The Maytrees Practice

Quality Report

Eastville Health Centre
East Park
Bristol
BS5 6YA
Tel: 0117 9510042
Website: http://www.maytreespractice.com/

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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 our inspection on 16th December 2014. We inspected The Maytrees Practice as part of our new comprehensive inspection programme.

Overall we found the practice is rated as good. We saw examples of a safe, effective, caring, responsive and well led practice. Patients reported high levels of satisfaction with the practice during our inspection and this was reflected in the comment cards we also received.

Our key findings were as follows:

- Patients were able to access urgent appointments, these were bookable on the day and less urgent appointments could be booked in advance. There was an online booking system available to patients.
- Patients were generally able to see a named GP of their choice for the majority of appointments.
- There were systems in place which ensured patient safety and prompt referrals to other services to ensure patients health was maintained or improved.
- The practice had systems in place which ensured a hygienic environment was maintained.
- Patients were treated with dignity and respect by a staff team who understood patients' needs. A translation service was available one day a week to help meet the needs of the local population.
- Communication within the practice and to other services outside the practice was effective.
- The leadership of the management team ensured staff were informed and supported to deliver safe and effective care to patients.

We saw several areas of outstanding practice including:

- One of the practices GPs provided primary care services to 35 patients in a local hospital which specialises in the management and treatment of patients with acute and complex mental health problems.
- The practice had access to a link worker translation service one day a week and provided additional access to this service for patients where family members were not deemed suitable to support the patient. The practice also made daily use of the telephone translation service to assist with patient communication.

Summary of findings

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

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

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from NICE and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing mental capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and planned. The practice could identify all appraisals and the personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

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

Are services responsive to people's needs?

Good

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

Summary of findings

to understand and evidence showed that the practice responded quickly to issues raised. We saw the practice had learnt from complaints and shared this learning with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt well supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The virtual patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

What people who use the service say

We spoke with 14 patients visiting the practice and three members of the patient participation group during our inspection. We received five comment cards from patients who visited the practice and saw the results of the last patient participation group survey. The practice also shared their initial findings from their current 'friends and family' survey. We looked at the practice's 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 Care Quality Commission's information management report about the practice.

The majority of comments made or written by patients were positive and praised the GPs and nurses who provided their treatment. For example; about receiving good care and treatment, about seeing the same GP at most visits and about being treated with respect and consideration.

We heard and saw how some patients found access to the practice and appointments easy and how telephones were answered after a period of waiting. However, some comments indicated it was not always easy to get through to the practice during the first hour of the practice opening, with 62% of patients saying it was easy to get through. The most recent GP survey showed 93% of patients found the appointment they were offered was convenient for them. Patients also told us they used the practices online booking systems to get appointments.

Patients told us their privacy and dignity was respected during consultations and they found the reception area was generally private enough for most discussions they needed to make. 94% of patients said they found the receptionists at this practice helpful. Patients told us about GPs supporting them at times of bereavement and providing extra support to carers. A significant number of patients had been attending the practice for over 10 years and told us about how the practice had grown, however they were always treated well. The GP survey showed 91% of patients said the last GP they saw or spoke with was good at giving them enough time and treating them with care and concern.

Patients told us the practice was always kept clean and tidy and periodically it was refurbished and improved repeat prescription facilities had been added. They told us during intimate examinations GPs and nurses wore protective clothing such as gloves and aprons and that examination couches were covered with disposable protective sheets. 84% of patients described their overall experience of this practice as good.

Areas for improvement

Outstanding practice

We saw examples of outstanding practice including;

- One of the practices GPs provided primary care services to 35 patients in a local hospital which specialises in the management and treatment of patients with acute and complex mental health problems.
- The practice had access to a link worker translation service one day a week and provided additional access to this service for patients where family members were not deemed suitable to support the patient. The practice also made daily use of the telephone translation service to assist with patient communication.

The Maytrees Practice

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, a practice nurse and an expert by experience.

Background to The Maytrees Practice

The Maytrees Practice, Eastville Health Centre, East Park, Bristol. BS5 6YA; is located close to the city centre of Bristol. The practice covers the areas of Easton, Eastville, Fishponds, Greenbank, Redfield, Stapleton, St. Werburghs, Whitehall and St Judes.

The practice is part of the Bristol area clinical commissioning group and has approximately 4,200 patients. The area the practice serves has a high number of patients from different cultural backgrounds with about 40% of patients from Black and other minority ethnic groups. Patient turnover is high due to the temporary nature of the local population. The area is amongst the most deprived in the country as defined by Public Health England.

The practice is in a health centre which is shared with another GP practice. The facilities provided include 3 consulting rooms, 1 treatment rooms, a phlebotomy room (for carrying out blood tests) and access to a shared health education room. There is level access into the practice and to all patient accessible areas; toilets are accessible with facilities for patients with disabilities and a baby changing area. Parking is currently unavailable on site due to construction of the health centres new premises. Parking was available close to the practice. There are a range of administrative and staff areas including meeting rooms within the practice, some of which are on the first floor.

There are three partners in the practice which included the practice manager. Additionally there are three salaried GPs working in the practice. All GP's are female and all work part-time. In addition there is a senior nurse, two practice nurses, a phlebotomist (staff who carry out blood tests) and a health care assistant. The practice also employs a small team of reception and administrative staff including a medical secretary. These teams are supported by a practice manager and an assistant practice manager/medical secretary.

The practice has a Primary Medical Services (PMS) contract to deliver health care services; the contract includes enhanced services such as extended opening hours. This contract acts as the basis for arrangements between the NHS Commissioning Board and providers of general medical services in England.

The practice has opted out of providing out-of-hours services to their own patients. This is provided by another organisation, Brisdoc, and patients are directed to this service by the practice during out of hours.

The CQC intelligence monitoring placed the practice in band six. The intelligence monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

Detailed findings

Why we carried out this inspection

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

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

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)

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations such as the local Healthwatch, NHSE Area Team and Bristol Clinical Commissioning Group (CCG) to share what they knew. We asked the provider to send us information about their practice and to tell us about the things they did well. We carried out an announced visit on 16 December 2014.

We talked with the majority of staff employed in the practice. This included three GPs, the practice nurse, a health care assistant, the practice manager and their assistant and three administrative/reception staff. We spoke with 14 patients visiting the practice during our inspection and received comment cards from a further five patients.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, where patient records had become muddled and the wrong information was provided about a patient attending a hospital consultation.

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

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last two years and we were able to review these. Significant events was a standing item on the practices 'Doctors' meeting agenda and a dedicated meeting was held quarterly to review actions from past significant events and complaints. There was evidence from meeting minutes with which we were provided that the practice had learned from these and the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff told us they knew how to raise an issue for consideration at the meetings and they felt encouraged to do this where relevant.

Staff used incident forms or emails on the practice intranet and sent completed forms to the practice manager. They showed us the system used to manage and monitor incidents. We tracked four incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example, where a patient became aggressive and vandalised part of the premises, the investigation showed a clear process for explaining the 'Zero Tolerance' policy and when to contact the police had been implemented. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken in line with the practices complaints policy.

National patient safety alerts were disseminated by the practice manager or one of the partners to practice staff via email or the records systems 'practice notes' facility. Staff we spoke with were able to give examples of recent alerts that were relevant to the care for which they were responsible. They also told us alerts were discussed at the practices 'Doctor' meeting which nurses also attended to ensure all staff were aware of any alerts that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young patients and adults. We looked at training records which showed that all staff had received relevant role specific training about safeguarding. We asked GPs, nurses and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older patients, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible through the practices online document system.

The practice had appointed dedicated GPs with lead responsibility for safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary skills and knowledge to enable them to fulfil this role. The lead GP was trained to level three in safeguarding children with all GPs working towards that level. Training had also been completed in safeguarding vulnerable adults, including older patients. All staff we spoke with were aware who the lead GPs were and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's patient records system. This included information to make staff aware of any relevant issues

when patients attended appointments. For example children subject to child protection plans, patients who required interpreters and patients on the mental health register.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. All nursing staff, including health care assistants had been trained to be a chaperone. If nursing staff were not available to act as a chaperone, the health care assistant and phlebotomist had also undertaken training and understood their responsibilities when acting as chaperones. The training included where to stand to be able to observe the examination and how to maintain patient dignity at all times.

The practice had systems in place for the identification and follow up of children, young patients and families living in disadvantaged circumstances, including looked after children and young carers. Representatives from the practice attended child protection case conferences and reviews where appropriate and provided reports if they were unable to attend. The practice had a policy of following up children who failed to attend appointments for example, for childhood immunisations. The practice repeatedly followed up non-attenders and had identified culturally based reasons for a substantial number of the non-attenders. The practice then took action to address the health beliefs of parents that led to their reluctance to submit children for immunisations. The nurse or administration team contacted the parent to identify the reason for non-attendance and action was taken to facilitate attendance at another appointment or appropriate action taken for ongoing non-attendance.

Older patients, families, children and young people and vulnerable people who were included in the list of most vulnerable patients were highlighted on the practices patient record system. The practice had a system in place for reviewing repeat medicines for patients with several different illnesses or who took multiple medicines. The practice had access to a pharmacist for one day each week, they reviewed prescribing and repeat prescribing as part of this system. GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as the police and social services.

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. Keys to medicines cupboards were held in a secure key safe with access limited to a small number of staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice nurse we spoke with was able to explain to us how they maintained the cold chain to ensure medicines were kept at correct temperatures. 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 in line with waste regulations.

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example, patterns of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice. The practice had access to a pharmacist for one day each week; they reviewed prescribing and carried out medicines audits. They produced a 'Top Tips' checklist for the practice to follow to ensure safe medicines management. We saw this document had been discussed in the September 'Doctors' meeting.

The nurses and the health care assistant 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 and the health care assistant had received appropriate training to administer vaccines.

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

Cleanliness and infection control

Good

Are services safe?

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. Cleaning was carried out by a contractor for the whole of the health centre and was monitored routinely by the practice. The contractor had recently been provided with the contract and had carried out a deep clean of the practice in November of this year. Staff told us how much cleaner the practice was with the new cleaning regime in place.

The practice had a member of staff with lead responsibility for infection control who had undertaken further training to enable them to provide advice about 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; the last one was completed on 2 December 2014. Any improvements identified for action were completed on time for example, ensuring cleaners stored sharps boxes securely prior to disposal. Minutes of practice meetings showed that the findings of the audits were discussed.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and equipment coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. For example, when carrying out intimate patient examinations. There was also a policy for the handling of a needle stick injury.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. Hand gels were also available in the reception area and health education room.

The practice had a policy for the management, testing and investigation of legionella (bacteria found in the environment which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients. The last independent Legionella check carried out on 6 June 2014 and indicated a medium risk in some areas of the health centre. We saw documents which indicated this work had been tendered for action and was due to commence shortly.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, blood pressure monitors and fridge thermometers.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). A risk assessment had been completed for roles which did not require a DBS check. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure 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. The use of locum staff was minimised to ensure continuity of patient care and where used the same locums were employed. The partners arranged their work and leave patterns so that at least one partner was in the practice each day to ensure decision about the practice could be made without delay.

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. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

Good

Are services safe?

The practice had recognised the issues of having an all female GP team. They had started making arrangements with the other practice in the health centre to ensure a male GP for a session each week for patients who might prefer a male GP.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included shared annual and monthly checks of the health centre, 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.

Identified risks were included on a risk log. Each risk was assessed, rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at GP partners' meetings and within team meetings. For example, the practice manager had shared the recent findings from an infection control audit with the team.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example, there were emergency processes in place for patients with long-term conditions. Staff gave us examples of referrals made for patients whose health deteriorated suddenly. Staff gave examples of how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. The practice's significant event log showed no medical emergencies concerning patients had occurred in the last two years.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. 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.

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 to which staff could refer incidents. For example, contact details of a power company to contact if the heating or lighting systems failed.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed staff were up to date with fire training and that they practised regular fire drills and alarm testing.

Risks associated with service and staffing changes (both planned and unplanned) were required to be included on the practice risk log. We saw an example of this, for example, the loss of a GP and the mitigating actions that had been put in place to manage this.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The patients we spoke with told us the care and treatment they received enabled them to improve or maintain their health. The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance and accessed guidelines from the National Institute for Health and Care Excellence (NICE), research documents 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 these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines and these were reviewed when appropriate.

The GPs told us they each had lead responsibility in specialist clinical areas such as diabetes, heart disease, asthma and mental health. The practice nurses supported this work, which allowed the practice to focus on specific conditions. GPs and nurses we spoke with were open about asking for and providing colleagues with advice and support. For example, GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of patient's mental wellbeing. Our review of the clinical meeting minutes confirmed that this happened.

The practices staff showed us data from the local CCG about the practice's performance for antibiotic prescribing, which was comparable to similar practices. The practice had also completed a review of case notes for patients taking blood thinning medicines which showed all were receiving appropriate treatment and were regularly reviewed. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. These patients were included on the practices list of the 2% most vulnerable patients. We were shown the process the practice used to review patients recently discharged from hospital, which required patients to be reviewed within two weeks by their GP according to the patients' needs.

National data provided by NHS England showed the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of patients with a range of diagnosis to specialists or consultants for further investigations. We saw no evidence of discrimination when making care and treatment decisions. Discussions with GPs showed the culture in the practice was that patients were referred on need and age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

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

The practice showed us ten clinical audits that had been undertaken in the last three years. About half of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, an audit about patients taking anticoagulant medicines World health organisations (WHO's) international normalisation ratio (INR) remained within the expected range. The audit showed that where patients INR blood test results frequently fell outside the expected range a review of their medicines was carried out which resulted in better outcomes for the patient.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). The QOF is a national performance measurement tool. For example, we saw an audit regarding the prescribing of medicines used to control neuropathic pain carried out following guidance from the clinical commissioning group (CCG). Following the audit, the GPs carried out medicines reviews for patients who were

Good

Are services effective?

(for example, treatment is effective)

prescribed these medicines and altered their prescribing practice, in line with the guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes.

The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, screening took place for 100% of patients with schizophrenia, bipolar affective disorder and other psychoses who had a record of alcohol consumption in the preceding 12 months. 88% of patients with diabetes had an albumin creatinine ratio test (the test can show whether the patient's kidney is functioning correctly) in the preceding 12 months, and the practice met the minimum standards for the QOF in asthma and chronic obstructive pulmonary disease (lung disease) management. We spoke with one of the partner GPs about the percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less as this was below the national average. They told us how the practice continued to work towards improving these figures by writing to all patients to remind them of tests and had opportunistically carried out tests at routine appointments. The practice had also funded a nurse to be trained in the diagnosis and management of type II diabetes to help improve patient testing.

The GPs and nursing team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how they reflected on the outcomes being achieved and areas where this could be improved. We saw evidence these discussions took place from the minutes of GPs and nurses meetings. Staff spoke positively about the culture in the practice relating to audits and quality improvement, stating there was an expectation that all clinical staff should undertake at least one audit a year.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The 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, they 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 achieved and implemented the gold standards framework for end of life care. It 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 practice had a positive working relationship with a local hospice which supported patient and family support. As a consequence of staff training and better understanding of the needs of patients, the practice had increased the number of patients on the register.

The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area. For example, the number of patients who were at risk from influenza who had received the seasonal influenza vaccination.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. We observed a good skill mix among the GPs with two having additional diplomas in children's health and obstetrics. 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 NHS England can the GP continue to practise and remain on the performers list with the General Medical Council).

All staff undertook an annual appraisal that identified learning needs from which action plans were documented. Our discussions with staff confirmed that the practice was proactive in providing training and funding for relevant courses. For example, a nurse was in the process of training

Good

Are services effective?

(for example, treatment is effective)

for a qualification in the diagnosis and management of type II diabetes and another member of staff had trained to become a phlebotomist (someone who takes blood samples).

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, in the administration of vaccines, cervical cytology and health checks. Those with extended roles for example, seeing patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease, were also able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage complex cases. It received blood test results, X ray results and letters from the local hospital including, discharge summaries, out-of-hours GP services and the 111 service reports both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting upon any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no reported instances within the last year of any results or discharge summaries that were not followed up appropriately.

The practice was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above that which is normally required under the core GP contract). We saw that the policy for actioning hospital communications was working well in this respect. The practice undertook routine audits of follow-up appointments to ensure inappropriate follow-ups were documented and that no appointments were missed.

The practice held multidisciplinary team meetings at least quarterly to discuss the needs of complex patients, for example, those patients with end of life care needs or children on the 'at risk' register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information sharing

The practice used computer based systems to communicate with other providers. For example, there was a shared system with the local GP out of hour's provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made the majority of referrals last year through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to hospital appointments. One GP showed us how straightforward this task was using the electronic patient record system and highlighted the importance of this communication with hospitals. The practice had also signed up to the electronic Summary Care Record and planned to have this fully operational by 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used computer based patient record system, EMIS Web, to coordinate, document and manage patients' care. All staff were fully trained to use the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. Paper records such as letters from consultants, were kept securely in a staff only area of the practice. We saw evidence audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe

how they implemented it in their practice. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff, for example with making 'do not attempt resuscitation' orders. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Patients with a learning disability and those with a diagnosis of a dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually or more frequently if changes in clinical circumstances dictated it and had a section stating the patient's preferences for treatment and decisions. For example, in their choice of end of life treatments. Staff we spoke with gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. We were shown examples of where an independent mental capacity advocate (IMCA) had been involved in supporting decisions for a patient with learning disabilities. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged 16 and under who have the legal capacity to consent to medical examination and treatment).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's written consent was documented in the patient notes with a record of the relevant risks, benefits and complications of the procedure. For other interventions such as intimate examinations, verbal consent was gained and recorded.

Health promotion and prevention

The practice had met with the Public Health team from the local authority and the CCG to discuss the implications and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the local area. This information was used to help focus health promotion activity.

It was practice policy to offer a health check with the health care assistant or practice nurse to some new patients registering with the practice dependent on identified issues. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18-25 and offering smoking cessation advice to smokers. Chronic Disease Management Clinics were provided by one of the practices nurses.

The practice also offered NHS Health Checks to all its patients aged 40-75. A staff member showed us how patients were followed up within a week if they had risk factors for disease identified at the health check and how they scheduled further investigations.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and all were offered and received an annual physical health check. The practice had also identified the smoking status of 94% of patients over the age of 16 and actively offered nurse-led smoking cessation clinics to these patients. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for cervical smear uptake was 88%, which was better than others in the CCG area. There was a policy to offer letter reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend annually. There was a named staff member responsible for following up patients who did not attend screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was in line with the CCG, and again there was a clear policy for following up non-attenders by the named practice nurse. The practice had identified that parents of Somali children did not like their children to have the measles, mumps and rubella (MMR) vaccination until after their child could walk and talk. The practice had a system in place to ensure that this group of patients received reminders about the vaccination until the family attended the practice. The clinical team also opportunistically reminded parents at routine appointments.

Good

Are services effective?

(for example, treatment is effective)

The practice kept a register of older patients who were identified as being at high risk of admission to hospital or who were near the end of their life and ensured they had up to date care plans. These were shared with other providers such as the out of hour's service. All vulnerable older patients discharged from hospital had a follow-up consultation where it was required. Follow-up consultations were also made during routine appointments.

Housebound patients had a named GP who took an overview of the patients care and liaised with the community nursing service to ensure support was also provided for carers. 'At Risk' patients were monitored monthly with individual patients discussed at the six weekly 'Doctors meetings', these meetings included nurses and community teams.

All older patients had been offered cognition testing. A similar number of patients with a new diagnosis of dementia recorded had a record of calcium, glucose, renal and liver function, thyroid function tests, serum vitamin B12 and folate levels recorded in line with national guidance. We saw evidence through meeting minutes of multidisciplinary case management meetings having taken place for the most vulnerable patients in this age range. Each patient over 75 years was provided with a named accountable GP. We saw evidence from multidisciplinary case management meetings which showed patients were routinely reviewed.

Patients with long term conditions had structured annual reviews for various conditions such as diabetes, chronic obstructive pulmonary disease (COPD) and heart failure. Patients with a diagnosis of diabetes had routine access to clinics and other services such as blood testing and advice. Patients had access to practice nurses who delivered a programme of support to patients who were newly diagnosed with type II diabetes. This was a Bristol wide initiative called "living with diabetes". 82% of patients with diabetes had received an annual foot check in the last 12 months. The GPs and nurses we spoke with told us they actively promoted lifestyle advice and gave patients information to help promote change. We saw evidence from multidisciplinary case management meetings which showed patients were routinely reviewed and for the most vulnerable patients a named GP was identified.

Families, children and young patients had access to a range of services within the practice and those provided in the health centre. These included, ante natal services, baby clinics, family planning and sexual health clinics.

Immunisation rates for all standard childhood immunisations such as, infant meningococcal vaccinations and measles, mumps and rubella were in line with, or better than, those in other local practices however some booster vaccinations had a lower uptake rate due to some cultural resistance to immunisations before the child could walk and talk. The practice ensured children had the highest priority to appointments. Extra appointments were provided when the need arose to accommodate ill children.

We saw information was available for young patients visiting the practice about sexual health and the clinics and services available to them, for example, contraception advice and chlamydia screening. We spoke with the midwives and health visitors who were visiting the practice. All told us about multidisciplinary working with the GPs and nurses in the practice and of regular meetings with the practice staff.

Working age patients had access to a range of appointments outside of normal practice times. These appointments included late evening appointments on two days each week. A small number, about 5%, of these could be booked via an online facility or by telephone. Health checks were offered when these patients attended routine appointments as were cervical smears and blood pressure checks.

The practice provided a range of lifestyle information for this group of patients including how to get support for managing stress at work, depression and other mental health problems. A range of social prescribing was used by the practice to support the working population remain well. For example, where patients were overweight they could be prescribed access to weight loss or walking groups. For other patients, referrals to counselling services were provided to improve their wellbeing.

Flexible appointment times including same day telephone consultations were available. The practice routinely saw patients from 8.45 am to 6:00 pm and had extended hours on Monday and Tuesday evenings. The GPs told us they saw patients until the last patient had been seen, this was confirmed by patients with whom we spoke. A range of

Good

Are services effective?

(for example, treatment is effective)

additional in-house services including, phlebotomy (blood tests), spirometry (a test that can help diagnose various lung conditions), international normalized ratio (INR) blood test monitoring, NHS health checks and minor surgery were provided.

Patients whose circumstances may make them vulnerable were identified on a register in the practice. The list included those patients from several vulnerable groups for example, patients with learning disabilities, patients who had drug or alcohol problems and children on the 'at risk' register. All patients with learning disabilities received annual follow-up appointments and medicines reviews.

The practice worked closely with and referred patients to a local service that assesses and meets the initial health needs of asylum seekers and new refugees arriving in Bristol. Asylum seekers were provided with urgent appointments until they were granted asylum or were deported.

We saw and heard about evidence of multidisciplinary team working to assist in the care management of vulnerable patients. We saw a local Drug Project provided a recovery orientated clinic for patients in the practice one day each week. We heard how the practice actively engaged with and supported the patients accessing the project and made routine referrals to them. We saw evidence of signposting patients to a range of support groups and third sector voluntary organisations for example, Bristol specialist drug and alcohol service and the addiction recovery agency.

Patients who experienced poor mental health were provided with a range of services through referrals to locally based services, for example, Child & Adolescent Services (CAMHS) and Adult Mental Health services. The practice carried out joint patient consultations with local mental health teams to ensure greater continuity of treatment for the patient and improved information sharing for the professionals involved. For example, in the types and choices of treatment available to the patients. Where there were concerns about a patient the practice liaised with the community mental health team for example, if a patient with chronic schizophrenia was declining blood tests and treatment for poorly controlled diabetes. This ensured the patient received interventions which helped maintain their health.

The GPs and practice nurses had received training in learning disabilities, mental health and dementia. The practice was able to evidence a positive dementia detection rate. We saw evidence from patient records of early diagnosis of dementia for elderly patients. We heard about referrals to speech and language therapists and how psychological services were also contacted. Carers of these patients were identified and alert notes made on the patient records system.

A named accountable GP was available to patients who experienced poor mental health with flexible appointment times including same day emergency appointments and telephone consultations. Staff were trained to be sensitive to patients distress and offered extended appointment times when appropriate. GPs and nurses were informed immediately of any undue distress shown by patients so they could speak with the patient and provide an earlier appointment.

One of the practices GPs supported 35 patients in a local private hospital with all primary care service needs. This hospital specialises in the management and treatment of acute and complex mental health problems. The hospital held the GP in high regard and valued the close working relationship with the practice. Additionally the practice supported patients with poor mental health through referrals to a local 'Ways to wellbeing' service. The service offers up to nine free one-hour sessions in a safe place during which a supporter will talk about the patient's interests, find opportunities to suit them and help them to take part.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice regarding patient satisfaction. This included information from the national patient survey, a survey of just over 100 patients undertaken by the practice's patient participation group (PPG) in 2013/14 and patient satisfaction questionnaires sent out to patients by each of the practice's partners. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated highly by patients. The practice was also above average for its satisfaction scores on consultations with GPs and nurses with 87% of practice respondents saying the GP was good at listening to them and 80% saying the GP gave them enough time.

Patients completed CQC comment cards to tell us what they thought about the practice. We received five completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with 14 patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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 hygiene and infection control was maintained and patients' privacy and dignity was maintained during examinations, investigations and treatments. We observed consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. A system had been introduced to allow only one patient at a time to approach the reception desk. This helped prevent patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it generally enabled confidentiality to be maintained. The practice had measures planned to improve patient confidentiality in their newly designed building.

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

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Staff told us that referring to this had helped them diffuse potentially difficult situations.

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 73% of practice respondents said the GP involved them in care decisions and 78% felt the GP was good at explaining treatment and results.

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.

We saw the practice promoted patient involvement through the information it provided. It displayed the NHS 'Ask three questions' leaflet in the waiting area so that patients could ask simple questions which would prompt better involvement in their treatment. There was other similar information available about memory loss, dementia and drugs and alcohol.

Staff told us translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available. We saw the practice had a translation

service which visited the practice each Thursday and heard from staff how they tried to encourage patients needing this type of service to attend the practice that day. We heard from staff and patients how the practice allowed a family member to attend appointments with the patient to assist with communication. However the relationship and gender of the person attending was considered, particularly if the family member was male and a female patient required an intimate examination. The practice then arranged for additional link worker time to be made available.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with, particularly the older patients were positive about the emotional support provided by the practice and rated it well in this area. The comment cards we received were also consistent with this information. For example, they highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room told patients how to access a number of local 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. For example, a leaflet from NHS Bristol and the city council about access to a local carers support centre. This information could be provided in other languages if requested or required.

Staff told us that if families had experienced a bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and / or by giving them advice about how to find a support service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' 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 NHSE Area Team and Bristol Clinical Commissioning Group (CCG) told us the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. For example,

- Improve health awareness
- Prevent illness
- Help people manage their own care effectively
- Reduce hospital admissions
- Provide more community support to help people remain at home

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). These included the introduction of 15 minute appointments for those GPs found to have the longest waiting times, increase nurse resource to assist GP's in chronic disease management and to review the appointment structure. We saw these had been implemented and were under continuous review in preparation for the proposed move to new premises in 2015.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The practice had access to online and telephone translation services and a GP who spoke five languages. One of the GP partners told us up to 5% of their consultations were provided with the assistance of interpreters.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed they had completed the equality and diversity training in the last 12 months and that equality and diversity was regularly discussed at staff appraisals and team events.

The practice was actively involved in a pilot project. This pilot project is a local NHS service offering medicines advice to Bristol's south Asian population. The idea for the service arose from research and anecdotal evidence that cultural differences, and not just language difficulties, meant patients from a South Asian background could be disadvantaged in understanding their medicines and how it fits alongside diet and other areas of life). Initial results showed positive engagement from the Asian patients registered with the practice.

The premises and services had been designed to meet the needs of patients with disabilities. There was level access into the practice. Parking spaces for patients who were disabled were unavailable at the time of our inspection due to building works but patients with disabilities could be dropped off once let through a controlled entrance barrier. All GP and nurse consulting rooms were on the ground floor. The practice had wide corridors to enable access for patients with mobility scooters. This made movement around the practice easier and helped to maintain patients' independence.

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

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.

The practice could cater for other different languages through telephone and visiting translation services. However information leaflets on noticeboards were not provided in languages which reflected the needs of patients.

Access to the service

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice routinely saw patients from 8.45 am to 6:00 pm and had extended hours on Monday and Tuesday evenings until 7:00 pm; the later appointments were bookable in advance. The GPs told us they saw patients until the last patient had been seen, this was confirmed by patients with whom we spoke.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information about the out of hour's service was provided to patients.

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to local care homes on an as required basis, by a named GP or nurse, and to those patients who needed one. The practice nurse also visited patients at home if they were housebound to monitor blood sugar levels for patients with diabetes and to provide flu vaccinations to patients in learning disability homes.

Patients were generally satisfied with the appointments system, with 93% of patients completing the last GP survey said the last appointment they got was convenient. They confirmed that they could see a GP on the same day if they needed to and they could see another GP if there was a wait to see the GP of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system. Simple complaints leaflets were available in the practice and information was available on the practices website. Comments and suggestions were also encouraged through forms provided in the waiting areas. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at 12 complaints received in the last 12 months and found these were satisfactorily handled, and dealt with in a timely way. We saw staff had spoken with the patients involved, or had sent an apology or had invited them into the practice to discuss the events leading to the complaint. The complaints log had a 'learning points' section which was shared with staff to improve services. For example, developing consistency in advising patients about self-management of minor illnesses and ensuring clear communication with patients who arrived late for appointments. Minutes of team meetings showed complaints were discussed which ensured all staff were able to learn and contribute to determining any improvement action that might be required.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's strategy and business plan. These values were clearly displayed on the practices website. The practice vision and values included to,

- Deliver a consistent and high quality service through highly competent clinicians
- Deliver equality of service, access and treatment
- Provide continuity of care
- Engage and communicate effectively with patients and the local community recognising cultural differences and sensitivities
- Promote equal opportunities and develop our staff

We spoke with six members of staff about the values of the practice, they all told us they knew and understood the vision and values and what their responsibilities were in relation to these.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop of any computer within the practice. We looked at 12 of these policies and procedures and all staff had confirmed that they had read the policies as part of their induction. All 12 policies and procedures we looked at had been reviewed annually and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control with one of the partners having lead responsibility for safeguarding. All members of staff we spoke with were clear about their own roles and responsibilities. They all told us they felt valued team members, were well supported by the partners and GPs and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice nurse told us about a local peer review system they took part in with neighbouring GP practices. The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, about the reviewing and prescribing of medicines.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us the risk assessments which addressed a range of potential issues, such as health and safety, infection control and maintaining business continuity. We saw that risks were regularly discussed at business team meetings and updated in a timely way.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly, every six weeks. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. We also noted that team away days were held annually with a plan to return to biannually once the new premises were completed. Staff liaison group meetings are held every two months and include representatives of each staff team. The minutes of staff meetings we read showed an openness of communication between staff and the management team and how staff from all roles contributed to practice development. For example the identification of administrative staff that some codes used by GPs were inconsistent with the current patient record system.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example disciplinary procedures, induction policy and the recruitment policy which were in place to support staff. We were shown the online staff information that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

The practice was proactive in planning for future needs; they told us they had encountered difficulties in attracting GPs to the area. Their intention is to replace a part-time salaried GP who is leaving the practice in the spring of 2015 but the response to adverts so far has been poor. The practice has been flexible with regard to the type of

Are services well-led?

Good

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

partnership it offered but they were still having difficulties. Despite this, the existing partners had shown their commitment to inner city practice in this area by investment in new premises on adjacent land.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, comment/suggestion cards and complaints received. We looked at the results of the annual patient survey and 62% of patients agreed telephone access was easy. We saw as a result of this the practice had introduced improvements to the way appointments could be made. We reviewed a report about comments from patients between January and March 2014, which had a common theme of appointments sometimes running late. The practice manager showed us improvements that had been made to the appointment system which included two GPs offering 15 minute appointments as opposed to the standard 10 minute appointments.

The practice had a virtual patient participation group (PPG) which had maintained its membership of 21 members. The PPG included representatives from various population groups; including African, Asian and Caribbean. The PPG had carried out annual surveys and the practice manager showed us the analysis of the 2013/14 survey. The results and actions agreed from these surveys were available on the practice website at the time of our inspection.

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 around diabetes 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 via any computer within the practice.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five staff files and saw that regular appraisal took place which included a personal development plan. Staff told us the practice was very supportive of training and that they had staff meetings where guest speakers and trainers attended.

The practice was aware of and was taking action to deal with the personal difficulties that arise when working with complex patients. This could be due to the complexity of clinical matters or the variations in psychosocial beliefs and behaviours of different population groups. One of the GPs in the practice was being supported to establish a Balint group within the practice. (A Balint group is a method of providing clinical supervision for family GPs. The group and the method are named after Michael Balint, a psychoanalyst. The groups are designed to improve GPs performance and to prevent burnout and enable staff retention). The practice has recognised the value of this type of support in developing the clinical team in the practice.

The practice openly recognised good performance and devotion to work. For example, one of the salaried GPs spoke enthusiastically about the support she received from the partners and how they supported her in her work at the Priory hospital and in allowing her to attend courses which were relevant to her role. A nurse commented about being supported to complete a diploma in the management of diabetes and another member of staff told us how two receptionists were developed to become phlebotomists. One of the GPs had been supported to take an active teaching role at a local university. She teaches medical students about the care and treatment of patients migrating to this country.

There was clear leadership visible in the practice with the lead GP and the practice manager having regular contact with all the practice staff. The small size of the practice team meant visibility is easier to achieve. The team had a unified vision for the future of the practice with patient centred care at the centre of daily practice.