality Report

Ridingleaze, Lawrence Weston, Bristol, BS11 0QE

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Medical Centre, Ridingleaze on 9 April 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, well-led, effective, caring and responsive services. It was also good for providing services for older patients, those with long term conditions, people of working age, the recently retired and students. In addition it was good for

providing services for families children and young patients, patients whose circumstances make them vulnerable and patients with poor mental health including those with dementia.

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

- Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff were receiving training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.

Summary of findings

- The practice was well equipped to treat patients and meet their needs. It had identified that the premises were too small and had worked with other services and shared information with patients about plans to move to a more suitable building in the future.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on. The practice manager had identified the need to motivate the patient participation group to be more active.

We saw an area of outstanding practice

- One of the GPs told us they carried out their own out of hours visits for patients receiving palliative care. They gave the patient or their carer their personal telephone number so they could contact the GP directly for support.

However, the practice should:

- Maintain a record of refrigerator temperatures to evidence that medicines were stored safely.
- Update the health and safety policy and keep it under review.
- Consider and disseminate relevant health and care guidance.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

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

Are services effective?

Good

The practice is rated as good for providing effective services. Data from national online sources showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for most staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data from national online sources showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice was well equipped to treat patients and meet their needs. It had identified that the premises were too small and worked with other providers and shared information with patients about plans to move to a

Summary of findings

more suitable building in the future. 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 with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. The new practice manager had identified actions needed within the practice and had compiled a development plan to address these. We saw actions had been completed within timescales and further actions were needed to secure improvement. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) had become dormant and the practice manager had identified actions within the development plan to address this. New staff had received induction training, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

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. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

There were weekly multi-disciplinary team meetings to discuss the most vulnerable patient and those with complex health needs. In addition there were monthly meetings to discuss those with palliative care needs. All patients over the age of 75 years had a named GP.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. GPs and nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a structured annual review to check that their health and medication needs were being met.

There was close working with the practice pharmacist to ensure audit and implementation of up to date prescribing guidance was carried out. Similarly there was close working with the community matron and district nurses for patients who were housebound.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young patients. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. 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. Appointments were available outside of school hours and the premises were suitable for children and babies. The practice had a policy for ensuring all patients under the age of five years were seen on the same day at the request of their parent.

Summary of findings

There was joint working with midwives, health visitors and school nurses. The practice was a 4YP practice (Wherever the 4YP logo is displayed patients can be sure that the services on offer are young people friendly) and had achieved standards to ensure it met the needs of young patients.

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. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.

The practice offered appointments before and after normal surgery hours for these patients and telephone consultations for those who did not require a face to face consultation.

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 and those with a learning disability. It carried out annual health checks for people with a learning disability and offered longer appointments for these patients.

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 recognised the difficulties some patients had making appointments and offered same day access. There were identified lead GPs for domestic violence, safeguarding vulnerable adults and substance misuse.

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). People experiencing poor mental health had regular and opportunistic

Summary of findings

reviews and the mental health team saw patients in the practice. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. Staff had received training on how to care for people with dementia.

Summary of findings

What people who use the service say

We spoke with six patients during our visit. They were complimentary about the way GPs and nurses involved them in decisions about their care and treatment. Four patients told us they were offered a range of options and could choose themselves. One patient said they accepted the GP knew best what treatment was suitable for them.

Two patients told us they were able to get a same day appointment with a GP or nurse however one did mention they had difficulty accessing the practice in the morning because the telephone lines were busy. The NHS England conducted a National Patient Survey and asked patients in the practice about their satisfaction with accessing the practice. Of those who responded to the survey carried out in 2014/2015 71% indicated they were generally satisfied with the ease with which it was able to get through to someone at the surgery by telephone. This was slightly lower than the England average of 75%.

Patients told us they knew how to complain but had no cause to.

Patients told us they were referred to secondary care services and how this was efficient. They also said there was good communication between the practice and the service they were referred to.

Two patients we spoke with told us about their experience during their pregnancy. They said there was good communication between the midwifery team and their GP.

One patient who was a carer told us about the good support they received from a GP.

A patient shared their experience with us through our website. They told us they had concerns they could not always see a GP of their choice. However, they added they felt all the GPs and nurses at the practice were “brilliant” and told us that referrals to secondary services were prompt and how this made them feel the practice really cared about its patients.

The practice implemented the Friends and Family Test which asked patients to indicate whether they would recommend the practice to others. For the first three months there were positive results indicating most patients would recommend the practice to others.

We sent comments cards to the practice in advance of our visit but none were completed.

Areas for improvement

Action the service SHOULD take to improve

Check emergency medicines to ensure they are in date and safe to use.

Update the health and safety policy and keep it under review.

Consider and disseminate relevant health and care guidance.

Outstanding practice

- One of the GPs told us they carried out their own out of hours visits for patients receiving palliative care. They gave the patient or their carer their personal telephone number so they could contact the GP directly for support.

The Medical Centre, Ridingleaze

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a specialist advisor GP.

Background to The Medical Centre, Ridingleaze

The Medical Centre in Ridingleaze at Lawrence Weston provides a service to over 6,500 patients and has been at its current site since the 1980's. Lawrence Weston is a post-war housing estate with over half of its 2,700 dwellings owned either by Bristol City Council or other social landlords.

The area has significant levels of deprivation being ranked in the ten most deprived areas in the city because of its Health Deprivation and Disability score. Those who live in Lawrence Weston were almost twice as likely to be disability benefits claimants when compared to the city average.

The practice team is made up of four GP partners and two salaried GPs making a total of 3.85 full time equivalent GPs. Five of the GPs were female. There were four practice nurses along with a phlebotomist, reception and administrative staff.

The practice shares a practice manager with another practice in the area working approximately half time in each. We were told the practice was looking towards a future of greater interactive and collaborative working between the practices. The practice had appointed an operations manager who was to commence employment shortly.

The practice has opted out of providing out-of-hours services to its patients. This service contracts with Brisdoc to provide out of hours services and patients are advised to contact them through the NHS 111 service.

Why we carried out this inspection

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

How we carried out this inspection

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?

Detailed findings

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)

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 9 April 2015. During our visit we spoke with a range of staff including GPs, the practice manager, nursing and administrative staff and we 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 records that reflected how the service was managed. We sent comment cards to enable patients and members of the public to share their views and experiences of the service however, none were completed for us.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, we saw the record of significant events included an occasion when a patient was prescribed medicine they were already receiving in the dosette box dispensed by their nominated pharmacy. The practice responded to this by reviewing and updating the prescribing policy and planning staff training in the issuing of repeat prescriptions.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed safety records and incident reports for the last year. The analysis showed a description of the event and the date it occurred. The date it was discussed was recorded along with analysis and action taken in response. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Significant events were a standing item on the practices monthly clinical meeting where they were reviewed. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were received by the practice manager and disseminated by email to practice staff. Monthly meetings were held for clinical staff and non-clinical staff. Following the meetings the minutes were shared with the whole staff team. This demonstrated all staff were made aware of recent alerts that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to all its vulnerable patients including, children, young people and adults.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware of who these leads were and who to speak with in the practice if they had a safeguarding concern. The lead GP for child protection had completed training to level three as required, with all other GPs working to this level. We saw the practice training plan listed the requirement for staff to complete training every three years. For administrative staff this was at level one and for nurses and the manager at level 2. There were similar requirements for adult safeguarding.

We looked at training records which showed that all staff had received relevant role specific training on safeguarding in February 2015. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans.

Staff we spoke with gave examples of how they escalated concerns about children and older patients to the practice child protection and safeguarding vulnerable adults leads.

There was a chaperone policy, which was displayed in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been

trained to be a chaperone. The practice manager had identified reception staff needed training so they could act as a chaperone if nursing staff were not available. This was identified in the practice training plan.

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 that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy by checking temperatures on a daily basis.

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 in line with waste regulations.

We saw reports that noted the actions taken in response to a review of prescribing data. For example, prescribing of anti-coagulant medicine, hormonal contraceptives and non-steroidal anti-inflammatory medicines. Patient records were audited and updated accordingly following medicines reviews to ensure they were up to date.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. They administered vaccines and other medicines using Patient Specific Directions (PSDs) that had been produced by the prescribing GP. We saw evidence that nurses had received appropriate training to administer the medicines referred to in both the PGDs and PSDs.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. 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 lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about hand washing and other aspects of hygiene management specific to their role.

We saw evidence that the lead had carried out an audit of infection control arrangements in March 2015. Actions in relation to infection control were included in the practice development plan and we saw some of these had been achieved including, arranging a new cleaning provider. We reviewed the infection control arrangements with one of the nurses and found them to be satisfactory.

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, personal protective equipment including disposable gloves, aprons and coverings 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 policy. We also saw procedures relating to the management of spillages and saw waste spillage kits were available. There was also a policy for sharps management and needle stick injury and staff knew the procedure to follow in the event of an injury.

Notices about hand hygiene techniques were displayed in staff areas and were displayed in patient toilets after we pointed out there were none there. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us all equipment was tested and maintained regularly and we saw equipment maintenance logs to show this was done on 2 April 2015 when equipment was calibrated. This included blood pressure measuring devices and spirometers. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date of 26 March 2015.

Good

Are services safe?

Staffing and recruitment

The practice manager was a member of the Chartered Institute of Personnel and Development and received various employment law updates. These updates enabled the manager to ensure the practice was operating in line with current legislation and guidance.

We looked at the practice recruitment policy and saw it clearly outlined the actions the practice would take when recruiting new staff or making promotions. There was a separate reference policy related to obtaining and giving references.

In the three staff files we looked at we saw there was a difference in the recruitment documentation. In the file for a member of staff who was recruited some time ago there was only one reference obtained and the statement of terms and conditions (contract) which was signed six months after employment commenced. In the file for the most recently recruited member of staff there was a completed application form, job description and person specification along with, a record of the interview. Two written references were obtained and the member of staff had signed the contract of employment prior to starting work. There was proof of identity including a photograph and right to work documents. In the third file we looked at for a member of staff who was yet to start work we saw the new process was being followed. This showed recent improvement in the recruitment arrangements.

We saw the practice manager had compiled a record of all staff with details of their professional registration and police check with the Disclosure and Barring Service (DBS). Where staff did not have a DBS check we saw, in the development plan, they had been applied for.

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. When required locum GPs were used. There was a practice protocol that outlined the information required in advance of them working in the practice including curriculum vitae, evidence of registration with the General Medical Council (GMC), names of two referees and details of GP work for the past three years. In addition, they needed to demonstrate they were on the NHS performers list and had medical defence cover (insurance).

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice had a health and safety policy however, this was dated June 2005 and the office risk assessment was dated November 2010. The practice development plan showed these were identified as being in need of updating. A health and safety champion had been identified and updates were due by the end of June 2015.

The development plan identified all risks and the practice manager had set dates for actions to be completed. The plan identified requirements for improvements in relation to staffing, patient service, the partners and the organisation. Each requirement had a date by which it would be achieved and documented when the actions had been completed.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example, there was regular overview of patients in nursing and residential homes to ensure the best care was provided. Weekly meetings between practice nurses, district nursing teams and the community nurse for older people were held to discuss the most vulnerable patients and those with complex health needs. There was close working with the practice pharmacist to ensure audit and implementation of prescribing guidance for people with long term conditions and a fortnightly meeting with health visitors to discuss children who were considered to be at risk. The practice maintained links with agencies concerned with domestic violence and regular multi-disciplinary discussions of unplanned hospital admissions. The practice maintained a good relationship with the local mental health team to ensure there was dialogue in relation to patients with poor mental health.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated

Good

Are services safe?

external defibrillator (used to attempt to restart a person's heart in an emergency). Records confirmed that the equipment was checked weekly and the defibrillator battery functioning was checked daily.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia in line with guidance from the Resuscitation Council UK. However, processes were not 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. We were told adrenalin for the treatment of anaphylactic shock was held in each of the consulting rooms and in reception.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. The practice manager had identified this needed updating and had set an action to review and update the plan by the end of April 2015.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. The practice secretary had been identified as the health and safety champion and was due to attend training in facilities management with the local medical committee in the week following our inspection.

Risks associated with service and staffing changes (both planned and unplanned) were included in the development plan. We saw the plan included recruitment of a salaried GP by the end of May 2015 to cover maternity leave and recruitment of additional reception staff that had been achieved.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. 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 although there was no system for cascading these formally in the practice. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs and these were reviewed when appropriate.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support.

We saw prescribing audits conducted in conjunction with the NHS Bristol clinical commissioning group (CCG). They reflected the collaboration between the CCG pharmacist and the practice and were designed to review patients on certain types of medicines and improve safety.

National data showed that the practice was higher than the England average in 2013/2014 with referral rates to secondary care services for emergency cancer admissions and emergency ambulatory care sensitive conditions. This was largely explained by the higher prevalence of deprivation in the practice area.

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

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to carry out clinical audits.

The practice showed us clinical audits that had been undertaken. There were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example we saw an audit relating to prescribing carried out over a six month period during 2014/2015. It showed there had been a decrease in the prescribing of certain medicines which had a positive impact on patients well-being. Another audit showed non-attendance of under 18 year olds at appointments. It showed an improvement in record keeping since the previous audit. The results were discussed at a clinical meeting in January 2015 when proposed changes were agreed to make further improvements. A re-audit was proposed to take place after one year.

The GPs told us clinical audits were often linked to medicines management information such as hypnotic prescribing, safety alerts or as a result of information from the quality and outcomes framework (QOF). (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 also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 83% of patients with diabetes had an annual blood pressure check which was above the England average. Information obtained from the Health and Social Care Information Centre showed the practice showed for 2013/14 the practice had fallen short of achieving maximum QOF points attaining 91.8% of those available. The registered manager told us the practice had achieved better results for 2014/15 including 97% of patients with atrial fibrillation being appropriately treated with anti-platelet or anti-coagulation therapy. The team made use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP, usually every six months. They also checked all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used.

The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to

Good

Are services effective?

(for example, treatment is effective)

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 implemented the gold standards framework for end of life care. It had a palliative care register and had regular monthly multidisciplinary meetings to discuss the care and support needs of patients and their families.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area. For example, in relation to the number of emergency cancer admissions, number of patients over the age of 65 years who had a seasonal flu vaccination and the number of patients with diabetes who had a foot examination in the last year.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date annual basic life support training. The practice manager had identified the frequency staff needed to attend training and was working towards all staff being up to date.

We noted a good skill mix among the doctors with three having additional diplomas in obstetrics and gynaecology and two with diplomas in sexual and reproductive medicine. One GP had a diploma in children's health and one had a certificate in treatment of drug misusers. All GPs were up to date with their yearly continuing professional development requirements and on the NHS England performers list. All either had 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).

All staff had annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed the practice was proactive in providing training and funding for relevant courses. For example, the medical secretary had been identified as lead for health and safety and was to attend an external facilities management course. However, one of the staff we spoke with told us their appraisal had not resulted in a training plan.

We were told all of the partners were enthusiastic educators and welcomed undergraduate medical students from their first to final years. Some patients were involved in teaching and were invited to speak with students so they could gain an insight into the effect of the patient's condition on their life.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, in cervical cytology, emergency contraception, and the management of asthma.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The duty GP who reviewed these documents and results was responsible for coding and the action required. All staff we spoke with understood their roles and felt the system in place worked well.

The practice held monthly multi-disciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs. In addition there were two weekly meetings with health visitors to discuss children on the 'at risk' register. Staff told us there were good links with the local authority children's team who were based in neighbouring premises.

Information sharing

The practice used electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals through the Choose and Book system. (Choose and Book is a national

Good

Are services effective?

(for example, treatment is effective)

electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that this system was easy to use.

The practice had also signed up to the electronic Summary Care Record. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used the EMIS electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

One of the GPs was the identified lead for mental health and there were good links with the local community mental health team. Patients could be seen within the practice by the crisis team and there were proactive links with the local 'Dementia Voice' nurse.

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 understood issues relating to consent.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. The electronic patient record system highlighted when reviews were needed and templates within the system were used.

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure. For contraceptive implants there was a consent form for patients to sign.

Health promotion and prevention

The practice had met with the Public Health team from the local authority and the CCG to discuss the implications and share information about the needs of the practice population.

All patients who wished to join the practice, and who lived within the practice area and were not registered with another GP in the area, could apply in person. They were required to bring proof of identity and address and complete a registration form and new patient questionnaire. New patients requiring repeat medicines were required to see a GP before a prescription would be issued. The practice was more relaxed about registering patients from the travelling community as they may not have proof of identity or address.

We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering immediate chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability who were offered an annual physical health check. The EMIS electronic patient record system alerted staff when these were due. Similar mechanisms of identifying 'at risk' groups were used for patients with poor mental health (including dementia) and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for cervical smear uptake was 89%, which was better than most others in the CCG area and higher than the England average of 82%. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance.

The practice maintained a register of patients identified as being at high risk of hospital admission and at the end of life. All patients over the age of 75 years had a named GP annual review and documented care plan. There were

Good

Are services effective?

(for example, treatment is effective)

monthly multi-disciplinary team meetings and there was close liaison with the manager of the local sheltered housing complex. Patients' who lived there had quarterly medicines reviews by the practice pharmacist.

The EMIS electronic patient record system alerted staff when patients with long term health conditions care was due for review. Quality and Outcomes Framework data for 2013/2014 showed the practice achieved similar to England average results for ensuring patients with diabetes had a cholesterol check within the preceding year.

The practice achieved good results for childhood immunisations with 100% take up for MMR, Infant meningitis C and the pneumococcal conjugate vaccine booster (PCV).

For working age patients, those recently retired and students the practice encouraged the use of online booking and prescription requests. There was in-house triage of gynaecology referrals to reduce unnecessary hospital attendance and staff were trained in high definition photography so that tele-dermatology referrals could be made. Tele-dermatology is a subspecialty in the medical field of dermatology and probably one of the most common applications of telemedicine and e-health. In tele-dermatology, telecommunication technologies are used to exchange medical information (concerning skin conditions and tumours of the skin) over a distance using audio, visual and data communication.

The practice maintained a register of patients whose circumstances make them vulnerable. For example, patients with learning disabilities and those receiving palliative care. There was an identified nurse to work with patients with learning disabilities and annual reviews were carried out.

The practice had a lead GP for addictions who had liaised with the Bristol Drugs Project (BDP) for a number of years. We were told how there had been a review of all of the patients on the BDP case load last year by the lead GP and a member of the BDP team to ensure they were receiving the most effective treatment to meet their needs.

There were monthly meetings with the community dementia liaison nurse and good links with 'Dementia Voice'.

We saw a range of information in the waiting room that provided patients with information about health conditions and support services available in the area.

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 national patient survey for 2014/2015 and a survey of 218 patients undertaken by the practice's patient participation group (PPG) in 2013. The evidence from these sources 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 91% of patients who responded felt the last time they saw or spoke to a GP the GP was good or very good at involving them in decisions about their care. This was higher than the average of 82% for practices in the Bristol Clinical Commissioning Group (CCG) area. Similarly, 95% of respondents felt the last time they saw or spoke with a nurse, the nurse was good or very good at involving them in decisions about their care.

The PPG survey results showed 92% of respondents found receptionists friendly and 87% found them to be efficient or fairly efficient. At the time of the survey in 2013, 63% of respondents indicated they would definitely recommend the practice and 30% would probably recommend. The NHS England survey results for 2014/2015 showed an increase with 71% indicating they would definitely recommend the practice to others. The Friends and Family Test was introduced in NHS services in 2014 and the practice was monitoring responses on a monthly basis. The monitoring showed most of those who gave feedback would recommend the practice.

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. 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' treatment so that confidential information was kept private. The practice switchboard was located away from the reception desk. An action taken from the patient survey results was to install a door between the reception and office area which helped keep patient information private. In addition reception staff were reminded to offer discussion in a private location away from the reception desk.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager.

Reception staff received training in diversity so that they could meet the needs of vulnerable groups including the traveling community. There were an increasing number of patients who originated from Poland. The practice had access to an interpreter service if needed.

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 rated the practice well in these areas.

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. When we spoke with patients they gave various examples of how staff at the practice had been helpful and how they had been given good advice.

The Medical Centre, Ridingleaze was a Four Young Person (4YP) practice. Services that displayed the 4YP logo had to meet a number of standards. Wherever the 4YP logo was displayed in doctor's surgeries patients could be sure that the services on offer were young people friendly. That meant that patients would be treated with respect and the practice would not pass on anything the patient had told them unless they had discussed and agreed it with the patient first.

Good

Are services caring?

Patient/carer support to cope emotionally with care and treatment

Information taken from Public Health England for 2013/2014 showed 25% of patients had caring responsibility compared to 18% as the England average and it was recognised that a higher percentage could mean an increased demand for GP services.

Leaflets in the patient waiting room and information on the practice website provided information to patients on how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer so they could speak with the patient about their responsibilities. We saw the written information available for carers to ensure they understood the various avenues of support available to them. We noted the new patient questionnaire asked for this to be declared on registration so they could be linked to a carers group. The practice recognised the needs of young carers and included contact details for the Bristol Young Carers Project.

We spoke with one of the GPs who told us they carried out their own out of hours visits for patients receiving palliative care. They gave the patient or their carer their personal telephone number so they could contact the GP directly for support.

Staff told us that if families had suffered bereavement, their usual GP contacted them. One of the GPs told us they visited the family to offer support.

The practice recognised large amounts of social isolation in the area and was involved in various social prescribing projects to help reduce this.

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 registered manager told us that through working with colleagues in public health the practice was looking towards long-term goals of improved wellbeing in the community. The practice was working collaboratively with the community and other service providers to develop a community hub where the practice would re-locate when the current lease expired. We saw information and plans for the community hub displayed in the waiting area to keep patients informed.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG) survey. These included the introduction of telephone consultations and installation of a door between the reception area and office in order to improve patient confidentiality. In addition the practice now informed patients by way of a notice, who the duty GP was and informed them on arrival what the likely wait will be if they are running late.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services.

For example, the practice was relaxed about registering patients from the travelling community who could not provide an address. In addition there were interpreter services available if needed.

The practice provided equality, diversity and human rights training. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months and that equality and diversity was regularly discussed.

The premises and services had been adapted to meet the needs of patient with disabilities. The practice was situated on the ground and first floors of the building with all services for patients on the ground floor.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and pushchairs and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice as well as baby changing facilities.

Access to the service

Appointments were available from 08.30 am to 18.30 pm on weekdays. The practice closed between 12.30 until 13.30 pm for lunch. The practice offered pre-bookable early morning appointments on Monday, Tuesday, Wednesday and Thursday mornings from 07.30 am and late evening appointments from 18.30 until 19.10 pm on these days. These appointments were specifically for patients who could not access appointments during the normal opening hours. The practice had introduced telephone consultations at the end of surgery. Appointments could be booked on line.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to two local care homes on a specific day each week, by a named GP and to those patients who needed to see a GP at other times.

There were appointments outside of school hours and children under the age of five years were always seen the same day at the request of a parent or guardian.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Patients could order repeat prescriptions in writing or on line and were available for collection after 48 hours. Some patients had their medicines delivered in dosette boxes and there was a designated member of staff for liaising with nominated pharmacists for this service.

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 saw that information was available to help patients understand the complaints system in the practice leaflet and set out fully on the practice website. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at 14 complaints received in the last 18 months and found records showed the patient's ID, date and nature of the complaint, the actions taken and the outcomes of the practices investigation of the complaint.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the complaints we saw and noted four were in relation to availability of appointments and three related to prescribing. There were no other themes however lessons learned from individual complaints had been acted on. For example, appointments had been made more available through on-line booking facilities and prescribing procedures had been updated.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were outlined in its statement of purpose. The practice vision and values included incorporating clinical governance and evidence based practice, risk management and reduction of risk to improve its services. It strived to be person centred and to have effective communication with patients.

We spoke with 12 members of staff and they demonstrated the vision and values and knew what their responsibilities were in relation to these.

Governance arrangements

The practice manager commenced working at the practice at the end of 2014 and had identified a number of areas where improvements were needed in relation to staffing, patient experience, the partnership and organisation. They compiled a development plan listing the areas identified and what was required to achieve improvement with target dates. The final completion dates for these improvements was the end of March 2016. Most achievements were to be met in 2015 and we saw many of the targets had been achieved.

One of the areas identified in an early meeting with the team was for staff to fully understand the roles of others within the practice. The manager had committed to provide an organisational chart to help staff understand by the end of April 2015.

Another identified need was to improve communication amongst staff. The practice manager implemented a programme of regular staff meetings. At a meeting in January 2015 it was highlighted that there was a need for improved communication and teamwork. Staff we spoke with all commented on the improved communication since then and some reflected on the feeling they were now part of a team.

There were named members of staff with lead roles. For example, there was a lead nurse for infection control and partners were the leads for child protection and safeguarding vulnerable adults. We spoke with eight members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at 11 of these policies and procedures. The practice manager had identified a number of policies and procedures that needed to be reviewed and updated and had included these in the development plan; we saw some of these actions had been achieved within the given timescale.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that impromptu meetings were held to review performance and QOF data was discussed towards the end of the cycle and action plans were produced to improve outcomes.

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example there were regular prescribing audits to ensure the prescribing was in line with National Institute for Health and care Excellence (NICE) guidelines and those produced by Bristol Clinical Commissioning Group (CCG). We also saw an audit of patients who did not attend appointments, an audit of fever in children and an audit of audiology referrals.

Leadership, openness and transparency

The partners met monthly and additionally had an evening meeting every quarter. There were monthly business meetings and monthly clinical meetings when significant events were discussed. There were also meetings every month for non-clinical staff where they also discussed significant events. In addition there were weekly meetings for the partners and weekly multi-disciplinary meetings with the community teams.

The practice manager was responsible for human resource policies and procedures. We reviewed the policies in relation to recruitment and the taking up of references. The practice manager had identified other staff policies and the staff handbook need reviewing and updating and had committed to review these by end of June 2015 as part of the development plan for the practice.

Are services well-led?

Good

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

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

The practice had gathered feedback from patients through patient surveys and complaints received. We looked at the results of the annual patient survey for 2013/2014 when 86% of patients booked appointments by telephone and 6% made face to face appointments in reception. At that time the practice did not offer online appointment booking but has since introduced this facility as 6% of patients felt this would be useful. Patients expressed concerns about accessing appointments and in response the practice changed the appointment system to increase the number of urgent appointments available each day.

There was concern about the level of confidentiality in the practice and a door was installed between the reception area and office so that telephone calls could not be overheard. In addition, reception staff were reminded to inform patients they could go to a more private area to discuss issues.

The practice had an active patient participation group (PPG) however, it had become dormant and was not meeting or actively representing the practices patients. The practice manager had included actions within the development plan to address this. They intended to contact all members of the PPG to ask them if they were still interested in being a part of the group by the end of May 2015.

The friends and family test was introduced by end of January 2015 and the practice was pleased with the results for the first three months of this year which indicated most patients would recommend the practice to others.

The practice had gathered feedback from staff through an evening event and staff meetings. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistleblowing policy which was available to all staff. Staff told us they would report concerns to management.

Management lead through learning and improvement

Staff told us they had appraisals with the practice manager and most said this led to a training and development plan. For example, lead responsibilities were identified for some staff and role specific training was identified. The practice manager had identified and included training requirements within the practice development plan. Staff told us they were in the process of completing some mandatory training as identified.

The practice welcomed medical students from their first to final year. We were told this provided the practice a special opportunity and rewarding experience as different year students questioned different things. It challenged the GPs as they were asked why they did things in a certain way. This helped the practice to keep up to date with clinical guidelines.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings and away days to ensure the practice improved outcomes for patients. For example, we saw the analysis of significant events recorded the date the event was discussed and the actions taken in response, including the staff responsible.