Leap Valley Medical Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Summary of this inspection

Page

Overall summary 2

The five questions we ask and what we found 4

The six population groups and what we found 6

What people who use the service say 9

Areas for improvement 9

Detailed findings from this inspection

Our inspection team 10

Background to Leap Valley Medical Centre 10

Why we carried out this inspection 10

How we carried out this inspection 10

Detailed findings 12

Action we have told the provider to take 28

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Leap Valley Surgery on Tuesday 19 May 2015. Overall the practice is rated as good.

The practice provides a service at the Leap Valley Surgery in Downend and Abbotswood in Yate. We did not visit the Abbotswood surgery.

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 had received 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.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- 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.

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

Importantly the provider should:

- Ensure all significant events are recorded to maintain a record of the event and learning identified.

Summary of findings

- Record prescription serial numbers when they are received in the practice so stocks can be audited.
- Ensure all prescription errors are recorded.
- Ensure the expiry date of the oxygen supply is recorded so it is not used when out of date.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

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

Are services effective?

Good

The practice is rated as good for providing effective services. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing 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 some reception staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Feedback from the practice survey showed patients were generally happy with the service provided by the practice. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. 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 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 and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Summary of findings

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 clinical governance meetings. 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) was active. Staff had received inductions and attended staff meetings.

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

The practice was working with Age UK on an integrated care project to support older patients with long term conditions to explore ways of improving their lives. There were weekly integrated care meetings with surgery staff, district nurses, community matron and social services to identify patients at risk of unplanned hospital admission.

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 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 named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multi-disciplinary package of care.

Where possible, the practice encouraged self-management of long-term conditions.

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. One of the GPs had a special interest in paediatric medicine and managed the care of any child who needed enhanced intervention.

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 examples of joint working with midwives and health visitors. There was a weekly drop-in clinic where parents could take their pre-school age children for routine checks or immunisations.

Summary of findings

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 reserved triage appointments throughout the day with each GP so patients from this group could access healthcare at a time that suited their commitments and lifestyle.

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 those who lived in a women's refuge and those with a learning disability. It had carried out annual health checks for people with a learning disability. It offered longer appointments for people with a learning disability.

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 offered a service to patients with substance dependency and worked with other organisations to ensure appropriate treatment was provided.

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 living with dementia). Patients experiencing poor mental health had an annual physical health check. 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

Summary of findings

organisations. Staff had received training on how to care for patients with mental health needs and dementia. When a patient was diagnosed with dementia they were given an information pack to give their families information and support. This included carer support information	

Summary of findings

What people who use the service say

We consulted with the managers of the three care homes the practice provided a service to. One of them told us they believed the practice to be well-led because of the way it provided safe, effective caring and responsive services. They told us about the patient centred approach adopted by the practice and how the practice addressed their resident's needs. Another of the care homes said the GP was always helpful and practical in meeting resident's needs.

The home manager told us about the support residents received including annual health checks and medicines reviews. They said the GP who visited had developed a good working knowledge of residents' health and conditions and could easily recognise when something was 'not right'. Best interests meetings were held when residents did not have the capacity to make informed decisions. The manager told us communication was good between the home and said receptionists were very helpful.

We saw the results of the friends and family test (FFT). Almost all those who responded to the FFT for Leap Valley Medical Centre and Abbotswood said they were likely or extremely likely to recommend the practice.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 16 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Two comments were less positive but there were no common themes to these. We also spoke with eight patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Areas for improvement

Action the service SHOULD take to improve

Ensure all significant events are recorded to maintain a record of the event and learning identified.

Record prescription serial numbers when they are received in the practice so stocks can be audited.

Ensure all prescription errors are recorded.

Ensure the expiry date of the oxygen supply is recorded so it is not used when out of date.

Leap Valley Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Leap Valley Medical Centre

Leap Valley Medical Centre serves the populations of Downend, Emersons Green, Yate and surrounding areas. It has two surgeries, the main surgery at the Leap Valley Medical Centre in Downend and the branch surgery at Abbotswood in Yate. We did not visit the Abbotswood surgery as part of this inspection.

Leap Valley Medical Centre offers a full general practice service with specialist clinics for children, patients with long term conditions and for patients needing minor surgery.

The practice is open between 8.00 am until 6.30 pm on weekdays.It has extended opening hours for a limited number of GP appointments and telephone consultations at the Downend surgery between 6.30pm and 7.00pm every evening except Thursday, and at the Abbotswood surgery on a Monday evening between 6.30 – 7.30pm. It also offers some early morning telephone consultations on Tuesday and Thursday.

Out of Hours, the practice contracts it's service with Brisdoc and patients can obtain assistance by dialling the NHS 111 telephone number.

The practice provides a service to over 10,000 patients with approximately 7,000 at the Downend surgery and approximately 3,000 using the Abbotswood surgery. Patients tend to use the surgery closest to where they live however; they can be seen at either surgery.

As a partnership there are three female GPs and two male GPs. The partnership employs two other male GPs and a female GP. Along with their general practitioner qualifications, some GPs hold other qualifications in obstetrics (care of women before childbirth) and gynaecology, minor surgery, family planning and diabetes care. One of the salaried GPs holds a qualification in teaching and learning for health professionals. In addition GPs had special interests in care of the elderly, sports medicine, mental health, joint problems, end of life care and coronary heart disease. One of the GPs has a special interest in paediatric medicine and manages the care of any child who needed enhanced intervention.

There is a nurse practitioner. A nurse practitioner is an advanced practice nurse that helps with all aspects of patient care, including diagnosis, prescribing treatments and consultations. The nurse practitioner has a special interest in inflammatory bowel disease, chronic obstructive pulmonary disease (COPD) and asthma.

The qualified practice and treatment room nurses carry out a variety of duties such as smears, injections, dressings etc. In addition to general nursing duties the two practice nurses provide care for patients with chronic conditions such as asthma, diabetes, coronary heart disease and hypertension.

The phlebotomist takes blood whilst the Health Care Assistant carries out well person checks and can take blood, check blood pressure, test urine, do ECGs (a heart test) and undertake simple dressings."

Detailed findings

District nurses, health visitors and community midwives are attached to the practice but are based at the Downend Clinic, a short distance from Leap Valley Medical Centre.

The practice is a teaching practice (teaching practices take medical students and training practices have GP trainees and F2 doctors). The practice had a GP registrar.

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We met with the South Gloucestershire Clinical Commissioning Group (CCG), NHS England area team and local Healthwatch. They had no concerns about Leap Valley Medical Centre. We also contacted three local care homes who gave positive feedback We carried out an announced visit on 19 May 2015. During our visit we spoke with a range of staff including GPs, the general, operations and support services manager, nurses and administrative staff. We spoke with six patients who used the service. We observed how people were being cared for and talked with family members and reviewed records. We reviewed 16 comment cards where patients shared their views and experiences of the service.

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People 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 prioritised safety and 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 a report of a significant event that occurred in December 2014. There was a description of the event which involved a passer-by who collapsed outside of the surgery. Staff were quick to respond and dealt with the situation calmly, providing first aid and obtaining further assistance by calling for an ambulance. The person was given first aid however, the first aid box could not easily be found. This was because the incident occurred one week after the move to new premises and the cupboard was untidy. The practice responded by ensuring it was readily available and all staff were made aware of its location. In addition, a notice was displayed identifying the qualified first aider as they were not called initially as clinicians were closer.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last year. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of three significant events that had occurred during the last year and saw this system was followed appropriately. Significant events were a standing item on the practice meeting agenda. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so. One of the GPs we spoke with felt significant event recording could be improved. They told us about a minor prescribing error however, this was not recorded.

Staff used incident forms on the practice intranet and sent completed forms to the operations manager. They showed us the system used to manage and monitor incidents. We tracked three incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result and that the learning had been shared. For example, we saw how the operations manager had shared learning from a significant event with other practices in the Clinical Commissioning Group (CCG) area. The significant event related to a complaint from a patient where the practice did not action an abnormal urine test result in a timely manner. There was a reason for this relating to the interpretation of results by the electronic patient record system. The practice devised a system for responding to test results that it passed on to other practices. Where patients had been affected by something that had gone wrong they were given an apology and informed of the actions taken to prevent the same thing happening again.

National patient safety alerts were disseminated by the operations manager to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed in meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action. One of the GPs told us and we saw how guidelines relating to gastro-oesophageal reflux in children was shared amongst the staff team electronically and in paper format in order that they were up to date with current treatment.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at the policies and procedures for child protection and safeguarding vulnerable adults and saw they included contact details for reporting suspicions of abuse.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil these roles. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

We looked at training records which showed that all staff had received relevant role specific training about safeguarding. 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.

One of the nurses told us about a child who had been referred to the local authority children's department child protection team because the practice had concerns. They also told us about the reporting of potential abuse of an older person. One of the GPs told us about a situation that did not meet the local authority adult safeguarding thresholds and how the outcome for the patient was that the practice provided on-going monitoring of their well-being.

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. There was active engagement in local safeguarding procedures and effective working with other relevant organisations including health visitors and the local authority.

We saw the minutes of monthly safeguarding meetings and noted there was a full record of the meetings maintained including discussions about police reports and reasons patients attended the hospital accident and emergency department.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms and on the practice web site. (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 and receptionists had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). When a chaperone was offered it was recorded in the patient's record along with their decision.

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 policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed room temperature and fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature. There was a contingency in place for if the fridges broke down. We saw the fridges were not hard wired but there was no sign on the plug to remind staff not to switch off the electricity supply. The practice immediately labelled the plug to prevent any accidental switch off of the fridges.

There was a full list of medicines held in the practice along with the date they were ordered and their expiry dates. 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 there was a policy for repeat prescribing and medicines review. It identified how an acute prescription could become a repeat prescription and who could make that decision. It also gave guidelines on reviewing repeat medicines and the reporting of errors and safety incidents. We saw an audit of medicines reviews was conducted in May 2015. It considered the medical notes for 25 randomly selected patients and showed only 64% patients had medicines reviewed in the last 12 months. Discussion and actions arising from the review showed there would be a re-audit in 12 months and ensuring medicines were reviewed.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were kept securely at all times. We noted the practice recorded the serial numbers of prescriptions used by the GPs. However, the practice did not record serial numbers when prescriptions were received into the practice making it difficult for the practice to audit potential misuse of prescriptions. The operations manager told us they would ensure the serial numbers of prescriptions received in the practice would be recorded.

Good

Are services safe?

There was a system in place for the management of high risk medicines which included monitoring in accordance with national guidance. Appropriate action was taken based on the results.

The practice had clear systems in place to monitor the prescribing of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse). They carried out regular audits of the prescribing of controlled drugs. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

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. The nurses also administered vaccines and other medicines using Patient Specific Directions (PSDs) that had been produced by the prescriber. We saw evidence that nurses had received appropriate training and been assessed as competent to administer the medicines referred to either under a PGD or in accordance with a patient specific directive (PSD) from the prescriber. A member of the nursing staff was qualified as an independent prescriber and she received regular supervision and support in her role as well as updates in the specific clinical areas of expertise for which she prescribed.

We saw a positive culture in the practice for reporting and learning from medicines incidents and errors. Incidents were logged efficiently and then reviewed promptly. This helped make sure appropriate actions were taken to minimise the chance of similar errors occurring again.

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, including requests for additional supplies of cleaning products. We spoke with the support services manager who told us about the monthly meetings they had with a representative of the cleaning contractor to review cleaning arrangements. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

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 (PPE) 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 found there was ample PPE available for staff along with means for the disposal of PPE. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

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 infection control specific to their role and received updates. We saw evidence that the lead had carried out an audit of hand-washing techniques in 2014 and there was a full infection control audit carried out be an external contractor in 2015. Actions arising from the audits were responded to in a timely way.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. There was hand gel in the waiting area adjacent to the patient sign in screen.

All of the floors and furniture had wipe clean surfaces.

The practice was not required to carry out tests for legionella (a bacterium which can contaminate water systems in buildings) as the modern water system had a built in programme to eradicate any bacteria contained within it.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records 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 and blood pressure measuring devices.

We saw evidence of weekly testing of the fire alarm system and equipment. Emergency lighting was tested monthly and there was three monthly testing of the panic alarm for

receptionists, electrical circuit breakers and the accessible toilet pull alarm. The passenger lift had a six monthly statutory inspection. All of these tests were entered in a diary.

Staffing and recruitment

The practice had a recruitment policy and separate staff vetting policy that set out the standards it followed when recruiting clinical and non-clinical staff. It showed all staff would have checks with the Disclosure and Barring Service (DBS). (These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

Records we looked at contained 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 the appropriate checks through the DBS.

We saw there were bespoke inductions planned for staff dependent on their role within the practice. For example, we saw induction checklists for a salaried GP and GP registrar in addition to the induction checklist for reception staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff 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.

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. There was a timetable to show when GPs were working at either the Downend surgery or Abbotswood, in Yate. The operations manager showed us records to demonstrate that actual staffing levels and skill mix met planned staffing requirements. When appropriate the practice took action to ensure staff were comfortable with working conditions. For example, receptionists worked at the front desk for a maximum of two hours at a time and when raised the nurse practitioner triage system was reviewed and a more balanced workload was implemented.

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 regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice had policies related to risk management, health and safety and associated legislation such as control of substances hazardous to health.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. Risks associated with service and staffing changes, both planned and unplanned, were required to be included on the log. We saw an example of this related to a staff members working arrangements and the mitigating actions that had been put in place.

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, staff gave us examples of how they responded to patients when they found test results required urgent referral. A baby with an eye infection who was irritable was sent to the Bristol Children's Hospital, and needed intravenous anti-biotic treatment because their infection had become more serious. A male patient, following a blood test was referred for an urgent urology appointment because their prostate specific antigen (PSA) level was raised and they were found to have prostate cancer. A further patient with breathing difficulties was called an ambulance by the advanced nurse practitioner who suspected she had a pulmonary embolism (PE). The nurse later found out the patient had multiple PEs that had been life threatening.

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 external defibrillator (used in cardiac emergencies). We saw there was a list of emergency medicines with dates of expiry that were checked monthly. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. All the medicines we checked were in date and fit for use. We noted the expiry date for oxygen was not recorded presenting a risk that it could be used when it was out of date.

Good

Are services safe?

One of the nurses told us there was a panic alarm built into the electronic records system and at the reception desk so all staff could be alerted if there was an emergency in one of consulting or treatment rooms or in the waiting area.

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 building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed.

The practice had carried out a fire risk assessment in 2014 that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised fire drills. A fire drill was carried out in February 2015 with a prompt response from staff and patients recorded.

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.

We discussed with the operations manager, GP and nurse how NICE guidance was received into the practice. They told us this was downloaded from the website and disseminated to staff. We saw minutes of clinical meetings which showed this was then discussed and implications for the practice's performance and patients were identified and required actions agreed. One of the salaried GPs gave an example of how NICE guidelines for the treatment of atrial fibrillation (abnormal heart rhythm) had been discussed at a clinical meeting.

Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines. One of the nurses told us before seeing a teenage patient diagnosed with acne they obtained the NICE guidance for the treatment of this condition to ensure that the most up to date treatments and prescribing were considered.

Staff described how they carried out comprehensive assessments which covered all health needs which were in line with national and local guidelines. They explained how care was planned to meet identified needs and how patients care and treatment were reviewed at required intervals to ensure their treatment remained effective. For example, the practice maintained a list of patients with diabetes were having regular health checks and were being referred to other services when required. The practice had devised a template for recording the checks carried out were in line with NICE guidelines. Feedback from patients confirmed they were referred to other services or hospital when required.

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. GPs and nursing staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to review and discuss new best practice guidelines, for example, for the management of respiratory disorders. Our review of the clinical meeting minutes confirmed that this happened.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. The practice health visitors for the elderly, commissioned by the South Gloucestershire Clinical Commissioning Group (CCG) from Sirona Care and Health used the Active Ageing care record for these patients (Active ageing is the process of optimising opportunities for health, participation and security in order to enhance quality of life as people age and is supported by the World Health Organisation). The patients were reviewed regularly to ensure multi-disciplinary care plans were documented in their records and that their needs were being met to assist in reducing the need for them to go into hospital.

We saw that after patients were discharged from hospital they were followed up to ensure that all their needs were continuing to be met. We were told about a poor hospital discharge. Nurses organised for the re-ablement team to visit poorly discharged patients (re-ablement is a time limited intervention by health and care services to support a patient to remain at home). They also arranged for a GP review and for the patients medicines to be dispensed in a monitored dosage pack.

The practice nurse had been trained to carry out hearing tests. They could assess patients and refer them to the NHS contracted audiology service for further assessment and treatment of provision of hearing appliances.

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

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information was used to improve care. 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

Good

Are services effective?

(for example, treatment is effective)

alerts and medicines management. The information staff collected was then collated by the operations manager and support services manager to support the practice to carry out clinical audits.

The practice showed us eight clinical audits that had been undertaken in the last two years. Four of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, an audit of joint and soft tissue injections showed that in-house treatment for pain relief had been maintained and screening of referrals to secondary care for this had all been appropriate. Another audit showed the total number of inadequate cervical smear tests fell below the agreed local average of 3% inadequate for each of the practice nurses who carried out the tests. The inadequate smear test results were reviewed by the practice and they found in many cases there were comments in the notes which indicated the clinician had advised the patient it may not be an adequate sample due to the circumstances presented.

Other examples included audits to confirm that the GPs who undertook minor surgical procedures, contraceptive implants and the insertion of intrauterine contraceptive devices were doing so in line with their registration and National Institute for Health and Care Excellence guidance.

The GPs told us clinical audits were often linked to medicines management information, 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). For example, we saw an audit regarding the prescribing of ACE inhibitors (used to relax blood vessels and lower blood pressure), diuretics (to promote the production of urine) and nonsteroidal anti-inflammatory drugs. The practice carried out the audit with the medicines optimisation team from South Gloucestershire Clinical Commissioning Group (CCG) as research showed the combination of the triple therapy resulted in an increased risk of acute kidney injury. The audit identified there were 10 patients prescribed the triple therapy out of the practice population of over 10,000. Nine of the patients stopped taking one of the medicines and the other patients had not stopped any medicines following a discussion with their GP where it was agreed they would continue with the therapy with appropriate monitoring and advice.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, the performance for diabetes related indicators and the percentage of patients with physical and or mental health conditions whose notes recorded smoking status in the last twelve months. In addition, the number of women aged between 25 and 65 years whose notes recorded them having cervical screening in the last five years. The results were all similar to the national average, as expected. QOF data was reviewed at the practices monthly clinical meetings. The practice was aware of all the areas where performance was not in line with national or CCG figures and had action plans setting out how these were being addressed.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement. One of the practice nurses told us about an audit they carried out relating to immunisations. They asked 30 patients their preference for having one or two nurses to give immunisations and 28 opted for one nurse. They told us they would share the findings with the GP partners.

The practice's prescribing rates were similar to national figures. However we did note that during 2013/2014 the prescribing rates for the number of Ibuprofen and naproxen items prescribed as a percentage of all non-steroidal anti-inflammatory medicines was better than the national average at 58% compared with the expected percentage of 71%.

There was a protocol for repeat prescribing which followed national guidance. The practice had implemented measures to ensure all patients had their medicines reviewed at appropriate intervals. This required staff to regularly check patients receiving repeat prescriptions had

been reviewed by the GP. 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 practice had a palliative care register and had regular monthly meetings involving most GPs, Sirona and a representative from the local hospice to discuss the care and support needs of patients and their families. The most in need patients on the palliative care register were also discussed at the weekly multi-disciplinary team meetings.

The practice also kept a register of patients identified as being at high risk of admission to hospital and of those with learning disabilities. Structured annual reviews were undertaken for these patients and those with long term conditions such as diabetes, chronic obstructive pulmonary disease and asthma. There was also a register of patients with poor mental health and a system where they were identified for annual review of their mental and physical health.

Doctors and the practice nurse undertook minor surgical procedures in line with their registration and National Institute for Health and Care Excellence (NICE) guidance. The staff were appropriately trained and keep up to date. The practice nurse was mentored by one of the GPs and had signed directives from the GP authorised them as being competent to remove skin tags and seborrhoeic warts, seborrhoeic warts are found in about 1% of pregnancies.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support, health and safety, infection control and safeguarding vulnerable adults and children. We noted a good skill mix among the GPs with a number having additional diplomas in sexual and reproductive medicine, obstetrics and gynaecology, diabetes and minor surgery. One of the GPs held a teaching and learning for health professionals qualification.One of the GPs had a special interest in paediatric medicine and managed the care of any child who needed enhanced intervention.

All GPs were up to date with their yearly continuing professional development requirements and 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).

The reception lead had introduced annual appraisal for the reception team that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses for example, in management and in medical terminology. As the practice was a training practice, doctors who were training to be qualified as GPs were offered had access to a senior GP throughout the day for support. We received positive feedback from the trainee we spoke with. They told us they had a planned three-week induction and attended practice meetings. They told us how they had been encouraged and commenced an audit in the management of paediatric urinary tract infections.

Practice nurses and health care assistants had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties. For example, the administration of vaccines and cervical cytology. Those with extended roles for example, seeing patients with long-term conditions such as asthma, chronic obstructive pulmonary disorder, diabetes and coronary heart disease, were also able to demonstrate that they had appropriate training to fulfil these roles. The practice nurse attended courses in relation to minor surgery and hearing tests.

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 these communications. Most Out-Of-Hours reports, 111 reports and pathology results were seen and actioned by a GP on the day they were received. The exception to this was when the GP was on a day off. If they were off longer than one day they would be reviewed by other GPs. Discharge summaries and letters from outpatients were usually seen and actioned on the day of receipt and all within two days

Good

Are services effective?

(for example, treatment is effective)

of receipt. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up.

Emergency hospital admission rates for the practice were low at 11% compared to the national average of 13%. The practice was commissioned for the unplanned admissions enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract).

The practice held weekly multi-disciplinary team meetings to discuss patients with complex needs. For example, those with multiple long term conditions, mental health problems, people from vulnerable groups, those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, a social worker, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate.

We attended a multi-disciplinary care meeting as part of our inspection. The community matron and nurse led the meeting and there was good participation by the GPs. We heard caring discussions carried out with empathy and respect for each other's viewpoint. The meeting focussed on the needs of patients and included a review of good prescribing practice in relation to dementia, blood pressure and chronic obstructive pulmonary disease.

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. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance and Out-Of-Hours services.

For patients who were referred to hospital in an emergency there was a policy of providing a printed copy of a summary record for the patient to take with them to Accident and Emergency. The practice had also signed up to the NHS 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. In addition the NHS locally was developing the Connecting Care Record that would hold additional information about a patient's health so they could be treated more effectively.

The practice had systems to provide staff with the information they needed. Staff used the EMIS Web 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. We saw evidence that audits had been carried out to assess the completeness of these records. The audit considered 10 consecutive consultations for each of the eight GPs for either of two days. It recorded a range of actions recorded as an outcome of the appointments and highlighted where improvements were needed. The report of the audit concluded a further audit would be conducted in a few months' time.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it. Staff told us how the Mental Capacity Act had been discuss at a practice meeting in response to a deprivation of liberty safeguard (DOLS) case raised in the media.

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. One of the GPs told us they had reviewed the care needs of 45 of the 55 patients with learning disabilities during the last year.

When interviewed, staff gave examples of how a patient's consent was obtained and recorded and how they would involve a GP so the patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of the Gillick competency test. (These are used to help assess whether a child under the age of 16 has

Good

Are services effective?

(for example, treatment is effective)

the maturity to make their own decisions and to understand the implications of those decisions). A GP told us Gillick competency had been discussed during a child safeguarding meeting.

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's consent was recorded with a record of the discussion about the relevant risks, benefits and possible complications of the procedure. Written consent forms were scanned into the electronic patient records.

Health promotion and prevention

It was practice policy to offer a health check to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. 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 chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers.

The practice's performance for the cervical screening programme was 81%, which was similar to the national average of 82%. A practice nurse had responsibility for following up patients who did not attend. The practice also encouraged its patients to attend national screening programmes for breast cancer screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance was above average for the majority of immunisations where comparative data was available. For example, flu vaccination rates for the over 65s were 79%, and at risk groups 51%.

There was a range of information on the practice website relating to 'self-help' and other local services. Self-help information included the suggested medicines that could be kept in a person's home such as Paracetamol, indigestion remedy and rehydration mixture. It also gave advice about their storage. In addition there was information about how the local pharmacist could give advice, attending the minor injury unit and NHS walk in centres and NHS 111 advice line.

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 2013/2014, the friends and family test results and a survey of 215 patients undertaken by the practice's patient participation group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care.

The evidence from all 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 the practice was rated just below the national average for patients who rated their overall experience of the practice as between fairly good and very good. The practice also achieved positive results for its satisfaction scores on consultations with doctors and nurses. For example 43% of respondents stated they always or almost always saw or spoke with the GP of their choice compared to the national average of 38%. When asked if the GP was good at treating them with care or concern 76% responded positively compared to the national average of 85%. Similarly when asked if the GP was good at involving them in decisions about their care 76% responded positively compared to the national average of 82%.

Patients completed Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. We received 16 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Two comments were less positive but there were no common themes to these. We also spoke with eight patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

The practice provided a service to three local care homes. One, a nursing home for older people specialising in end of life care and the other two for adult with learning disabilities. Each of the home managers responded positively about the service provided.

We saw the results of the friends and family test (FFT). Almost all those who responded to the FFT for Leap Valley Medical Centre and Abbotswood said they were likely or extremely likely to 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/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 that confidential information was kept private. There was a notice at reception asking patients to stand back until it was their turn so that other patient's confidentiality could be respected. The practice switchboard was located away from the reception desk which ensured patient information was kept private. Patients said they found the receptionists at the practice helpful.

The practice devised a letter to be given to those staying at a women's refuge. It outlined how the practice endeavoured to keep people's information safe. It acknowledged they may not have the documentation required for registering at the practice and advised how to obtain their NHS number. The refuge had a PO Box address and the letter advised people to use this so there would be no traceable address on correspondence leaving the practice.

There was a note on the practice website 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.

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. Patient feedback on the comment cards we received was also positive and aligned with these views.

The practice acknowledged to us it needed to improve the care planning processes. It had found the work to be more labour intensive than initially thought. The managing partner told us they needed dedicated time to conduct and review the care plans but recognised this would take time away from other patient contacts. The audit of records showed most patients did have appropriate health management plans in place.

End of life planning was discussed with older patients and patients with long term conditions. Patients with diagnosed learning disabilities and poor mental health discussed health management as part of their six monthly or annual reviews.

A parent told us how the GP they saw with their child with learning disabilities always spoke with and involved the child and because they had no speech and could not respond verbally, sought assurances from the parent.

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area.

The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

The practice website had a dedicated 'Carer's' page. It defined carers and gave information about carer's looking after their own health. It advised patients to tell their GP they had caring responsibilities and advised how to obtain the carers emergency card. The carer's emergency card identified the person as a carer and could be used in an emergency situation to alert the emergency communications team to advise them the person the carer looked after needed help.

The carer's information advised that a carer's assessment could be obtained to access services, gave information about contacting the carer's support centre and listed useful contact organisations.

The practice had a carer's information leaflet with registration form to inform the practice that the patient was a carer. There was a dedicated leaflet for young carer's.

The practice website acknowledged the death of a loved one could be extremely difficult to deal with and referred patients to the practice guide to coping with a death. It was designed to help with immediate practical matters and provide information that may be useful in the weeks following bereavement. In addition there was a list of useful contacts including, Cruse Bereavement Care and the Probate and Inheritance Tax helpline.

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 practice had weekly integrated care meetings to identify older patients and those with long term conditions who may need additional support because of their risk of admission to hospital. There were health checks for patients with long term conditions and those with poor mental health. The practice held multi-disciplinary meetings to discuss children and vulnerable adults who were subject of safeguarding alerts and worked with the local hospice to consider those patients with end of life care needs. In addition the practice worked with local care homes and a women's refuge.

The practice recognised that over half of patients over 75 years lived alone and could have no friends or relatives nearby. In recognising this social isolation it promoted a national befriending scheme, the Retired and Senior Volunteer Programme (RSVP) and made the contact details of the local area coordinator available.

In advance of a new contract hopefully becoming available with the South Gloucestershire Clinical Commissioning Group next year, the practice was working collaboratively with two other local GP practices within their pre-defined cluster. The registered manager told us if the contract was secured the practice would continue its approach with other organisations to develop new pathways for patients with long term conditions and end of life care. In addition it would like to provide an urgent care service from 8am until 8pm involving a dedicated GP and community/practice nurse.

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). This included the development of the coping with bereavement advice leaflet, making information available about transport to enable patients to get to the new premises and promoting the on-line appointment booking system.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, one of the GPs had a special interest in paediatric medicine and was an associate specialist in paediatric A&E medicine at the Bristol Children's Hospital. This GP managed the medical care of any child who needed enhanced intervention. There was a child health clinic every week with a GP available for any immediate concerns.

It supported a local women's refuge and took steps to ensure these patients felt safe. It had produced an information leaflet and one of the health visitors supported patients who stayed there. Practice staff received training in relation to understanding domestic violence.

The practice supported two local care homes for adults with learning disabilities and provided a weekly visit to each of the homes. Patients who lived in the homes had a care plan and an annual Cardiff health check. (The Cardiff health check was designed to help primary care provide high quality annual checks for people with a learning disability. It was produced by the RCGP Clinical Champion for Learning Disability and learning disability group in 2010).

The premises and services had been designed to meet the needs of people with disabilities. The practice was accessible to patients with mobility difficulties as facilities were all on one level. The consulting rooms were also accessible for patients with mobility difficulties and there were access enabled toilets and baby changing facilities. There was a large waiting area with plenty of space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence.

There were male and female GPs in the practice; therefore patients could choose to see a male or female doctor.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training.

Access to the service

The surgery was open from 08:00 to 18:30 Monday to Friday. The branch surgery at Yate was closed between 13.00 and 14.00 each day except Wednesday when the surgery closed at 13.00. Appointments were available during these times and until 19.00 each day except Thursday at the Downend Surgery. Extended hours

Good

Are services responsive to people's needs?

(for example, to feedback?)

appointments at the Abbotswood surgery were available each Monday evening between 18.30 – 19.30. Some early morning telephone consultations were available on Tuesdays and Thursdays."

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. The practice website gave information about Out Of Hours emergency arrangements and also details of the NHS 111 advice line and sign posting service. There was information about the minor injuries unit at Yate and at Southmead Hospital in addition to the contact details for the Bristol City Walk-in Centre and South Bristol Community Hospital Urgent Care Centre.

Longer appointments were available, if required, for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to three local care homes on a specific day each week, by a named GP and to those patients who needed one.

The practice offered planned weekend reviews with a GP to support hospital admission avoidance and hospital discharge via the One Care Consortium"

The practice patient survey information we reviewed showed patients responded positively to questions about access to appointments and generally rated the practice well in these areas. For example, 85% of respondents to the surgery indicated they were satisfied with the practice opening times 10% said they were dissatisfied and 5% did not know the surgery opening times.

Most patients indicated they were happy with the surgery opening times and most preferred to make an appointment by telephone. In response to a question about whether patients' needs were addressed by the practices triage system 94% respondents indicated they were and 92% said this was convenient for them.

Patients we spoke with were satisfied with the appointments system and said it was easy to use. They confirmed that they could see a doctor on the same day if they felt their need was urgent although this might not be their GP of choice. They also said they could see another doctor if there was a wait to see the GP of their choice.

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. The operations manager was the 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 complaints leaflet available in the waiting room. None of the patients we spoke with had ever needed to make a complaint about the practice.

The practice showed us a review of complaints for 2014/2015. We looked at the report and no themes had been identified. However, lessons learned from individual complaints had been acted on and improvements made to the quality of care as a result. We saw that complaint were investigated and responded to within timescales as outlined within the complaints procedure. When appropriate, patients were given explanations for the reason for their complaint and an apology.

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. It aimed to prevent patients from dying prematurely, enhance the quality of life of patients with long term conditions and help patients recover from episodes of ill health or injury. In addition, it aimed to ensure patients had a positive experience of health care and to treat them in a safe environment where they were protected from avoidable harm.

We spoke with 15 members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. It was clear the welfare of patients was their top priority.

Governance arrangements

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 and all of them had been reviewed and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and there were designated leads for safeguarding children and vulnerable adults. GPs had special interests in paediatric medicine, sports medicines and drug and alcohol services. We spoke with 15 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.

There were designated staff who took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. The included using the Quality and Outcomes Framework to measure its performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice had a clinical governance committee made up of the GP partners, a nurse and managers. They met every three months to discuss issues around the safe working of the practice to ensure the whole team was committed to providing safe services.

The practice also 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, we saw audits relating to medicines prescribing, diabetes management, joint and soft tissue injections and record keeping. Evidence from other data from sources, including incidents and complaints was used to identify areas where improvements could be made. Additionally, there were processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff. The practice regularly submitted governance and performance data to the Clinical Commissioning Group (CCG).

The practice identified, recorded and managed risks. It had a risk management policy, carried out risk assessments where risks had been identified and action plans had been produced and implemented. For example in relation to infection control and medicines management. The practice monitored risks on a three monthly basis to identify any areas that needed addressing.

The practice held monthly staff meetings where governance issues were discussed. We looked at correspondence arising from these meetings and found that performance, quality and risks had been discussed.

The operations manager was responsible for human resource policies and procedures. We reviewed a number of policies, which were in place to support staff. These included human resources and whistleblowing along with equal opportunities. Staff we spoke with knew how to find policies if needed.

Leadership, openness and transparency

The partners in the practice were visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff. All staff were involved in discussions about how to run the practice and how to develop the practice; the partners encouraged all members of staff to identify opportunities to improve the services delivered by the practice.

We saw from minutes that a range of meetings were held every three months for reception staff and monthly for

Are services well-led?

Good

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

team leaders. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and confident in doing so and felt supported if they did. Staff said they felt respected, valued and supported by the partners in the practice, the practice management and colleagues.

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

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the patient participation group (PPG), survey and complaints received. It had a 'virtual' PPG and communicated with members via email. (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care). The PPG was broadly representative of the practice population and the practice reported it had written to specific patients to invite them to join the PPG where there were groups under-represented.

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 were available on the practice website. We spoke with two members of the PPG and they were very positive about the role they played and told us they felt engaged with the practice.

The practice had also gathered feedback from staff through staff meetings and the introduction of appraisals for reception staff. 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.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at four staff files and saw evidence of training. Staff told us that the practice was very supportive of training. We saw an example of shared learning. One of the GPs sent a message to all GPs and the nurse practitioner. It related to a pre-school child with a particular condition. The GP shared information about the consultation and pointed to specific guidance in relation to the condition.

The practice was a GP training practice. One of the GPs had a qualification in teaching and learning for healthcare professionals and was supporting a GP registrar.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients. For example, in relation to accessing patient discharge summaries on line rather than chasing them up with the hospital Trust.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.