# Northville Family practice

## Quality Report

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Date of inspection visit: 4 August 2014
Date of publication: 19/02/2015

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

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# Summary of findings

## Overall summary

Northville Family Practice provides consultations with GPs and a range of appointments for treatment. The practice is located at 521 Filton Avenue, Northville, Bristol, BS7 0LS.

Prior to the inspection we met with the South Gloucestershire Clinical Commissioning Group, NHS England, The Avon Local Medical Committee and Healthwatch South Gloucestershire. This ensured we obtained a range of intelligence from organisations that work closely with the practice. During our visit to the practice we spoke with patients and staff.

We obtained information from Public Health England that showed the practice had over 5,000 patients. These included some of Asian origin (5%) patients who were Black (3.4%), Chinese (1.7%) and of other non-white ethnic groups (2.5%). The information showed life expectancy for males as 77.6 years and 81.8 years for females.

The practice supported older patients, patients with long term conditions and those who suffered with poor mental health. In addition it provided services for mothers, babies, children and young patients along with, those of working age and the recently retired. There were some travellers registered with the practice.

We spoke with all staff on duty on the day of our visit, these included the GPs, nurses and administrative staff. We spoke with eleven patients. We also received four comments cards containing additional feedback from patients. We found the practice to provide safe, caring and effective treatment that was responsive to patient's needs. There was effective leadership indicating the practice was well-led.

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.

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

**Are services safe?**
We found Northville Family Practice to be safe. There were effective recruitment procedures which ensured staff were suitable to work in the practice. Arrangements for the cleanliness of the premises and minimising infection risk were comprehensive and there were safe systems of work which included responding to and learning from significant events. Equipment was maintained and available to respond to medical emergencies. Medicines were stored appropriately.

**Are services effective?**
The practice had effective arrangements for the promotion of health and for care and treatment of patients. There were suitable facilities, equipment and staff to deliver the service and the practice consulted with people to improve outcomes for patients.

**Are services caring?**
The practice was caring and respectful to its patients who were treated with dignity. Patients were involved in decisions about treatment and gave consent when appropriate.

**Are services responsive to people's needs?**
We found the practice was responsive to patient's needs. It was accessible and the practice listened and responded to concerns and complaints.

**Are services well-led?**
We found the practice was well managed with systems which ensured that patients received the care they needed. There was effective leadership and governance arrangements and the practice sought feedback from patients. The practice demonstrated a commitment to continued professional development for its staff so that patients were treated by staff that had up to date knowledge.

# 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

The practice had considered the needs of its patients, particularly those who were elderly or who had restricted mobility. Reasonable adjustments had been made. There was level access to the practice with a ramp at the main door and level access to all surgeries and toilet.

A partner GP told us the practice aimed to prevent hospital admissions where possible and maintained connections with the clinical commissioning group (CCG). They told us how the practice shared essential information about the most vulnerable older patients with the GP out of hour's service and ambulance service. This enabled the other services to respond appropriately to patients and help avoid unplanned hospital admissions when the practice was closed.

A programme of immunisation was available for older people who were eligible for the influenza vaccine.

We saw an older patient with a hearing impairment being greeted by the practice nurse. The receptionist had recognised their impairment and added a message to the electronic records system to alert the nurse to the patient's impairment because they may not hear the loudspeaker announcement. We saw that the nurse came out to meet the patient when their appointment was due to commence.

An older patient we spoke with told us how they had been visited at home when needed. The staff we spoke with told us how this type of service was available to all older patients if they were unable to get to the practice for appointments.

### People with long-term conditions

We saw patients with long term conditions could access information about the services available at the practice on the practice website. It showed that in addition to routine GP consultations the practice offered a wide range of services and information which might help patients without having to see their GP.

Services included appointments for chronic disease management such as asthma, diabetes, chronic obstructive pulmonary disease (COPD) and hypertension (raised blood pressure). Information included self-help leaflets, short video clips about diagnosed illnesses and links to other services that might be able to help or advise if the practice was closed.

# Summary of findings

The practice nurse told our GP specialist advisor they were one of two nurses who saw patients with a diagnosis of diabetes. They said they referred patients to a diabetic liaison nurse for insulin conversion (a change between taking tablets and having injections to control their diabetes) when changes to insulin was necessary.

**Mothers, babies, children and young people**

There were no maternity or ante-natal clinics held in the practice. The GPs and nurses we spoke with told us patients were referred to a clinic nearby in Filton for these services. In support of post natal care a programme of immunisation was available for children.

A parent told us the practice was good with their children and what they particularly liked was the way GPs spoke with the child rather than the parent. Another parent contacted us to say the practice was proactive and had sent a letter to arrange for their child to have a Meningitis vaccination. They felt this letter was a helpful way to make it easier for parents to take their child to the practice during the school break. The practice manager confirmed this was the intention of the practice.

We saw a General Medical Council poster in the waiting area of the practice which advised young patients about their rights when being seen by a GP. It showed that what young patients said to the GP was confidential and that GPs should be asking them first before sharing information about them with anyone else. The information stated they could decide to see the GP on their own and that they would be treated with the same respect as adults. The guideline was in line with the Gillick competency guidelines. These referred to decisions about whether a child was mature enough to make decisions for themselves and if they had the ability to be seen alone or with a chaperone rather than with their parents. Where this was the case, we were told patient records would be updated to reflect the current arrangements.

**The working-age population and those recently retired**

Patients could make appointments outside of their working hours. There were appointments available early morning and early evening on Thursday and some pre-bookable Saturday morning appointments.

**People in vulnerable circumstances who may have poor access to primary care**

The reception and waiting area was open however there was a 'privacy window' to the side of the reception where patients could talk in confidence with a receptionist.

# Summary of findings

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|---|---|
| The practice chaperone policy considered the needs of patients in vulnerable circumstances. It advised that clinicians should consider whether intimate or personal examination of a patient was justified and whether the nature of the consultation posed a risk of misunderstanding. We saw that it advised that GPs and nurses should always give the patient a clear explanation of what the examination would involve, adopt a professional and considerate manner and afford the patient sufficient privacy. | |
| **People experiencing poor mental health**<br>A GP partner told us about the initiatives they were involved with including the South Gloucestershire Dementia Project. The project linked the local council, clinical commissioning group and other agencies to provide information and support for people with dementia. Patients were able to be assessed in their home environment as they had an assessment at home carried out by the memory care nurse. | |

# Summary of findings

## What people who use the service say

We spoke with eleven patients during our visit. A patient told our expert by experience they had never heard anyone speaking negatively about the practice. Another said they felt the practice was perfectly adequate. One patient told us they had chosen to remain with the practice even though they had moved house. They said this was because they liked the practice.

Another patient told our expert it was difficult to get an appointment for that day and could not get to see the GP of their choice. They told us when they visited on one occasion the GP came straight out to see them and sent them to hospital for treatment. Another patient said that to get a same day appointment they had to call the practice before eight o' clock in the morning. They told us the practice phone was sometimes engaged and their call would not be answered until they tried later. On these occasions they said they were unable to get a same day appointment. One patient told us they the felt the practice was quite flexible and another commented that the service they received was always good.

Patients told us they understood they could have a chaperone if needed. They told us they had never requested to have one. Patients said that appointments were not interrupted and their privacy was maintained.

Ten of the eleven patients we spoke with told us they always left their appointment with a clear understanding of what the GP had discussed with them. One patient said when the GP discussed their condition with them they understood at the time but added it did not always "sink in".

Patients told us the practice was effective in meeting their needs. Two patients told our expert by experience their diet had been discussed with them routinely as part of their health review. One patient said it was discussed as they had lost weight recently.

A patient told us how they needed assistance in making end of life decisions in respect of their spouse. They said the practice was very good in helping them.

Patients said they felt the practice was clean and tidy.

One Patient we spoke with described the staff as brilliant and another described them as friendly and nice.

A patient told us how they had been able to have home visits when needed. They said this was important to them as they were unable to visit the practice.

We sent comments cards to the practice in advance of our visit. This was to capture the views of patients. There were four posted into our box when we emptied it. One related to the treatment a patient received at North Bristol NHS Trust. The others related to the Northville Family Practice.

One patient described their GP as professional, empathetic, active and engaging when talking to them. They told us the GP was keen to provide a solution and sought the correct means for their on-going treatment. Another patient described the practice as clean, hygienic and safe, with polite staff most of the time. The other patient described their GP as caring and compassionate and told us they listened without judgement. They added that the GP offered realistic and rational advice. They said they felt safe and supported.

## Areas for improvement

**Action the service SHOULD take to improve**

The practice should improve arrangements for gaining patient feedback as the recent survey and patient comments to us indicated levels of dissatisfaction with availability of appointments and accessibility to appointments.

There should be better recording and dissemination of information in relation to lessons learnt from significant event analysis so that this can be shared with all staff in the practice.

There should be an identified 'lead' person within the practice in relation to safeguarding so that staff are aware of who they should report to.

# Summary of findings

The practice should improve arrangements for the storage of information in relation to the clinical audits carried out so that this information is readily available.

# Northville Family practice

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

A CQC Lead Inspector and a GP specialist advisor and the team included a Practice Manager from out of the area and an Expert by Experience. Experts by Experience are a part of the inspection team.

## Background to Northville Family practice

Northville Family Practice is a partnership shared by three practising GPs. The practice has three salaried GPs, practice nurses and healthcare assistants. The practice manager is supported by administrative staff and receptionists. The practice is situated in a largely residential area of South Gloucestershire. The patient population is mixed with young families, patients of working age and older patients. The practice is close to the University of West of England and provides services to some students.

All of the GPs work on a part time basis providing a service on weekdays from 8.30 am until 6pm. There are extended hours on aThursday to offer early morning appointments from 7.30 am for treatment and early evening consultations with a GP until 7.15pm. There are pre-bookable appointments available on some Saturday mornings usually after bank holiday weekends.

The services are provided at 521 Filton Avenue, Northville, Bristol BS7 0LS.

The practice does not provide an Out of Hour's service. Emergency arrangements for Out of Hour's is provided by an external service provider.

## Why we carried out this inspection

We inspected this practice as part of our new inspection programme to test our approach going forward. This provider had not been inspected before and that was why we included them.

## How we carried out this inspection

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

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

The inspection team always looks at the following six population areas at each inspection:

- Vulnerable older people (over 75s)
- People with long term conditions
- Mothers, children and young people
- Working age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health.
- Before visiting, we reviewed a range of information we hold about the practice and obtained information from the practice in advance. We also asked other organisations to share what they knew. These included

the South Gloucestershire Clinical Commissioning Group, The Avon Local Medical Committee, Healthwatch South Gloucestershire and the community district nursing support team.

We carried out an announced visit on 4 August 2014. During our visit we spoke with a range of staff including GPs, the practice manager, nurse, healthcare assistant and administrative staff and spoke with patients who used the service. We observed how patients were being greeted at reception and in the waiting room and talked with carers and family members. We reviewed comment cards where patients shared their views and experiences of the service.'

# Are services safe?

## Our findings

### Safe patient care

Significant events were managed by the GPs. We reviewed a number of these and saw a significant events recording form (SEA) about an event where medicines had been stored at the incorrect temperature. It recorded the name of the staff member who had completed the record and description of events including, actions taken, what could have been done better and the lessons learnt. There was space for recording steps to be taken to avoid similar events, learning needs and how they would be met.

### Learning from incidents

A partner GP told our accompanying GP that SEAs were discussed from time to time and more formally every three months. There was no log of SEAs in the practice and the outcome of these discussions was not disseminated to other staff in the practice.

### Safeguarding

The practice chaperone policy was revised in June 2014. A chaperone is a person who adcts to protect a patient and their GP during a medicl examination. We saw it advised when to use a chaperone, who could act as one and the procedures for GPs and nurses to follow. The practice maintained a register of those who had been trained to act as chaperone and had instructions for how they should behave.

We saw a sign in surgeries advising patients they could ask for a chaperone. Some staff confirmed they had completed training to be a chaperone. Only those staff who had completed the training could act as chaperone.The practice manager showed us the register of those who had completed the training. It showed there were two staff available to act as chaperone that day.

We looked at the policy relating to the protection of vulnerable adults and child protection. There were definitions of who would be classed as a vulnerable adult and the different types of abuse that could occur were listed. It included a statement related to the practice commitment to ensure children's welfare was promoted. The contact details for the relevant agencies were listed along with instructions for staff to follow and a flowchart to help in decision making.

We saw the flowchart for reporting of safeguarding concerns displayed in reception however, the contact details for reporting to other agencies were not included in the flowchart. The GPs did not have the contact details available in the surgeries.

One of the reception staff told us how they once had concerns about a young mother's treatment of their child. They reported their concerns to one of the GPs who arranged for a health visitor to see the mother.

The staff we spoke with told us if they had concerns about something they saw or heard that could put patients or their colleagues at risk they would follow the whistleblowing policy. It outlined how staff could report in confidence and how they would be protected. The policy gave advice on how to raise a concern and explained how the matter would be handled. We saw that the policy included the contact details for a whistleblowing charity should staff wish to raise concerns externally.

### Monitoring safety and responding to risk

All staff had training in dealing with medical emergencies and resuscitation on an annual basis. The practice had medicines for use in an emergency along with oxygen and an automatic external defibrillator. We checked the oxygen and medicines and found they were within use by dates. The defibrillator was in working order, checked daily and maintained according to the manufactures recommendation.

### Medicines management

We looked at the medicines management policy. It outlined how the practice would store medicines safely and only be administered by those staff who were authorised to do so, according to their professional guidelines and practice policy. It included what to do in the event of an adverse reaction and in the event of missing medicines.

Each of the treatment rooms had a lockable fridge where medicines were stored. Each nurse recorded the temperature of the fridge twice each day to ensure they were operating at the correct temperature and medicines were kept safely.

The practice nurse showed us the range of medicines that were kept for routine use, such as vitamin B12 and vaccines in case of an emergency, such as adrenaline. We saw these were stored appropriately and stock balances were

maintained by the nurse.The practice secretary dealt with incoming hospital discharge letters and change patient records to ensure they showed up to date information about patients medicines.

### Cleanliness and infection control

A practice nurse checked infection control arrangements daily and recorded their actions. The practice nurse also ensured all items of equipment were cleaned weekly, if they were not used.

We looked at the arrangements for infection prevention and control. We found effective arrangements for hand hygiene which included sanitising gel in surgeries, treatment rooms and at reception. Sharp instruments were stored and disposed of safely. Re-useable instruments were decontaminated appropriately and single use sleeves were used on thermometers. There were suitable arrangements for the handling of specimens to be sent for analysis. We observed the environment to be clean and tidy with suitable arrangements in place for the disposal of waste. We saw that staff had appropriate immunisation against contracting vaccine preventable infections.

We saw there was a contract with a commercial cleaning company. The contract showed that all areas of the practice were cleaned with daily and weekly tasks specified. The practice manager showed how they checked the cleanliness of the practice every two months and reported their findings. We saw the practice manager challenged the company in July 2014 regarding the quality of service provided. Issues with the cleaning contractor led to cancellation of the contract. A new contractor was engaged to maintain the cleanliness of the practice.

The practice had guidance from the Health and Safety Executive (HSE) on the Control of Substances Hazardous to Health (COSHH). The products were stored securely. We saw there were COSHH risk assessments for the products used in the practice .

The practice had arranged for a Legionella test to be carried out but had not received the outcome report.

### Staffing and recruitment

Patients told our expert by experience they felt safe when being treated in the practice. They felt there was enough staff with the necessary skills to care for them.

The practice manager told our expert about the arrangements for staff cover. Administration staff arranged their own cover for absences. The secretary arranged locum GP cover and ensured that checks were carried out. They checked the up to date performers list and if they had not previously worked in the practice they were required to submit a Curriculum Vitae (CV). One of the partners in the practice approved the suitability of a locum GP for work in the practice.

The human resources policy outlined the checks that would be carried out before employment was offered in the practice. We looked at five staff records selected at random. Staff completed an application form and references had been obtained. Criminal records checks such as through the Disclosure and Barring Service (DBS) were carried out to ensure they were suitable to work in the practice.). We saw all staff had a contract of employment and job descriptions were in place. For nursing staff, there was information related to their registration with the Nursing and Midwifery Council (NMC) and details of their professional indemnity insurance. Staff provided evidence of their identity and immunisation status.

### Dealing with Emergencies

The practice had two appointed fire marshals and arrangements were in place should they not be available. We saw that the fire marshals attended training in fire safety and their role. The fire alarm test record showed that the alarm system was checked weekly. We saw the fire procedure identified action to be taken in the event of fire that included staff responsibilities and guidance on how to use fire-fighting appliances. Staff had awareness of their responsibilities for the safety and protection of patients and themselves. We saw the fire safety risk assessment had been reviewed in July 2014. It recorded that portable appliances had been tested in July 2014 and identified methods of raising an alarm in the event of fire and escape routes.

The fire procedure was displayed in several areas of the practice. Patients and staff could see what they needed to do in the event of a fire.

We checked the medicines and equipment for use in an emergency and found most equipment had been calibrated and emergency medicines were in date. The GP expert noted that the blood pressure monitor in one surgery was due for calibration on 17 July 2014.

# Are services safe?

**Equipment**

There was a schedule of planned maintenance that showed the budget allocation for ensuring works were carried out. We saw this included costing for internal decoration and essential supplies such as gas and maintenance and testing of systems. This included testing the portable electrical appliances and medical equipment, such as the defibrillator and blood pressure monitors. Records showed that equipment was serviced annually.

# Are services effective?

(for example, treatment is effective)

## Our findings

**Promoting best practice**

A partner GP told us the practice aimed to prevent hospital admissions where possible and maintained connections with the clinical commissioning group (CCG). They told us how they shared essential information about patients with the GP Out of Hours service and ambulance service so that they could respond appropriately to patients.

The practice worked with the local district nursing team and a community matron. They told us about the initiatives they were involved with including the South Gloucestershire dementia strategy and the winter pressure pilot, to reduce hospital admissions of vulnerable patients by offering a service at weekends.

The practice nurse told us they referred patients to a diabetic liaison nurse when necessary.

The community district nursing team told us about regular meetings they had with the practice that included hospice staff and community matrons.

Management, monitoring and improving outcomes for people

The clinical governance policy stated that in order to monitor quality the practice would carry out regular clinical audits, review patient feedback, review service governance plans and review incidents and serious events regularly.

The practice had a system in place for completing clinical audit cycles. We looked at the report of an audit of female patients with Polycystic Ovary Syndrome (PCOS)k. This was to check that the practice was complying with guidance on the management of PCOS. The audit was carried out in 2011 and again in 2013. It identified that the practice had improved in the review of patients with PCOS and met national guidelines.

A similar audit was carried out to check that patients prescribed Hormone Replacement Therapy (HRT) were reviewed annually.Records showed that where risks outweighed benefits, assessment for stopping the HRT was carried out. The results showed a drop in the number of patients who had an annual review in the last year however, they also showed a significant drop in the number of patients having HRT. Actions included inviting patients for review. We were told the assistant practice manager was responsible for and ensured the re-call appointments were made.

We looked at the NHS Choices website that was set up to enable patients to leave reviews about the medical services they used. These related to telephone access, appointments, being treated with dignity and respect, involvement and the provision of information.. The practice manager had replied to the one review on the NHS Choices website they had received since being in post. We saw when reviews were received the practice manager shared them with the staff team.

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# Are services effective?

## (for example, treatment is effective)

### Staffing

We looked at the human resources policy which outlined the supervision and appraisal arrangements for staff. This had been developed to ensure staff reached their full potential and maximised the outcomes for patients. Staff thought it was a positive process.

We saw evidence which showed all staff had an annual appraisal. The administrative staff had their appraisal with the practice manager who assisted one of the partners in the appraisal process for GPs and nursing staff. The practice manager had bi-annual reviews with the salaried GPs.

Information changes about the practice or new information on how to deliver effective care was shared with staff by email. The practice manager and GPs also used a communication book and a board for messages about the day to day management of the practice.

Our accompanying GP met with a partner GP who told them there were three GPs in the partnership. In addition they employed three part time salaried GPs. One of the GPs had been revalidated and the others were due for revalidation either later this year or next year. Validation is the process carried out by the Royal College of General Practitioners where GPs demonstrated they were up to date and fit to practise.

The locum GP at the practice told us they found the computer records system easy to use and found the quality of records to be satisfactory.

### Working with other services

The community matron, assigned to the practice, was involved in care planning for patients and used a 'risk profiling' tool to assist with this. There were meetings every two weeks with the community nursing team to discuss patients needing home visits.

The practice also had links with emergency care practitioners from the local community health service that provided intermediate care following a patient's discharge from hospital.

A patient told us if they needed treatment for a specific reason the GP referred them to another service provider. Other patients told us they had been referred to hospital for an x-ray or scan. One patient told us their referral had been made very quickly. They were happy because this affected the speed with which they had an appointment with a consultant at the hospital.

### Health, promotion and prevention

The information leaflet for new patients gave the practice opening times and information about the GPs who worked there. We saw the leaflet described what people should do if they needed to see a GP out of hours, in an emergency. In addition there was information for patients about appointments for urgent medical problems, telephone consultations and home visits.

The practice offered a range of health promotion and prevention information to all patients using the practice. The promotion and prevention was provided as part of normal GP and nursing appointments. It was supported by a range of information within the practice and on the provider's website. Information was available about; health and lifestyle issues such as keeping healthy, living a healthy lifestyle, preventing illness, and preventing any existing illness from becoming worse. Leaflets included information on**; c**oughs and colds; diarrhoea; stomach ache and other minor illnesses. Information such as this helped patients to avoid unnecessary calls to the practice and enabled them to access ways of relieving signs or symptoms of illness.

We saw a range of leaflets inn the reception area. These related to patient transport services, the NHS smoking cessation service and fees for private services available at the practice.

We saw a General Medical Council poster was on display advising young patients about their confidentiality rights when seeing a GP.

# Are services caring?

## Our findings

Respect, dignity, compassion and empathy

The practice manager told our accompanying practice manager that the staff handbook had been updated to include statements in relation to equality and diversity.

The reception and waiting area were open -plan however there was a 'privacy window' to the side of the reception where patients could talk in confidence with a receptionist.

We saw that the clinical governance policy referred to patient privacy and dignity and recognised this as a priority. It stated that it was the policy of they practice to ensure all patients who received services would feel they were treated with respect with their right to privacy and dignity upheld and promoted. The patients we spoke with told us they felt they were treated with dignity and respect by the practice staff.

A partner GP told us the practice took pride in providing high quality care that was up to date and in line with ncurrent good practice. They said patients were encouraged to see their own GGP for continuity. Tjhey perceiverd that patients hade good relationships with the nursing and reception st6aff. This was reflected in the practice patient survey and other patient comments.

All patients were seen in private unless they chose to be accompanied by a partner, parent or chaperone. Consulting room doors were closed and clinical examination areas were screened to ensure patient privacy and dignity. All surgeries were separated from the waiting area. We saw no evidence that staff entered the surgeries unannounced, during our inspection, demonstrating patient's privacy and dignity were respected.

Patient satisfaction surveys were carried out on an ongoing basis. The receptionists asked patients to complete the survey forms however, there was no facility for these to be given back to the practice anonymously, or to make suggestions without their identity being revealed.

We saw a range of leaflets in the waiting area including information about patient transport services, the NHS stop smoking service and fees for private services available at the practice.

Involvement in decisions and consent

There was a statement which related to patient consent within the clinical governance policy. It stated the GP would explain invasive treatment to patients fully and obtain their consent in advance of the treatment. Where patients were unable to give consent the procedure would be explained to their representative.

There was a leaflet for patients relating to consent issues and a form for the GP to complete to record they had explained the procedure to be carried out. It also recorded any potential risks from the procedure.

Patients were involved in decisions about their care. GPs discussed changing patient's medicine with them when requested by the patient or because the GP felt there was a better alternative for the patient. Patients told us they always left their appointment with a clear understanding of what the GP had discussed with them.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

Responding to and meeting people's needs

We met with the locum GP working in the practice on the day of our visit. They told us the practice provided good personal care. Examples of how care was planned and patients were treated were given.

The practice website provided information about opening times and there were facilities for making appointments on line and for ordering repeat prescriptions. We saw there were profiles of the key staff within the practice and the facility for patients to complete reviews of the service. The website had health news updates..

Patients could access information about the services available at the practice on the practice website. It showed that in addition to routine GP consultations the practice offered a wide range of services. These included appointments for chronic disease management such as asthma, diabetes, chronic obstructive pulmonary disease and hypertension (raised blood pressure). Other services offered at the practice included blood and urine tests, as requested by the GP. In addition, there was a wound care and dressing service, suture removal, blood pressure monitoring and electrocardiograms (ECGs) to record the activity of the heart. A programme of immunisation was available for children and those who were eligible for the influenza vaccine. We saw that dietary and lifestyle advice was available including, support to stop smoking. Travel advice and vaccination was also available.

The GP told us about the difficulty in recruiting male GPs The partners and salaried GPs were female however, male locum GP's were used but they would not be available for all appointment times.

The practice telephone answering service gave patients information about what to do in the event of an emergency or Out of Hour's.

Patients awaiting the results of blood or urine sample tests were asked to contact the practice during the afternoon when the practice was quieter. We saw that samples were appropriately labelled and couriered for testing. Patients telephoned the practice during the afternoon and were given the results of their tests.

The practice patient population included some patients whose first language was not English. The practice manager told us they used a translation service where necessary. This ensured patients who had difficulty understanding English could have information shared with them in a way which they understood.

### Access to the service

There were evening appointments available on Thursdays and some Saturday morning appointments. .

Some patientstold us they had difficulty having a same day appointment with their preferred GP . There was guidance in the form of a flowchart to assist reception staff when making appointments. We saw it prompted staff to ask if the appointment was required urgently and whether a telephone consultation would be sufficient. There were a range of different options. Some appointment slots were reserved for same day emergency appointments. Patients could be given an appointment for afternoon surgery or could 'sit and wait'. This involved patients arriving at midday and waiting to be seen by a GP.

We spoke with 11 patients during our visit. Patients told us they were happy with the practice. They gave anecdotal evidence to support why they were happy and to demonstrate the practice was responsive and their needs were met.. Most patients thought their GP clearly explained diagnosis and treatment to them.

### Concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

We saw the practice complaints procedure informed patients how to complain and gave the timescales for acknowledgment of their complaint and investigation. The procedure outlined what patients could do if they did not want to complain directly to the practice and included the contact details for the Independent Complaints Advocacy Service (ICAS). It also included the contact details of the Health Service Ombudsman who patients could contact if they were not happy with the way their complaint had been handled.

We looked at the practices analysis of complaints for the year ending 31 March 2014. It showed five complaints were received. All the complaints were investigated and patients received responses within the timescales outlined in the

# Are services responsive to people's needs?

## (for example, to feedback?)

practices complaints procedure. Four of these were related to clinical decisions and one concerned the administration of the practice. The practice had not received any complaints since the beginning of April 2014.

Some patients told us they would not know how to complain. Others said they would ask the receptionist. We saw the complaints procedure displayed prominently alongside the electronic 'arrival' system and was also indicated on the practice website.

# Are services well-led?

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

## Our findings

### Leadership and culture

Each member of staff was issued with a comprehensive staff handbook. We saw that along with the main conditions of employment it covered areas such as health and safety, pay and benefits, employee matters and house-keeping.

The handbook was supported by a range of appendices that contained further policies and procedures. This enabled staff to be fully aware of the expectations of them in their role so patients would receive a consistent service in line with practice protocols.

### Governance arrangements

The human resources policy outlined the arrangements for the induction, training and meeting continuing professional development (CPD) as required by the relevant professional regulatory bodies.

We saw there was a 'first day' induction checklist that covered an introduction to the practice, terms and conditions of employment, the rules of the practice and health and safety. We looked at the induction and training plan for a newly appointed member of staff. The plan outlined what would be covered and by whom and who would provide the member of staff's supervisor with feedback on performance. Over the period of induction there was time set aside for there to be an exchange of feedback between the staff member and their supervisor. This enabled each to be sure that the learning was effective and patients would receive consistent treatment.

The most recently recruited staff member said their induction had been thorough and was still ongoing. At the end of the probationary period a performance appraisal report was completed. We saw all staff had appraisals and supervision meetings at six monthly intervals. We saw a schedule of planned meetings to review staff performance. Staff confirmed they found supervision and appraisal purposeful.

### Systems to monitor and improve quality and improvement

### Patient experience and involvement

One Patient we spoke with described the staff as brilliant and another described them as friendly and nice.

We saw a patient with hearing impairment being greeted by the practice nurse. The receptionist had recognised the patient's impairment and added a message to the electronic records system which alerted the nurse to the patient's impairment because they may not have heard the loudspeaker announcement.

A parent contacted us to say the practice was proactive and had sent a letter to arrange for their child to have their Meningitis vaccination. They felt this was to make it easier for parents to take their child to the practice during the school break as they knew of other parents who had received similar letters from the practice. The practice manager confirmed this was the intention of the practice.

The parent told us that when they arrived at the practice the receptionist was friendly and told the child they remembered them as a younger child. We were told that during the appointment, the nurse explained the purpose of the vaccine, checked for allergies and provided reassurance and put the child at ease. They also explained the possible side effects. The child told their parent that they thought the staff were nice and friendly.

On the practice website we saw there was information about how patients could become involved in the Patient Representation Group. We saw patients who signed up for the 'virtual' group would be asked to complete surveys from time to time. There was an online form for patients to use in order to register their interest.

The patient representation group arrangements commenced in April 2013 and an end of year review report was produced. We saw the aims of the practice were to maximise patient participation in use of the electronic system, maximise 'in practice' participation by the completion of survey questionnaires and to exploit the links with a local charity through regular liaison. The report of the end of year review recorded the practice disappointment with the results. Only two per cent of those registered with the practice participated. The report identified a range of recommendations to help encourage patient feedback.

We met with the chairperson of the local community charity committee. The Charity raised funds to support patients from the GP practices in Filton. They asked the practices if there was any equipment they needed to

# Are services well-led?

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

support patients and if they could, provided the equipment. The charity also provided social support to patients who lived in Filton by arranging days out and providing a visiting service.

### Learning and improvement

A range of meetings were held. The GP partners met weekly. The nurses met every two weeks and every six weeks the practice manager attended their meeting. The administrative team met six weekly. All minutes of meeting were shared with the staff team. Records of meetings showed all relevant topics were discussed which ensured that staff were familiar with policies, procedures and changes to practice. The nurses met every two weeks and every six weeks the practice manager attended their meeting. The administrative team met six weekly. All minutes of meetings were shared with the staff team.

A range of training for staff was organised by The Avon Local Medical Committee. This included 'Strategic Leadership' training for the practice manager. We looked at the staff training plan. It showed us what training had taken place prior to our visit and what had been planned for the rest of the year. We saw there was training related to accessing patient records, health and safety and induction for newly appointed staff. In addition, some staff attended training related to domestic violence. The training planned for the rest of this year included consent, resuscitation and dealing with medical emergencies, patient care skills and confidentiality.

Records showed the training completed by staff. For clinical staff, we saw there was training in infection prevention, family planning and emergency contraception, child immunisation, ear care and chronic obstructive pulmonary disease. We also saw that one of the nurses had a diploma in asthma care, another had trained in influenza vaccination and one had attended an 'introduction to respiratory and cardiovascular disease in general practice' course. Some staff attended training entitled 'domestic violence – the primary care response'. All staff attended training in child protection and safeguarding vulnerable adults and dealing with medical emergencies including resuscitation. Several staff had trained in first aid and fire safety.

Our accompanying GP spoke with the health care assistant working on the day of our visit. They told us they had training in medical emergencies and resuscitation, ear syringing, administering injections and echocardiogram, an ultrasound scan to record the activity of a patient's heart.

Administrative staff had time allocated for continuing professional development (CPD). This amounted to one hour every four weeks. During this time the practice manager or assistant practice manager guided staff through assisted training exercises or staff could carry out self-directed learning. Our accompanying practice manager saw there was a range of websites that staff had access to, to complete training requirements. These included customer service, telephone etiquette and basic medical terminology.

Staff told us they felt supported and felt able to contribute in staff meetings. One member of staff told us how other staff had been supportive and flexible in response to their personal circumstances. They felt there was good team working in the practice.

The practice manager attended the local practice managers' forums. This enabled them to access information and support to enable them to manage the practice effectively.

### Identification and management of risk

We looked at the clinical governance policy to see how the practice identified and managed risk. In addition to giving an overview of arrangements specifically related to infection control including, decontamination and waste management. It referred to general precautions such as hand washing, the wearing of personal protective clothing and equipment (PPE), along with the prevention of blood borne viruses. We saw and heard about staff following these arrangements throughout our inspection.

The practice recognised that changes to operation, new staff and new contractors may have left infection control arrangements unsuitable so brought forward the audit that was planned to commence in September 2014. The audit was carried out in June and July 2014 and showed that all infection control arrangements were effective.

# Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

## Our findings

The practice had considered the needs of its patients, particularly those who were elderly or who had restricted mobility. Reasonable adjustments had been made. There was level access to the practice with a ramp at the main door and level access to all surgeries and toilet.

A partner GP told us the practice aimed to prevent hospital admissions where possible and maintained connections with the clinical commissioning group (CCG). They told us how the practice shared essential information about the most vulnerable older patients with the GP out of hour's service and ambulance service. This enabled the other services to respond appropriately to patients and help avoid unplanned hospital admissions when the practice was closed.

A programme of immunisation was available for older people who were eligible for the influenza vaccine.

We saw an older patient with a hearing impairment being greeted by the practice nurse. The receptionist had recognised their impairment and added a message to the electronic records system to alert the nurse to the patient's impairment because they may not hear the loudspeaker announcement. We saw that the nurse came out to meet the patient when their appointment was due to commence.

An older patient we spoke with told us how they had been visited at home when needed. The staff we spoke with told us how this type of service was available to all older patients if they were unable to get to the practice for appointments.

# People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

## Our findings

We saw patients with long term conditions could access information about the services available at the practice on the practice website. It showed that in addition to routine GP consultations the practice offered a wide range of services and information which might help patients without having to see their GP.

Services included appointments for chronic disease management such as asthma, diabetes, chronic obstructive pulmonary disease (COPD) and hypertension (raised blood pressure). Information included self-help leaflets, short video clips about diagnosed illnesses and links to other services that might be able to help or advise if the practice was closed.

The practice nurse told our GP specialist advisor they were one of two nurses who saw patients with a diagnosis of diabetes. They said they referred patients to a diabetic liaison nurse for insulin conversion (a change between taking tablets and having injections to control their diabetes) when changes to insulin was necessary.

# Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

## Our findings

There were no maternity or ante-natal clinics held in the practice. The GPs and nurses we spoke with told us patients were referred to a clinic nearby in Filton for these services. In support of post natal care a programme of immunisation was available for children.

A parent told us the practice was good with their children and what they particularly liked was the way GPs spoke with the child rather than the parent. Another parent contacted us to say the practice was proactive and had sent a letter to arrange for their child to have a Meningitis vaccination. They felt this letter was a helpful way to make it easier for parents to take their child to the practice during the school break. The practice manager confirmed this was the intention of the practice.

We saw a General Medical Council poster in the waiting area of the practice which advised young patients about their rights when being seen by a GP. It showed that what young patients said to the GP was confidential and that GPs should be asking them first before sharing information about them with anyone else. The information stated they could decide to see the GP on their own and that they would be treated with the same respect as adults. The guideline was in line with the Gillick competency guidelines. These referred to decisions about whether a child was mature enough to make decisions for themselves and if they had the ability to be seen alone or with a chaperone rather than with their parents. Where this was the case, we were told patient records would be updated to reflect the current arrangements.

# Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

## Our findings

Patients could make appointments outside of their working hours. There were appointments available early morning and early evening on Thursday and some pre-bookable Saturday morning appointments.

# People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

## Our findings

The reception and waiting area was open however there was a 'privacy window' to the side of the reception where patients could talk in confidence with a receptionist.

The practice chaperone policy considered the needs of patients in vulnerable circumstances. It advised that clinicians should consider whether intimate or personal examination of a patient was justified and whether the nature of the consultation posed a risk of misunderstanding. We saw that it advised that GPs and nurses should always give the patient a clear explanation of what the examination would involve, adopt a professional and considerate manner and afford the patient sufficient privacy.

# People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

## Our findings

A GP partner told us about the initiatives they were involved with including the South Gloucestershire Dementia Project. The project linked the local council, clinical commissioning group and other agencies to provide information and support for people with dementia. Patients were able to be assessed in their home environment as they had an assessment at home carried out by the memory care nurse.