Avonmouth 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

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Avonmouth Medical Centre on 1 April 2015. Overall the practice is rated as good.

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

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

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

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

Importantly, the provider must:

Summary of findings

- Ensure that the staff recruitment process is applied to all staff and so protects patients against the risks of the employment of unsuitable staff.

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 safe. We found the practice had systems, processes and practices in place to keep people safe and these were communicated to staff. Staff understood their responsibilities to raise concerns and incidents. Safety was monitored using information from a range of sources. For example, we were shown the investigations and significant event analysis that had been carried out and the action taken. Staffing levels and skill mix was planned and reviewed so that patients received safe care and treatment at all times. The arrangements in place to safeguard adults and children from abuse reflected relevant legislation and local requirements. The practice also had arrangements in place to respond to emergencies and other unforeseen situations such as the loss of utilities.

Are services effective?

Good

The practice is rated as good for effective. The practice demonstrated patients' needs were assessed and care and treatment was delivered in line with current legislation, standards and evidence-based guidance. Information about the outcomes of patients' care and treatment was routinely collected and monitored through auditing and data collection. For example, the practice undertook clinical audits to evaluate prescribed treatment. We found staff had the skills, knowledge and experience to deliver effective care and treatment. Patient's consent to care and treatment was always sought in line with legislation and guidance, such as written consent for insertion of subcutaneous medicines.

Are services caring?

Good

The practice is rated as good for caring. Patients' feedback about the practice said they were treated with kindness, dignity, respect and compassion while they received care and treatment. We were given examples of how the practice had gone over and above what was expected of the service. We observed a strong patient-centred culture. Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieve this. We were told by all the patients we spoke with how much they valued the relationship they had with the nurses and GPs in the practice. Patients were treated as individuals and partners in their care. We were given examples of patient's making choices and being informed of the best care pathways for their treatment. We found the practice routinely identified patients with caring responsibilities

Summary of findings

and supported them in their role. Patients told us their appointment time was always as long as was needed, there was no time pressure, and patients were reassured that their emotional needs were listened to empathetically.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. It reviewed the needs of its local population and engaged with the NHSE Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found there was continuity of care, with urgent and routine appointments available the same day. The practice had excellent facilities and was equipped to treat patients and meet their needs. We found the practice was involved with providing integrated health services and embedded these in the local community services. The practice was responsive to changing risks including deteriorating health and wellbeing or medical emergencies. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had a clear vision with quality as its top priority. High standards were promoted and owned by all practice staff, and teams worked together. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. There was a high level of constructive engagement with staff and a high level of staff satisfaction and staff retention. The practice gathered feedback from patients via surveys. Staff had received inductions, regular performance reviews and attended staff meetings and social 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 and had a range of enhanced services, for example, in 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.

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 multidisciplinary package of care. Patients diagnosed with long term conditions were supported through a range of clinics held for specific conditions such as, asthma, chronic obstructive pulmonary disease (COPD) and heart failure. Patients receiving palliative care, those with cancer diagnosis and patients likely to require unplanned admissions to hospital were added to the Out of Hours system to share information and patient choice with other service providers.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours, two appointment sessions blocked each afternoon for under 16 year olds with additional protected appointments for over 16 year olds.The premises were suitable for children and babies. The practice ensured parents were contacted if a child had not attended the practice for immunisations and there were systems to monitor

and follow up children when they did not attend hospital appointments. We saw routine audits were carried out by the practice to highlight non-attenders for immunisations and other appointments.

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 reflects the needs for this age group. The practice offered extended hours and the 'out of area' enhanced service.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those 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 held a learning disability register. Patients were invited to the practice for annual health checks through a standard letter offering a 30 minute appointment with a practice nurse followed up with a 30 minute consultation with a GP. It offered longer appointments for patients with a learning disability because it incorporated annual health checks for other conditions such as heart disease.

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). 100% of people experiencing poor mental health had received 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. We saw evidence of the 'Do Not Attempt Resuscitation' decisions in place which had been reviewed to allow patients to change their mind. The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND and SANE. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

We spoke with six patients visiting the practice and we received 19 comment cards from patients who visited the practice. We also looked at the practices NHS Choices website to look at comments made by patients. (NHS Choices is a website which provides information about NHS services and allows patients to make comments about the services they received). We also looked at data provided in the most recent NHS GP patient survey and the last Care Quality Commission inspection report about the practice.

The comments made or written by patients were very positive and praised the care and treatment they received. For example, patients had commented about how helpful the receptionists at the practice were and about being satisfied with the opening times. Many patients commented the service they experienced at the practice as excellent. All of the patients we spoke with gave very positive feedback about the practice. In particular patients told us how much they valued the relationship they had with the GPs and nurses. Patients told us that they felt listened to and understood when they attended for consultations and treatment. We were told appointments took as long as was needed and no one felt rushed or hurried.

We found the practice had a virtual patient network (VPN). Information was circulated through the network via emails or newsletters. The practice had distributed information electronically to the VPN and on the website. The practice had also commenced their current 'friends and family' survey via paper and by a mounted computer tablet on reception.

Areas for improvement

Action the service MUST take to improve

Ensure that the staff recruitment process is applied to all staff and so protect patients against the risks of the employment of unsuitable staff.

Avonmouth 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 special advisor and a nurse special advisor.

Background to Avonmouth Medical Centre

Avonmouth Medical Centre is sited in an industrialised area of Bristol. It has approximately 2600 patients registered with a majority ethnicity of White British. The practice provides services to Avonmouth which encompasses a dockland area.

The practice operates from one location:

Collins Street,

Avonmouth,

Bristol,

BS11 9JJ

The practice is made up of three partners, one GP, one nurse practitioner and the practice manager. The practice has a personal medical service contract and also has some additional enhanced services such as extended hours for pre booked appointments and unplanned admission avoidance. The practice is open on Monday 8am – 7.30pm and Tuesday to Friday 8am – 6.30pm.

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

Patient Age Distribution

0-4 years 5.64 % lower than Clinical Commissioning Group (CCG) average

5-14 years 9.85 % lower than CCG average

15-44 years 44.86 % lower than CCG average

45-64 years 26.51 % higher than CCG average

65-74 years 7.34 %

75-84 years 4.29 % higher than CCG average

85 years + 1.51 % lower than CCG average

Patient Gender Distribution

Male 55.22 % higher than CCG average

Female 44.78 % lower than CCG average.

0.31 % of patients lived in care homes which was lower than CCG average.

10.16 % of patients from Black and Minority Ethnic (BME) populations which was lower than CCG average.

The practice is in an area of high deprivation, with a higher than Clinical Commissioning Group average number of patients over 75 years.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and

Detailed findings

regulations associated with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2015, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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

How we carried out this inspection

Before visiting, we reviewed a range of information we held about the practice and asked other organisations to share what they knew. This included the Bristol Clinical Commissioning Group (CCG), NHS England and Healthwatch.

We carried out an announced visit on 1 April 2015 between 9am - 5pm.

During our visit we met and spoke with two of the GPs. We spoke with the practice nurse and with the practice manager and the reception staff on duty. We spoke with six patients in person during the day. We received information from the 19 comment cards where patients and members of the public had shared their views and experience of the service.

We observed how the practice was run, the interactions between patients and staff and the overall patient experience.

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Good

Are services safe?

Our findings

Safe track record.

The practice had robust systems in place for the safety of patients and staff who worked at the service. For example, we saw that the health and safety issues for the practice were delegated to a trained member of staff who took responsibility to ensure safety audits were carried out. The practice ensured that all staff were trained to a level of competence which kept patients safe. We saw records of training which indicated staff had been updated to understand and implement the latest guidance for treatment such as how to deal with cardiac arrest. We spoke with two GPs and reviewed information about both clinical and other incidents that had occurred at the practice. We were given information about seven incidents and received notification for one incident which had occurred during the last 12 months. These had been reviewed under the practices significant events analysis process. These incidents included an anaphylactic reaction and a coding error. We read each event was categorised and all were reviewed for any trends; where changes in practice had been highlighted we were able to confirm they had been implemented. When events needed to be raised externally, such as with other providers or other relevant bodies, this was done and appropriate steps were taken, such as providing information to NHS England in response to a complaint. National patient safety alerts (NSPA) and other safety guidance was checked and circulated to the relevant staff.

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

Learning and improvement from safety incidents.

There was a range of systems in place for recording incidents and taking appropriate action to improve systems and processes so that further incidents were prevented. For example, the practice had a system in place for reporting, recording and monitoring significant events. All significant events were dealt with as they arose and there was shared learning to prevent any recurrence. Significant events and complaints were discussed at the formal partners meeting as well as any ad hoc partners meetings which happened more frequently. The practice had access to "Safety and Improvement in Primary Care - the essential guide".

The records we reviewed showed that each clinical event or incident was analysed and discussed by the GPs, nursing staff and senior practice management. When we spoke with other staff we were told that the findings from these Significant Events Analysis (SEA) processes were disseminated to other practice staff if relevant to their role. We found the level and quality of incident reporting showed the level of harm and near misses, which ensured a robust picture of safety.

We saw from summaries of the analysis of these events and complaints which had been received that the practice put actions in place in order to minimise or prevent recurrence of events. For example, where a reduction in timeframe between immunisations had occurred, the discussion focussed on the action to be taken, and what could be done differently to prevent recurrence.

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

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

Reliable safety systems and processes including safeguarding

There were comprehensive systems to keep people safe, which took account of current best practice. Staff knew how to recognise signs of abuse in older people, vulnerable

adults and children. They were also aware of their responsibilities. Staff knew how to share information, record information about safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible. All staff we spoke to were aware who the leads were for safeguarding adults and children and who to speak to in the practice if they had a safeguarding concern. The practice had knowledge and awareness of domestic violence issues and the process of reporting incidents.

The GP partner took the lead with safeguarding children, and at risk adults for the practice. The partner GP was the child protection lead, level three trained and attended link meetings with other leads three to four times a year where they were able to discuss concerns. For example, they took a concern about the process of over five's who are out of health visitor supervision and under the supervision of school nurses, also academies are not obliged to have school nurses so there was no oversight of vulnerable children. All of the GPs we spoke with had been trained to level three, safeguarding children and we saw GPs had completed a range of modules to achieve this. The lead safeguarding GP was aware of the patients who had been assessed as vulnerable children and adults. Information from the GPs demonstrated good liaison with partner agencies such as the police and social services and they participated in multi-agency working. The practice had two children who could be identified as at risk but were not on the risk register. The partner GP timetabled monthly meetings with health visitors to discuss all patients who may be of concern, and the discussion was recorded on the individual patient's record.

The practice approach to safeguarding was that awareness of abuse issues were everybody's responsibility. In order to raise awareness, knowledge and understanding within different staff groups, the lead GP conducted an exercise in awareness of what, where and whom to raise concerns with. Staff were given different patient scenarios which may occur within the practice, and asked about the response. For example, a vulnerable adult where an older person had dementia and was looked after at home, and how this impacted on the family. These were discussed as a team to promote shared learning.

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

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

Medicines management

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

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of according to clinical waste disposal regulations.

The practice worked in partnership with the Bristol Clinical Commissioning Group appointed pharmacist, who provided feedback of the practice performance in respect of medicine management. We were told the practice had actively engaged in reviews of prescribing antiemetic, antibiotic and antiplatelet medicines. The partner GP had also worked closely with the pharmacist on medicines optimisation which had impacted on prescribing and improved patient care at the practice. For example, the anticoagulant review had resulted in the withdrawal of one of the medicines to promote patient safety. We also found a current audit in process of polypharmacy (multiple medicines) in older patients in order to rationalise medicines and ensure effective prescribing.

Good

Are services safe?

The nurse administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses had received appropriate training to administer vaccines. There was a system in place for the management of high risk medicines, which included regular monitoring that followed the national guidance. We found appropriate action was taken based on the results.

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

Cleanliness and infection control

We observed the premises to be reasonably 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. It was noted that the practice had been registered by Bristol City Council as a provider of a publically accessible toilet facility. The two treatment rooms had access to a sluice area where samples could be safely disposed.

The practice had a nurse with lead responsibility 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 annual updates. We saw evidence that the practice had carried out audits for the previous two years and that any improvements identified for action were completed on time. For example, cleaning all non-disposable privacy curtains.

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

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with wall mounted hand soap, hand gel and hand towel dispensers were available in treatment rooms. Taps were elbow operated and work surfaces had sealed and rolled edges to reduce the risk of cross infection accumulating. Waste bins were foot operated in clinical area to maintain hygiene standards. The practice also had bespoke spillage kits to remove any potential hazard from spilt bodily fluids.

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

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal).We saw records for the practice that confirmed regular checks were carried out according to the policy which reduced the risk of infection to staff and patients.

Equipment

The practice was suitably designed and adequately equipped. The building, its fixtures and fittings were leased by the practice and as part of the agreement the landlord employed specialist contractors as needed to maintain the building. Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records such as certificates that confirmed this.

All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A

schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer.

Other equipment such as fire extinguishers were also serviced and tested annually in line with fire safety requirements. Fire alarms and emergency lighting were also regularly tested and serviced to meet the recommendations for fire safety. The security alarm was also tested annually.

There was a range of appropriate seating in the waiting areas such as lower chairs for children and chairs with arms to aid less mobile patients to stand; all appeared in safe condition. The practice was in the process of replacing seating which was not easily washable. Adjustable examination couches were available in all treatment rooms which had appropriate privacy screening.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. We looked at employee files for the most recently recruited permanent member of staff and found the process had been followed. We were able to see they 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 criminal records checks through the Disclosure and Barring Service (DBS). When looking at the staff files we saw there was an induction checklist appropriate to the role of the staff member. Staff we spoke with confirmed these had been implemented. We also reviewed the information held by the practice about staff used for locum work and found that for the GPs the records were completed, but there were some gaps in evidence for the locum nurses in respect of training. We were provided with this evidence immediately after the inspection which demonstrated the locum nurses were suitably trained and qualified for their role. The staff files did not all contain the documentation as required by regulation however the practice manager had identified this and had started to obtain the required information.

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. Currently the practice did use locum GPs but a small team of three were employed to ensure consistency of care was maintained as far as possible.

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

Monitoring safety and responding to risk

The partner GP dealt with Medicines and Healthcare Products Regulatory Agency (MHRA) and any patient safety alerts and disseminated them to other staff as needed, or instigated the action necessary to comply with the alert. The partner GP had a diploma in therapeutics and this was an area of special interest and so had MHRA alerts sent to them directly. The practice manager also received these alerts and they were cascaded to other clinicians; the practice manager ran a search on the registered patients and if appropriate action was needed would ensure it was taken.

The practice had a system in place to ensure staff were alerted if there was an issue related to the patient, these may be to alert staff to look in the "confidential information" section of the records or an alert which was direct information such as "patient requires longer appointment".

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative. Cleaning materials were stored in a way which met the Control of Substances Hazardous to Health (CoSHH) guidelines.

We saw that any risks were discussed within meetings. There were systems in place for monitoring higher risk

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

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We were told there was always first aid equipment available on site ; one member of staff was a designated first aider and the practice manager a nominated first aider. We looked at the accident recording log book and found when accidents had occurred at the practice, they were recorded and appropriate action taken to prevent recurrence.

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

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

Emergency equipment available included oxygen and an automated external defibrillator. The equipment appeared to be in good working order and designated staff members routinely checked this equipment. Equipment was available in a range of sizes for adults and children. The staff team had undertaken training in basic life support as a team, on the premises using their own equipment. This meant staff were familiar with equipment and working together in an emergency situation.

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

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

The building had a fire system and firefighting equipment, which was in accordance with the fire safety legislation. A fire risk assessment had been undertaken that included actions required to maintain fire safety. We saw records that showed the system had been maintained and tested.

Records showed the practice had commissioned bespoke fire training which had taken place on the premises which ensured staff were up to date with fire training.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with told us about their approaches to providing care, treatment and support to their patients. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate. We found the safe use of innovative and pioneering approaches to care and how it was delivered are actively encouraged. New evidence-based techniques and technologies are used to support the delivery of high-quality care for example, teledermatology was offered to patients with dermatological conditions. The GPs photographed patients using high quality digital imaging equipment and then sent them electronically to a consultant dermatologist. For the patient this meant that an initial diagnosis was made within a few days and a follow up appointment if required, arranged. Using teledermatology provided rapid access to a specialist diagnosis for patients and was an efficient use of healthcare services.

The practice used an assessment tool aligned with professional knowledge of patients to identify high risk patients and it participated in joint working with other health and social care professionals and services to avoid any crisis in their health. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients care plans. We saw that the practice provided the emergency admission avoidance enhanced service. This meant patients in this category who were recently discharged from hospital were reviewed within 48 hours. This was monitored by the staff on receipt of discharge summaries, who ensured they were followed up by the most appropriate staff member.

The patients we spoke with told us there was a holistic approach to assessing, planning and delivering care and treatment and we were given examples of how GPs and nurses involved them in their care and treatment. For example, patients told us they were always given treatment options and supported to make a decision on what would be most appropriate for them. We were told how the treatment they received helped them to get better or to maintain their health. The most recent survey undertaken by the practice (2014-15) used the CFEP (an organisation which produced specific surveys for primary care) system. The response was that 85% of all patients who responded rated the practice as good, very good or excellent.

There was also a programme of medication reviews specifically for patients on multiple medicines (polypharmacy).

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

Management, monitoring and improving outcomes for people

We spoke with GPs about how they reviewed and assessed they were meeting patient's needs. We heard information from Quality Outcomes Framework (QOF), significant events, new guidance and feedback from patients generated clinical audits. QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures. The practice had annually achieved a consistent QOF score of over 97% for example; the practice achieved 100% for reviewing patients with dementia, and exceeded the target for influenza vaccinations for all groups coming first out of the practices in the CCG area. The practice also used the information

Good

Are services effective?

(for example, treatment is effective)

collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national) clinical targets.

The practice showed us clinical audits that had been undertaken in the last year. These were a range of completed audits from which the practice was able to demonstrate the changes resulting since the initial audit. For example, we saw there had been an initial audit to establish if children who presented with a temperature of 37.9 degrees had their peripheral capillary oxygen saturation levels measured (NICE guidance). The practice introduced this diagnostic test as part of their examination process; the reaudit demonstrated that it had been achieved for 100% of patients. We saw partially completed audits (one cycle) of patients living with a learning disability to ensure their review followed the Cardiff protocol which is a comprehensive health review. The audit was completed because of identified data anomalies within this cohort of patients. Clinical staff had training at the end of last year on the Cardiff protocol from the local learning difficulties team. The findings were that 11 patients were on the register, and six had been reviewed as per the Cardiff protocol; the remainder were in the process of being followed up for review. The practice also met the learning difficulties team to review the current patients on the list and to ensure that their list concurred with their service users, this was an annual meeting. These audits had direct impact on patient care and ensured that the clinical staff working at the practice implemented best practice.

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

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

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

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that staff were up to date with attending mandatory courses such as annual basic life support. If there were gaps in training, particularly e learning, this was highlighted and planned for individual staff. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

The practice had an established pattern of meetings to ensure staff understood the demands of the service. There was a meeting at the start of the week between the partners which allowed staff to be informed and plan for any events in the forthcoming week. On a daily basis, all the staff met informally at lunchtime where issues could be shared and to plan the most effective way in which to provide a service to patients.

The nurse practitioner/prescriber and practice nurses had defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, insulin initiation, administration of vaccines, cervical cytology and family planning. We were told by all levels of staff that they

Good

Are services effective?

(for example, treatment is effective)

were provided with the time and the opportunity to undertake training and personal development. Staff told us annual appraisals identified learning needs and from this action plans were developed and documented.

Working with colleagues and other services

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

There was multidisciplinary team working for patients identified as at risk through age, social circumstances and multiple healthcare needs. Regular meetings with other professionals such as the community matron, community nursing teams, health visitors and palliative care team took place. Staff felt this system worked well and there was a team approach to supporting their patients.

We were told that the staff were committed to working collaboratively, people who have complex needs were supported to receive coordinated care and there were innovative and efficient ways to deliver more joined-up care to patients who used services. The partner GP also carried out home visits to housebound diabetic patients with the specialist diabetes nurse so that patients received a full service, and carried out joint visits with the dementia specialist nurse so that an integrated approach to their care could be planned.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. The practice also used the Choose and Book system for secondary appointments, patient to patient electronic transfer of medical records and summary care records. The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. The practice also had an internal system to shared documents and records relating to the running of the service, clinical protocols, policies and procedures were all available to staff electronically.

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

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling them. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. We were told that patients were supported to make their own decisions and documented this in the medical notes. Patients with a learning disability and those with a diagnosis of dementia were supported to make decisions through the use of care plans, which they were involved with. These care plans were reviewed three monthly or more frequently if changes in clinical circumstances dictated it. The practice had a policy, procedure and information in regard to best interests' decision making processes for those people who lacked capacity. The practice confirmed that the GPs involved patients and families in 'Do Not Attempt Resuscitation' decisions and were shown an example of where this decision had been reviewed and the patient had changed their mind. This information was recorded on the care plans for vulnerable patients.

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

There was a practice policy for documenting consent for specific interventions including a patient's verbal consent which was recorded in the electronic patient notes and written consent for minor surgical procedures, such as insertion of intrauterine devices.

We spoke with patients who confirmed that consent was asked for routinely by staff when carrying out an examination or treatment. They also told us that staff

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Are services effective?

(for example, treatment is effective)

always waited for consent or agreement to be given before carrying out a task or making personal contact. They also confirmed that if patient's declined this was listened to and respected.

Health promotion and prevention

The practice had met with the local authority and the clinical commissioning group in respect of public health and health promotion, to identify and share information about the needs of the practice population. The practice website had information about healthy lifestyles as well as practical guidance about self-treatment for minor illness. We noted the culture of the practice was to use their contact with patients to help maintain or improve mental, physical health and well-being. This was reflected by the information available to patients in the waiting room.

It was practice policy to offer a health check with the health care assistant or practice nurse to all new patients registering with the practice. New patients' health concerns were identified and arrangements made to add them into any long term health monitoring processes such as the diabetes, asthma or heart conditions clinics or reviews. The practice provided information and signposted patients to services which help maintain or improve their mental, physical health and wellbeing. For example, by offering smoking cessation advice to patients who smoke. The practice told us they had a higher population of patients who smoked than the CCG average. They had a trained smoking cessation advisor who had achieved considerable success.

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

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

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

The practice participated in the 4YP scheme (for young people) and provided contraceptive advice and chlamydia testing kits. Advice and information was readily available in the practice about a wide range of topics from health promotion to support and advice. Information was also available on the practice website or patients were directed to links to other providers for specific advice.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the latest national patient survey information for 2014, a survey of 374 patients with a return rate of 26%. The evidence from all this showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed 83% of patients felt that their overall experience was good or very good and 95% had confidence and trust in the last GP they saw or spoke to.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 19 completed cards which 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. We also contacted the patient participation group prior to our inspection. They told us they were satisfied with the care provided by the practice. Patients commented they felt GPs took an interest in them as a person and overall impression was one of wanting to help patients. We were given examples of the GPs taking additional time to ensure patients received the care they needed such as making contact with patients outside of normal working hours and contacting secondary medical services to ensure referrals were received. We also spoke with six patients during the inspection who told us they were treated with respect and would recommend the practice.

Both patients and staff expressed the service had a holistic approach and a culture which put patients first. Patients told us their appointment time was always as long as was needed, there was no time pressure, and patients were reassured that their emotional needs were listened to empathetically. This was echoed by the comments received from health care professionals attached to the practice, who rated the practice highly for their professional and caring approach.

Patients also spoke highly of the relationships between them and the staff at the practice. We heard staff recognised and respected patients' needs taking personal and social needs into account. For example, the practice worked in partnership with numerous organisations within the Bristol area which supported patients in with different needs such as the Bristol Dementia Partnership with dementia navigators and the Bristol Drug Project whose project workers were based at the practice for easier access for people with chaotic lifestyles.

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The reception desk was not separated from the waiting room. We asked the staff how they prevented patients overhearing potentially private conversations between patients and reception staff. They explained to us they had been trained not to give confidential information over the phone but to ask the patient who was calling to supply the information which they could then verify. In respect of giving test results the practice had the facility to take the call in a confidential office. We also saw that a room was available in reception if patients wished to have confidential discussion with the receptionist. We observed this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

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

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 86% of respondents felt the GP was good at explaining tests and treatment to enable informed choices.

Good

Are services caring?

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.

Staff told us that telephone translation services were available for patients who did not have English as a first language. We saw the website had a facility for translation of information.

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

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 83% said the last nurse they saw or spoke with was good at treating them with care and concern. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this patient information. For example, these highlighted that staff responded compassionately towards carers and family members when they needed help and provided support when required.

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

The practice had funded a new post of care coordinator which was planned to assist with care plans reviews for vulnerable patients and provide information to patients and carers about available services. The practice's computer system alerted GPs if a patient was also a carer. This meant that all carers were identified and sent relevant information about the local carer's organisation. Staff (clinical and non-clinical) told us they knew their patients very well and ensured that carer accessed a full range of services. This may be benefits advice, carer breaks/holiday, and emergency card scheme, introduction to voluntary agencies and social services, as well as general support.

Staff told us that if families had suffered bereavement, they contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. Useful information about bereavement was available on the website.

The information from patients showed patients were positive about the emotional support provided by the practice staff. They told us they were able to speak to the GPs and nursing staff who answered their questions well and were patient with them when they needed reassurance. The practice had also been proactive in identification of the difficulty travelling across Bristol to other services and had worked to ensure that services wherever possible were based at the practice, such as mental health services.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. The NHS England Area Team and Bristol Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised.

Patients and staff told us that all patients who requested urgent attention were always seen on the day of their request this included patients requiring home visits. The practice had provided a responsive service by holding clinics, such as the diabetes clinic, on a regular day each week for patients who found it difficult to attend variable appointment times.

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

The practice had identified that they could support patients by reducing the need to attend hospital for minor operations. A GP with specialist interest provided joint injections as needed.

Tackling inequity and promoting equality

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

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

The services for patients were on the ground floor. We noted that the practice was a dementia friendly environment with good lighting, clear signage and use of colour contrast to assist patients around the premises.

The practice had recognised the needs of different groups in the planning of its services. The practice provided home visits to patients who were unable to attend the practice and to those living in residential or nursing homes. We also found that the practice was involved in co-commissioning of specialist services with other practices. They had planned to co-commission an over 75's nurse specifically to visit the patients at home to carry out routine health checks and care planning.

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

Access to the service

The practice was open on Monday 8am – 7.30pm and Tuesday to Friday 8am – 6.30pm. The nurse practitioner had offered appointments daily for minor illness however this was suspended in their absence. The practice also offered a GP telephone consultation service. The practice did not provide out of hours services to its patients, this was provided by Bris Doc and information on the out-of-hours service was provided to patients. Appointments were available outside of school hours for children and young people with two afternoon appointment slots blocked each day for patients under 16. Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed.

The practice was also flexible with appointments taking place which met patient need such as with home visits or joint home visit with other health care professionals.

Patients told us they were aware that appointment times were not limited to ten minutes but lasted for however long was needed. This system was valued by patients although it meant that they may have had to wait beyond the time they expected. Patients were also made aware when they arrived for appointments if appointment times were late, and that if a child or baby arrived and needed to be seen

Good

Are services responsive to people's needs?

(for example, to feedback?)

urgently, then they would be seen by the next available GP. The patients were aware that they could request to see a specific GP otherwise we were told they were happy to see any of the GPs at the practice. For pre-booked appointments patients could choose which GP they saw so there was continuity in their care. The feedback we received from patients was that they were very happy with their access to appointments. The practice also had an online booking system for planned appointments.

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

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 looked at all the complaints received in the last 12 months and found these were satisfactorily handled and dealt with in a timely way. An acknowledgement had been sent out, the issues investigated and a response sent to the complainant. The practice took account of complaints and comments to improve the service, for example, complaints were discussed by the team so staff could contribute and learn.

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

There was a method to identify common areas of complaints. Each complaint or comment was also reviewed. Where potential serious concerns had been identified these were elevated as a significant event and then reviewed in more depth by the management team.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We heard from all the staff we spoke with that there was a 'patient first' ethos within the practice. This was corroborated by the patients we talked with. We found the partners in the practice understood their role in leading the organisation and enabling staff to provide good quality care. We found details of the vision and practice values were part of the practice's statement of purpose and reflected in their business planning. The practice vision and values included putting patient care at the heart of all their decision making processes; to ensure that patients are seen by the most appropriate healthcare professional as quickly as possible whilst fully involved in their own care, and understanding the immediate psychological and social aspects of a patient's which impact on their well- being. Staff told us that they treated patients with courtesy, dignity and respect at all times by putting patients at the centre of everything the practice does. The practice also participated and engaged with colleagues as part of the North & West Bristol CCG locality.

We looked at minutes of the recent practice meetings the partners had discussed the vision and values. The patients we spoke with about the practices values told us they felt these were being achieved. There was a whole team approach to change and innovation which involved the staff and related agencies such as the clinical commissioning group (CCG). We found examples of involvement in pilot schemes and working collaboratively with other practices to access funding for innovation, such as a community nurse specifically for older patients. The practice culture was innovative, forward looking and adaptable.

Governance arrangements

Staff were able to demonstrate their understanding and commitment to providing high quality patient centred care. The leadership, governance and culture were used to drive and improve the delivery of high-quality person-centred care. The practice had a number of policies and procedures in place to govern activity and these were available on a shared drive which staff could access from any computer in the practice. We looked at a number of these policies and procedures and found that they had been reviewed regularly and were up to date. GPs and nursing staff had clinical protocols and pathways to follow for some of the aspects of their work. For example, the handling of vaccines and medicines or ensuring a consistent approach was made for patient referrals. The nursing and administrative staff had daily work plans which ensured staff understood the expectations of them.

Information on the practice website also informed patients about policies such as confidentiality and how patients could access their own records. The practice also had a policy to follow for patients who made freedom of information requests. Staff we spoke to confirmed they understood these topics and would be able to support patients.

There was a clear leadership structure with named members of staff in lead roles. The partner GP took the lead role for clinical care and the partner practice manager took the lead for the day to day business of the practice. We spoke with six members of staff and they were all clear about their roles and responsibilities. They told us they felt valued, well supported and knew who to go to in the practice with any concerns. We found that the responsibility for improving outcomes for patients was shared by all staff. The practice gave us examples where both non–clinical and clinical staff had worked together, for example, on recalling patients who had not attended for review or vaccinations.

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

The practice had systems in place to monitor and improve quality. The practice had completed clinical audits at the request of the CCG and for their own professional development of the service. The practice had an ongoing programme of clinical audit which it used to monitor quality and systems and to identify where action should be taken. The audits undertaken demonstrated that there was an improvement in patient care following the process.

The GP partner had ensured they sought suitable support for their clinical role by attending forums regularly such as a monthly continued professional development meeting;

Are services well-led?

Good

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

the locality meetings with the CCG and having regular meetings with the two permanent locum GPs with whom latest guidance was discussed with the impact on practice for implementation of change to improve patient care. We were told how after attending clinical meetings the information was recorded and shared with the team. An example of this was the latest guidance for fasting lipid blood tests. The new process was more patient friendly as no fasting was necessary. The information was shared with clinical colleagues and reception staff because they would have the initial patient contact and needed to explain why the change had occurred. This example demonstrated the team ethos of the practice whereby everyone had a contribution to make to patient care.

The practice also held regular twice monthly clinical governance meetings to discuss quality audits, serious and significant events, complaints, patient feedback, performance data and other information relating to the quality of the service. We saw meeting minutes and reports that demonstrated the practice routinely reviewed data and information to improve quality of service and outcomes for patients. We found the practice approached governance and improvement in a supportive and collaborative way. For example, we read a review of a patient recently referred under the two week wait target for cancer diagnosis. The treatment for each patient was discussed and further actions agreed as a team. The practice also accessed the referral review team who provided feedback information and guidance on referral which was a source of further learning.

There was evidence that the practice took the welfare of its staff seriously for example, performance was reviewed to enable staff to develop and improve, and social events were organised to promote a team ethos. The administrative staff had a 'work uniform' provided by the practice which consisted of three different coloured blouses, the team coordinated themselves to wear the same colour.

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

Leadership, openness and transparency

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

We heard from staff at all levels that team meetings were held regularly and that the practice had an open agenda to which any member of staff could add a topic. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at meetings. Locum staff were invited to the meetings this meant they felt included and valued in the running and development of the service.

The practice had a partner who worked as the practice manager to enable the business and administration of the service. Their responsibilities included the development and implementation of practice policies and procedures. The practice manager provided us with a number of

Are services well-led?

Good

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

policies, for example the recruitment policy and induction programmes which were in place to support staff. We were shown the online staff information that was available to all staff. Those we spoke with knew where to find these policies if required.

The practice was proactive in planning for future needs; staff were being provided the opportunities and access to additional training to develop new services and enhance their skills. For example, we were told about the training and support available to develop the service for patients with chronic obstructive pulmonary disease.

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

Seeking and acting on feedback from patients, public and staff

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

There was a virtual patient participation group (PPG) which included representatives from various population groups; patients of working age and recently retired and older patients groups. 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.

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

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

Management lead through learning and improvement

There was a strong focus on improvement and learning shared by all staff. The staff we spoke with demonstrated an understanding of their area of responsibility and each took an active role in ensuring a high level of service was provided on a daily basis. The GPs we spoke with told us how they conducted routine condition and medicines reviews. GPs and nurses routinely updated their knowledge and skills, for example by attending learning events provided by the Bristol Clinical Commissioning Group (CCG), completing online learning courses and reading journal articles. Learning also came from clinical audits and complaints. We heard from the GPs that sharing information and cascading learning through the team was an established process and one which kept the staff informed and up to date. The practice had completed reviews of significant events, complaints and other incidents. Significant events were a standing item on the practice meeting agenda and were attended by the partners. There was evidence the practice had learned from these events and that the findings were shared. For example, a change in practice when coding patients with chronic kidney failure so they were not prescribed inappropriate medicines.

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Staff told us that the practice was very supportive of training which developed the service. In the staff records we found that regular appraisals took place, which included a personal development plan, for all staff except the practice nurse team. We were told the lead nurse practitioner had taken responsibility for this but due

Are services well-led?

Good

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

to their absence; the practice had instigated an informal appraisal with the nurse lead from the local medical committee. This process needed to be formalised so that the nurse team had a clearer direction.

The practice had participated in research and were keen to reinstate this as it was seen to contribute to the practice remaining up to date with the latest developments in clinical care.