Thornbury Health Centre - Burney

Quality Report

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

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Overall summary

Thornbury Health Centre, which is also known as the Foubister practice is one of two GP practices based on the same site. The site adjoins a local community hospital and GPs from the practice were responsible for overseeing some of their inpatient beds. The building was purpose built and designed to be fully accessible to patients with disabilities. Services were provided by six permanent GPs, a regular locum GP and a team of nurses, which included a nurse prescriber and a nurse practitioner. A practice manager oversaw the day-to-day running of practice activities. The practice was supported by an active patient forum.

Our inspection took place on Thursday 7 August 2014 and involved two inspectors and two specialist advisors. During our inspection we spoke with the GPs and nurses employed at the practice, the practice manager, the assistant practice manager and three members of administrative and reception staff. We spoke with three patients and received comment cards from a further six patients. We also spoke with the chairperson of the patient forum. Prior to the inspection we met with the South Gloucestershire Clinical Commissioning Group (CCG), the local Healthwatch for South Gloucestershire and NHS England. We also contacted healthcare professionals (health visitors and community nurses) who work closely with the practice. All the views expressed by patients and other healthcare professionals about the practice were very positive with a collective view that patients were at the centre of the practice's service delivery.

We looked at how the practice met the needs of the six designated patient groups. These are: older patients, patients with long-term conditions, mothers, babies, children and young people, patients of working age and those recently retired, patients in vulnerable circumstances who may have poor access to primary care and patients experiencing a mental health problem.

We found the practice had specific provision for long-term health conditions such as clinics for patients living with diabetes, which met this need across the patient groups. We also found the practice had specific clinics for patient groups such as immunisation for meningococcal C meningitis (Men C) and septicaemia for younger adults to protect them against meningitis. The practice was aware of the needs of their practice population and had taken steps to improve or make the services more accessible for their patients. For example, the appointment system was changed in 2013 so patients were able to access same day appointments for urgent care.

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 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?

The practice had a range of systems in place to ensure the safety of patients who used their practice. This included safe patient care and appropriate use of equipment to support the patient both in the practice and when they required support at home. The environment was purpose built and effectively maintained. It was clean and tidy throughout with monitored cleaning schedules and infection control measures. All staff in the practice ensured vulnerable patients were cared for appropriately and where there were concerns about a patient's vulnerability, the relevant authorities were alerted. There were sufficient emergency medicines and equipment in place to ensure medical emergencies could be managed effectively. There was evidence that the practice worked with other health and social care professionals to safeguard their patients and improve patients' health and treatment outcomes.

Are services effective?

We found the practice was effective because it delivered care and treatment in accordance with recognised best practice, and worked with other care and support services to provide continuity of care for patients. The practice had systems and processes in place to ensure that standards of care were effectively monitored and maintained. Clinical audits had been completed, which had resulted in improvements to patient care and treatment. Patients were supported to manage their own health by well trained staff. Patients were satisfied with the treatment they received. The level of staffing at the practice enabled the effective delivery of quality care. The practice worked collaboratively with other health professionals to ensure good treatment outcomes for their patients.

Are services caring?

The practice was caring. The patients we spoke with were complimentary about the caring, compassionate attitude of staff. Patients were treated with dignity and respect and staff provided privacy during all consultations. Reception staff maintained patient confidentiality when registering or booking in patients. Patients felt well informed about their care and treatment.

Staff gave patients the information they required about their treatment to ensure they were able to make informed choices. All GPs and nurses were aware of and used the Gillick competency (tools used to decide whether a child (16 years or younger) is able to

Summary of findings

consent to his or her own medical treatment, without the need for parental permission or knowledge) when deciding whether a child was mature enough to make decisions for themselves. Services were provided by caring and involved staff.

Are services responsive to people's needs?

The practice was responsive to patients' needs. The practice understood the different needs of the population it served and acted on this information to plan services. The practice had established a patient forum to help understand patient needs. The practice had carried out patient surveys and had identified areas of practice improvement. Information available in the practice promoted good health and wellbeing. The GPs and nurses worked with patients to promote self-care and independence in a responsive way. This was maintained as reception staff routinely offered available appointments with the patients' preferred clinician. Patients told us that they found the phone appointment system for urgent care was excellent and they could always get a same day appointment. The practice had a clear complaints procedure and there had been very few complaints to or about the practice.

Are services well-led?

The practice was well-led. Staff felt they were well led and supported by the GPs, practice manager and each other. Patients also felt the practice was well led and there was a positive culture of patient care. The practice had a range of governance policies and protocols that covered all aspects of the services it provided. We saw these were routinely reviewed and updated to reflect current guidance. The practice was proactive in gaining patient feedback. A patient survey that was carried out by the practice in October 2013 showed high levels of patient satisfaction with the services provided. Risks were managed and monitored effectively and the practice learned from day-to-day occurrences and incidents or complaints to improve the practice. The practice had a well-established staff team. All staff were clear about the values and aims of the practice.

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 older patient population registered with the practice was higher than national England average, with 25% of registered patients were over 65 years old, equating to approximately 2,300 patients. Each patient over the age of 75 years old was allocated a specific GP as their point of contact.

The practice supported residential care homes and nursing homes by making visits to patients living in these types of homes.

The practice also provided medical cover for the adjoining Thornbury Hospital inpatient service and worked closely with the community services.

The practice offered vaccination services, diabetes services, and specialist clinics for patients with long-term conditions, extended opening hours and access to a GP of their choice and preferred gender.

People with long-term conditions

Patients with long term conditions, such as diabetes, asthma and chronic obstructive pulmonary disease (COPD) made up 41% of the practice. The nurse team had specialisms such as management of diabetes, that allowed the practice to monitor patients.

The practice had winter initiatives which involved self-monitoring by patients.

The practice operated a virtual ward for patients who were vulnerable due to medical conditions. This was held a weekly multidisciplinary meeting with other professionals, such as community nurses and health visitors, to ensure an integrated care approach to patients with complex healthcare needs.

Patients with long-term conditions could access vaccination and screening services, extended opening hours and could access a GP of their choice and preferred gender.

Mothers, babies, children and young people

The practice offered a range of services for mothers and babies. Health visitors were based in the practice during normal working hours. The practice nurses offered vaccination services for children and younger adults.

Summary of findings

GPs met regularly with midwives and health visitors to discuss any patients at risk or vulnerable families. The practice was equipped to welcome children and babies into the practice.

Children with special educational needs were identified by the practice and this highlighted any additional healthcare needs they may have, including any annual health check-ups.

This section has not been rated as we did not have enough information on which to make an informed judgement.

The working-age population and those recently retired

The practice had extended opening hours to support the working age population and those recently retired, and made it easier to access appointments by introducing an online booking service.

Patients accessed vaccination and screening services, such as health checks, through extended opening hours and could access a GP of their choice and preferred gender.

This section has not been rated as we did not have enough information on which to make an informed judgement.

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

The information provided about the practice from the clinical commissioning group showed it was based in a low deprivation area. There were also a low number of patients whose ethnicity was not white British, this was 1.8% of patients.

The practice had 47 patients registered with them who had been diagnosed with a learning disability. The practice liaised with the local learning disability nurse to ensure that where risks were identified they were communicated with appropriate professionals.

The practice area covered a community of travelling people the practice had no specific measures in place for patients in this population group but told us that they applied the same principles they used to provide safe effective care to all their patients.

This section has not been rated as we did not have enough information on which to make an informed judgement.

People experiencing poor mental health

The practice had a small number (less than 1%) of its patients who were experiencing a mental health problem. The practice worked closely with the local mental health crisis team. Where possible the practice tried to ensure the patient saw the same GP for continuity of care.

Summary of findings

There was also a facility in the same building as the practice for patients to receive counselling for drug and alcohol misuse and smoking cessation.

The practice worked in partnership with other professionals, as well as referring those patients who were experiencing a mental health problem promptly.

This section has not been rated as we did not have enough information on which to make an informed judgement.

Summary of findings

What people who use the service say

During the inspection we spoke with five patients who told us they were very satisfied with the service received. Patients described the practice as excellent and helpful and told us they would recommend the practice to other patients.

Six patients completed our comment cards and these showed a high level of satisfaction with all areas of the practice, including comments made about staff being respectful and considerate, GPs listening to patients and providing clear explanations of the problem. The practice had recently identified issues with the appointment system and several patients commented about the difficulty getting through on the telephone. Information about changes to the system was posted on the practice website for those who used it and on the surgery notice board for other patients.

The practice had a patient forum that consisted of approximately 18 members. The practice arranged regular meetings with these members to discuss any improvements that could be made to the practice. Patients who attended the forum said the practice listened to them and took their views into account when making decisions about the practice.

The practice completed an annual patient satisfaction survey. The last one had been completed for the year 2013/2014. This showed 79% of patients who responded rated the practice as good, very good or excellent. The survey showed the least satisfactory area of the services provided was the telephone access system, which was kept under review by the practice manager.

Areas for improvement

Outstanding practice

Our inspection team highlighted the following areas of good practice:

- The practice provided medical support for the local community hospital inpatient beds.
- Some staff at the practice had participated in specialist training which enabled them to be involved a variety of research projects through in the Research Ready programme, which ultimately benefitted patient care. For example, the nurse prescriber told us about a research project which had reviewed the effectiveness of prescribing of antibiotics to children whose presenting symptom was a cough. Patients were informed about the research programmes.

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Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector. In addition, the team included a GP specialist advisor, a pharmacist, and a practice manager.

Background to Thornbury Health Centre - Burney

The practice is located at Thornbury Health Centre, Eastland Road, in Thornbury, near Bristol, and supports around 9,300 patients in an approximate 5 mile radius of the town. The practice also provides medical care for the 24 inpatient beds at the local community hospital.

The patient population was predominantly white British or white other with 1.8% of patients from minority ethnic groups and 25% of patients were over 65 years old. The practice supports residential and nursing care homes. The patient forum was made up of a representative mix from the patient group.

The appointment booking service was open five days a week and offered patient appointments between 8am and 6.30pm Monday to Friday, with extended opening on Tuesday and Thursday evenings and Saturday mornings. There were daily urgent care clinics for patients who had an illness requiring same day medical care. Patients were booked into these clinics at 12.15pm and 4pm each day.

The practice operated as a partnership between the GPs who worked a total of 36 sessions across the week. The practice employed a nurse prescriber who held minor illness clinics on seven days each fortnight. The practice did not offer Out-of-Hours care, but provided telephone information to patients about Out-of-Hours and emergency appointments that would be provided by another agency. This information was also available in the practice brochure and on their website.

Why we carried out this inspection

We inspected this surgery 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:

Detailed findings

- 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 had received from the surgery and asked other organisations to share their information about the service.

We carried out an announced visit on 7 August 2014 between 8.00am - 5.00pm.

During our visit we spoke with a range of staff, including GPs, nurses, receptionist, practice manager, the assistant practice manager and administrative staff.

We also spoke with patients who used the service. We observed how people were being cared for and reviewed personal care or treatment records of patients.

Are services safe?

Our findings

The practice had a range of systems in place to ensure the safety of patients who used their practice. This included safe patient care and appropriate use of equipment to support the patient both in the practice and when they required support at home. The environment was purpose built and effectively maintained. It was clean and tidy throughout with monitored cleaning schedules and infection control measures. All staff in the practice ensured vulnerable patients were cared for appropriately and where there were concerns about a patient's vulnerability, the relevant authorities were alerted. There were sufficient emergency medicines and equipment in place to ensure medical emergencies could be managed effectively. There was evidence that the practice worked with other health and social care professionals to safeguard their patients and improve patients' health and treatment outcomes.

Safe patient care

Patients were able to request an appointment with the GP of their choice and this was arranged by the reception staff at the practice. This promoted continuity of care and respected patient choices. The duration of appointments varied based on patient needs; for example, the staff at the practice had a good awareness of the communication difficulties experienced by patients with learning disabilities and ensured that longer appointment times were allocated. Staff also understood that patients may be supported by a carer or a relative to act as an advocate for them, and this information was recorded on the patient record. Urgent care appointments were available each working day and the practice had extended working hours.

The practice used an electronic patient record system. Any significant medical concerns or additional support needs were added as alerts to patients' records. These appeared when a record was opened and alerted the clinician to anything significant relating to that patient and their care. Routine recall appointments alerts were entered into the system to ensure patient care and treatment was monitored and so that patients were reminded to have their medical conditions reviewed.

The GPs and nurses we spoke with told us about routine condition and medicines reviews. The GP and nurses routinely updated their knowledge and skills, for example by attending learning events provided by the South Gloucestershire Clinical Commissioning Group (CCG), completing online learning courses and reading journal articles. Learning also came from clinical audits, significant events analysis and complaints.

Learning from incidents

The practice had a system in place for reporting, recording and monitoring significant events. We read the records to review how the practice dealt with incidents that impacted on patient care. We read the significant event records and saw that there had been very few incidents relating to the practice. The practice had a system to put in place corrective action following any incidents and to share any learning with all staff to avoid repeated problems. For example, there had been an error with a referral for a diagnostic test. We saw the incident had been investigated to find out how the problem occurred. We were told by the practice manager how they had reviewed the incident and amended the procedures to reduce the risk of the incident recurring. The incident was raised at a staff meeting and then followed up further at a practice "away day".

The GP specialist advisor spoke with the GPs at the practice and found that they were aware of their responsibility to complete a significant event/incident form for investigation and action. We were told significant events were discussed as they arose as urgent action may be required. Staff confirmed information was shared and any remedial action agreed and implemented as a team.

The staff had regular meetings where they could review any themes and change processes if needed and there was an annual overview of significant events collated by the practice manager. This enabled the practice to review any themes and change processes if needed.

The GPs also told us how they dealt with drug safety alerts and how this impacted on their prescribing for patients. The practice had a summary of prescribing audits, which ensured the information and action indicated by drug safety alerts was implemented by the practice. The practice manager also received Medicines and Healthcare Products Regulatory Agency (MHRA) alerts and took appropriate action as needed.

Safeguarding

The practice had an effective system in place to identify and manage risks to patients. We saw appropriate policies in place and Department of Health and local authority

Are services safe?

guidance regarding supporting all vulnerable patient groups was being used. We saw telephone numbers of relevant agencies relating to safeguarding concerns were available in the practice.

We spoke with the four GPs on duty at the practice. They were asked about their training in relation to the safeguarding of vulnerable adults and children. We were told they were trained to level three in child protection with updates provided through the South Gloucestershire Clinical Commissioning Group (CCG). The GPs had also completed safeguarding training for vulnerable adults and domestic violence. All the staff we spoke with demonstrated a good understanding of the types of abuse that might occur, as well as the signs and symptoms of abuse. These staff told us they had completed safeguarding training and this was confirmed when we looked at their training records. The GPs and nurses were aware of the Gillick competence requirements and ensured children were accompanied by an adult if they needed to see a GP or nurse until such a time as they could demonstrate consent to their own treatment.

GPs met monthly with health visitors to enable regular discussion and information sharing about looked after, at risk children and any vulnerable families. The health visitors we spoke with confirmed that these arrangements worked well and that they could access the staff at the health centre easily to share information. The meetings were minuted and made available for all relevant staff to read. The practice had approximately 10 children with safeguarding issues and each had a nominated GP. The GPs confirmed they had been invited to attend case conferences but could not always attend however, they completed any documentation for the meetings and were provided with minutes and actions. They confirmed that they were sometimes required to attended serious case reviews for patients registered with the practice.

The practice provided medical cover for local nursing and residential care homes and the inpatient beds for the adjoining community hospital. The GPs confirmed they applied the same safeguarding principles to patients who lived in these settings as they were perceived to have a greater degree of vulnerability.

The practice had a chaperoning policy available to all patients, which gave patients the opportunity to see a GP or nurse accompanied by a skilled and knowledgeable chaperone. This policy also supported the safety of staff.

Monitoring safety and responding to risk

The practice was located in a purpose built environment which they shared with three other leasehold tenants. The health and safety of the building and external grounds was managed by another tenant. We saw the audits and maintenance plans for the practice and grounds. There was a process in place to ensure defects were reported and actioned in a timely way. The practice retained responsibility for the safety of their patients and employees, and had procedures in place that promoted safe working practice.

The specialist practice manager looked at how the practice planned the staff team to safely meet patient needs and found that audits identifying peak times for patient contact were used in staff planning. Staffing levels were set based on the number of patients registered with the practice and varied depending on demand throughout the week. The staffing rota was planned two weeks in advance and was supported when necessary by regular staff from an agency. This ensured there was sufficient cover for staff annual leave. All staff were flexible and able to cover shortfalls to ensure patient care.

We saw a range of information was available in the practice which provided details of organisations patients or staff could contact if physical health emergencies or mental health crises occurred, either during or outside of practice opening times. The reception staff showed us contact telephone numbers of relevant organisations they could contact and there was a detailed emergency incident procedure available. Staff told us how they recognised and responded to changing risks to patients and staff. Staff told us they had recently been trained in what to do in an urgent or emergency situation and about the practice's procedures in such circumstances.

We saw there was sufficient and up-to-date emergency equipment available for use by all trained and competent staff working in the practice. Designated staff members routinely checked this equipment. Emergency medicines were also available in the practice and were routinely audited to ensure all items were in date and fit for use.

Medicines management

Medicines were prescribed and given to patients appropriately. The pharmacist inspector with us during our inspection provided specialist knowledge of medicines management services within a GP practice. We saw there

was a policy and procedure for issuing repeat prescriptions which was dated 2012. We were told policies and procedures were under review and this policy would be reviewed.

The pharmacist inspector spoke with the administrative staff about the process for repeat prescriptions. All staff attended a "prescription medicines explained" course run by the Avon Local Medical Committee. Staff completed six weeks' basic training before starting to issue repeat prescriptions. A member of staff confirmed their training and explained that the GPs oversaw the process and were available to respond to any queries. For example, if there was a time lapse between repeat prescriptions then the patient was directed to a GP for advice or authorisation.

There were appropriate arrangements in place for obtaining medicines. The practice set a target of getting medicines to patients within 72 hours. This included 48 hours to write the prescription and 24 hours for the pharmacy to receive and process. The local care homes for which the practice was responsible submitted routine repeat prescriptions. These were overseen by one of the GPs who would be aware of any discrepancies and changes to medicines. We were told when patients were discharged from hospital the administrative staff read the discharge summary and made adjustments to medicine records, which were then authorised by the GP.

GPs and nurses were responsible for monitoring the effectiveness of diagnostic testing. An alert was placed on the computer system to ensure relevant tests had taken place and it was safe for the patient to continue taking medication.

We found the practice had a system in place to ensure prescription pads were kept securely and the serial numbers of those currently in use were recorded. Children and young adults and patients over 75 years old were prescribed one months' supply of medicines at a time. Other groups usually had two months' supply, with the exception of patients at risk who were given more frequent prescriptions to reduce the risk of overdose.

We saw the medicines were stored securely, in a position that was easily accessible by staff, and checked regularly. The medicines which were kept on the premises were stored in a locked cabinet. We saw a stock list that was checked to ensure medicines were replaced when necessary and there was a record of when medicines were used.

A medicine storage protocol was available for staff. The practice stored vaccines and other medicines requiring refrigeration in dedicated medicine refrigerators. The temperature of the medicine refrigerators was recorded twice daily. The keys to some medicine storage areas were not kept securely. This increased the risk of unauthorised access to these medicines. The nurses relocated the keys during the inspection.

Cleanliness and infection control

Patients were cared for in a clean, hygienic environment. A visual check of the practice showed that all areas appeared clean, tidy and free from items that could cause infection control risks. Clinical areas of the surgeries had designated clinical spaces with surfaces that could be wiped clean. Appropriate personal protective equipment such as examination gloves and plastic protective aprons were available in these areas and were stored appropriately. There were hand washing facilities and alcohol gels were available throughout the practice. Medical equipment used in patient examinations was mainly single use items that were then disposed of appropriately. Waste bins were foot operated and lined with the correct colour coded bin liners. Waste was stored in locked bins until it was regularly collected by the waste disposal contractor. Clinical sharp objects such as needles were disposed of in recognised sealed containers and disposed of in line with current guidance.

The senior practice nurse had a lead responsibility for ensuring effective infection control and had completed an audit. This had identified minor issues, all of which had a plan of remedial action. For example, the integrity of the surfaces of walls in the treatment rooms were beginning to become an issue and this had been raised with the building manager for action. Staff had received training to ensure effective hygiene practices were maintained. Appropriate signage was available throughout the practice that reminded staff and patients about good hygiene practices. Annual hygiene audits were undertaken in conjunction with the practice's infection control service. A daily record of all areas cleaned was maintained and routinely checked by the cleaning contractor.

Are services safe?

Patients were protected from the risk of infection because appropriate guidance had been followed. All cleaning materials and chemicals were securely stored and Control of Substances Hazardous to Health (COSHH) information was available to ensure their safe use. Surgeries were deep cleaned as required and at least annually. To ensure the practice was a safe and hygienic environment, the building manager told us about spot checks they undertook to ensure appropriate cleaning took place. This was confirmed by the staff we spoke with. Legionella testing was carried out and documented with an action plan in place to reduce the potential risks of infection.

Staffing and recruitment

The practice had relevant staffing and recruitment policies in place to ensure staff were recruited and supported appropriately. The practice manager specialist advisor discussed the procedures for staff recruited to the practice. We looked at the recruitment folder for a new member of reception staff. We found evidence that relevant checks had been made in relation to identification, registration and to ensure they were suitable people for the job role before staff were appointed. The practice obtained references and carried out a recruitment process which included interviewing. Criminal record checks were applied for via the Disclosure and Barring Service (DBS) and once received their reference numbers were recorded on the staff file.

We saw the current induction plan for a newly appointed member of the receptionist team. The plan showed they had completed training in many areas based on their role, such as telephone answering, patient care and safety, health and safety and fire procedures. All the staff we spoke with told us they felt well supported by the GPs and nursing team, as well as by the practice manager and each other. They told us they felt skilled and supported in fulfilling their role. We saw staff had training and development plans and yearly appraisals, which were built into training plans so that staff had opportunities to develop their skill base.

Dealing with Emergencies

The practice had arrangements in place to manage emergencies. All staff had recently completed basic life support training and were able to tell us the locations of all emergency medical equipment and how it should be used. The medical equipment appeared to be in good working order, had recently been checked and was appropriately accessible. Equipment was available in a range of sizes for adults and children. We were told there was always a first aider and first aid equipment available on site when the practice was open.

Emergency medicines were available in a secure area of the practice. All medicines were in date and fit for use and were checked by the senior practice nurse monthly. They held a list of the medicines expiry dates and had a procedure for replacing medicines at that time.

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

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

The practice had an alarm system within the computerised patient record system to summon help. We saw there was a business continuity plan in place to deal with any systems failures such as loss of electricity.

The building had a fire system and firefighting equipment, which was in accordance with the fire safety risk assessment which had been conducted in May 2014. Staff received fire training as part of their basic induction to the practice. We saw there was an annual fire safety evacuation of the building and fire wardens were available during the times the practice was open.

Equipment

The practice was suitably designed and adequately equipped. The fabric and fixtures and fittings of the building were maintained on behalf of the practice by one of the joint tenants. We saw equipment such as the weighing scales, blood pressure monitors and the

electrocardiogram (ECG) machine were routinely available, serviced and calibrated where required. There was an automated external defibrillator (AED) centrally located and all staff were trained in its use.

All portable electrical equipment was routinely portable appliance tested (PAT) and displayed current stickers indicating testing. Single use examination equipment was stored hygienically and was disposed of after use. Other equipment was wiped down and cleaned after use. When equipment became faulty or required replacement, it was referred to the practice manager who arranged for its replacement.

Equipment such as the computer based record system were password protected and backed up to prevent data loss. We asked staff how they monitored and maintained the equipment provided to patients for use at home. The nursing staff took responsibility for this equipment (home blood pressure monitoring and 24-hour blood pressure monitoring), and it was included in the routine maintenance and testing plan.

Are services effective?

(for example, treatment is effective)

Our findings

We found the practice was effective because it delivered care and treatment in accordance with recognised best practice, and worked with other care and support services to provide continuity of care for patients. The practice had systems and processes in place to ensure that standards of care were effectively monitored and maintained. Clinical audits had been completed, which had resulted in improvements to patient care and treatment. Patients were supported to manage their own health by well trained staff. Patients were satisfied with the treatment they received. The level of staffing at the practice enabled the effective delivery of quality care. The practice worked collaboratively with other health professionals to ensure good treatment outcomes for their patients.

Promoting best practice

Patients' care and treatment needs were assessed and delivered in line with current legislation, standards and guidance. The practice subscribed to a range of medical journals, publications and online resources for access to guidance on recognised evidence-based practice. Each GP ensured they developed their knowledge and skills through a continuing professional development (CPD) pathway. The GPs had their professional development checked during appraisal and revalidation, which took place every five years. The practice nurses completed a similar pathway and were supervised by the lead nurse.

The practice used a networked computer system for patient records, which could be accessed by staff according to their role and responsibilities.

Patients' needs were assessed and treatment prescribed in line with National Institute for Health and Care Excellence (NICE) and other guidance. Staff discussed any initiatives and guidance at their daily informal meeting and at formal lunchtime meetings. The practice had regular input from the South Gloucestershire Clinical Commissioning Group pharmacist who updated them on guidance relating to medicines and prescribing. For example, a recent meeting covered the topic of chronic kidney disease and raised blood pressure and at the next meeting would be a discussion relating to atrial fibrillation in diabetes.

The practice regularly received updates from the Medicines and Healthcare Products Regulatory Agency (MHRA) which enabled the practice to ensure effective treatment of patients. The practice also subscribed to the British National Formulary (BNF) which provided guidance and best practice about the safe use of medicines.

We reviewed insulin prescribing as this was indicated on the national Quality and Outcomes Framework statistics as being below the national average for GP practices in England. The senior partner of the practice explained the nurse prescriber working at the practice had expertise in managing patients with diabetes. Therefore patients were closely managed using the latest good practice guidance which indicated newer insulin combinations were used at a lower dose and therefore less was prescribed.

There were processes for making referral to specialist or investigative services. The GPs and practice manager confirmed to us urgent referrals were completed on the same day and others within a 48 hour window.

Management, monitoring and improving outcomes for people

The patients with long-term conditions we spoke to told us their conditions were well managed and routinely monitored and had found their health conditions had stabilised leading to improved health. We saw monitoring and management programmes for patients with long-term health conditions such as diabetes, anaemia and coronary heart disease, who had regular blood tests, which showed the effective and safe level of the medicine in their system.

The practice had a system in place for completing clinical audit cycles. Each GP completed a clinical audit for the practice. Two examples we were told of were a comparative view of prescribing of broad spectrum antibiotics by the GPs in the practice and the second an audit of referrals to accident and emergency.

The practice participates in the Quality and Outcomes Framework (QOF). Performance was reported on the NHS Choices website. The practice did not achieve as well as they expected in two areas, so in order to address this, a single partner was now taking responsibility for monitoring the QOF and any shortfalls were addressed.

Staffing

The staff we spoke with told us they all received an annual appraisal and attended regular staff meetings. The minutes of staff meetings confirmed this. Nursing staff received clinical supervision from the lead nurse and had a weekly meeting to discuss clinical issues and diagnosis. All staff

Are services effective?

(for example, treatment is effective)

told us they had access to training related to their roles. All staff had recently completed basic life support training. The practice had a detailed induction programme for new staff which included orientation within the practice such as learning the procedures specific to their role, reception skills and also basic training courses. We saw evidence of this in the files.

GP illness and planned absence was managed and the partners covered any shortfalls and the practice had a regular locum GP. The practice had staffing and recruitment policies in place to ensure staff were recruited and supported appropriately. There was evidence ongoing checks had been made in relation to professional registration and continuing professional development.

Staff told us they were alerted to concerns about faulty equipment from Medicines and Healthcare Products Regulatory Agency (MHRA) alerts by the practice manager.

All the staff we spoke with told us they felt well supported by the GPs and nursing team, as well as by the practice manager and each other. They told us they felt skilled and supported in fulfilling their role through a range of learning programmes. The patients we spoke with told us they felt staff were appropriately skilled and knowledgeable in whichever role they provided.

Working with other services

The practice had well established working arrangements with a range of other services such as the community nursing team, the local authority, local nursing and residential services, the hospital consultants and a range of local voluntary groups.

The patients we spoke with told us they had been referred quickly to specialists and consultants for further tests or treatment. They also told us how they were referred to voluntary groups for support at times, as well as community nursing services. Patients told us they had received test results promptly and had discussed with GPs and nurses their options for ongoing treatment and support.

We spoke with the community nurses and they confirmed to us there were effective working relationships with the practice. They told us referrals were provided in a prompt manner and when they contacted the GPs for further treatment this was responded to positively and promptly.

The records system used by the practice allowed for blood results and information from other healthcare providers to be recorded. For example, discharge letters were scanned onto the system and were available to the clinicians.

Health, promotion and prevention

The practice offered a range of health promotion and prevention to all patients. The promotion and prevention was provided as part of routine GP and nursing appointments and was supported by a range of information available within the practice and on the practice'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 diet, obesity, smoking, exercise, alcohol, preventing heart disease, cervical screening, and breast screening.

Information and treatment was also available for patients about mental wellbeing, dementia, managing stress, bereavement and psychological support via the practice website. The practice had a "smoking cessation" clinic which could be accessed through self-referral or by a member of the staff team.

The practice offered a variety of screening programmes for patients. New patients were offered screening through the new patient check system. Routine health checks were available for diabetes, hypertension and prostate problems and routine and opportunist screening was available for chlamydia, dementia and cervical cancers. The practice also offered health promotion advice and counselling for a variety of issues such as substance and alcohol misuse and contraception.

The practice had a weekly multidisciplinary primary care team for vulnerable patients where patient care was discussed. The practice reviewed and shared information and worked with community teams to promote good care practice and prevent hospital admission. The practice operated a shared care system with Out of Hours services for vulnerable patients, those who may be at the end their life or for those acutely unwell who may need out of hours support. They ensured care plans were updated and accessible to the out of hours team. This process promoted continuity of care for patients and reduced hospital admissions.

Are services caring?

Our findings

The practice was caring. The patients we spoke with were complimentary about the caring, compassionate attitude of staff. Patients were treated with dignity and respect and staff provided privacy during all consultations. Reception staff maintained patient confidentiality when registering or booking in patients. Patients felt well informed about their care and treatment.

Staff gave patients the information they required about their treatment to ensure they were able to make informed choices. All GPs and nurses were aware of and used the Gillick competency (tools used to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge) when deciding whether a child was mature enough to make decisions for themselves. Services were provided by caring and involved staff.

Respect, dignity, compassion and empathy

The patients we spoke with about the practice told us about the excellent levels of treatment they received and the respect, dignity, compassion and empathy they were shown by all members of the practice team. We were told that nursing staff offered support and reassurance to patients when they received unpleasant or painful treatment.

We saw that the reception staff treated all patients with dignity and respect when they arrived for appointments. Patients were greeted in their preferred manner and conditions were not discussed in a way that could undermine their privacy. The practice had a self-service booking-in system at reception however, receptionists checked that patients were able to use it successfully and were on hand to provide help. The reception area was separate from the waiting area, which further aided patient privacy.

When patients were called for appointments, the GP or nurse came out to collect the patient and welcomed them by name. Where patients had poor mobility they supported the patient in getting into the treatment room. All patients were seen in private, unless they chose to be accompanied by a partner, parent or chaperone. Practice doors were closed and clinical examination areas were screened to ensure patient privacy and dignity. All consultation rooms were separated from the waiting area and were lockable. We did not see any staff enter them unannounced during our inspection.

We were told that the practice had a whole practice approach to supporting patients following bereavement. One GP described how they worked with the community nurses team to arrange telephone contact and support visits to ensure patients had the support they needed. We were also told that the practice supported patients with complex health needs by offering regular follow-up and review appointments, and specialist nurse clinics for long-term health conditions. End of life care was closely monitored in partnership with the community nurses and responsive visits were made as needed.

Involvement in decisions and consent

We found patients at the practice were able to express their views and were involved in making decisions about their care and treatment. We observed how patients were involved in their care and treatment throughout their visit to the practice. New patients were asked to complete new patient information forms, which included details of their previous health conditions and the current medicines they took. We were told by staff and patients how a first appointment was usually a health assessment consultation and how patients gave signed consent for their care and treatment. The signed forms were kept on the patient records.

The specialist advisor asked the GPs how they ensured the patient was at the centre of their work, they said that GPs were flexible and approachable, and that a GP who was not involved in consultation appointments was on call at every point of the day. We were told that the GPs ensured patients were offered the choice of staying at home or being in hospital for treatment. In particular, they discussed the realistic expectations of what a hospital admission would provide. We were also given an example of patients being offered a choice of location and provider for elective care.

Patients told us that their GP consulted with them about the choices of treatment available to them and how that treatment could be provided. For example, the patient could have a treatment carried out in the practice by one of the GPs or, if they preferred, they could be referred to one of

Are services caring?

the local hospitals. One of the patients we spoke with told us they were offered the choice of treatment at one of two local centres. They told us they were given sufficient information to make an informed choice.

Patients were consulted with to ensure informed decisions and choices were made. All staff were aware of the Gillick competencies. These refer to decisions about whether a child is mature enough to make decisions for themselves and has 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. One patient confirmed their experience of always accompanying their child for consultation. They patient told us about consent forms they signed to agree to the treatment for their child and they confirmed they understood risks of the treatment and had the alternatives explained. We also were told that in addition verbal consent was sought from the child before any treatment took place.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

The practice was responsive to patients' needs. The practice understood the different needs of the population it served and acted on this information to plan services. The practice had established a patient forum to help understand patient needs. The practice had carried out patient surveys and had identified areas of practice improvement. Information available in the practice promoted good health and wellbeing. The GPs and nurses worked with patients to promote self-care and independence in a responsive way. This was maintained as reception staff routinely offered available appointments with the patients' preferred clinician. Patients told us that they found the phone appointment system for urgent care was excellent and they could always get a same day appointment. The practice had a clear complaints procedure and there had been very few complaints to or about the practice.

Responding to and meeting people's needs

The practice understood the different needs of the population it served and acted on these to design services. For example, appointments were offered into the early evening on week days to help working families. The practice had also reviewed patient demand and expanded their workforce to include a nurse practitioner for minor illness clinics and a nurse prescriber who took responsibility for long-term health conditions, such as diabetes.

The practice had a high number of older patients with multiple comorbidities (which are medical conditions presented simultaneously in a patient), and therefore had complex medical needs. To promote continuity of care for these patients, every patient over 75 years had a named GP. The practice was also in the process of completing the care plans for all patients over 75 years and were working additional sessions and in partnership with the community matron and the older person's community nurse who provided additional information to inform the plans.

We were told about the local processes for referring patients to specialist care such as use of the depression scoring system for assessing suicide risk and referral to mental health services. The GP specialist advisor found there was no specialist resource within the practice for children and younger adults however, the health visitors were located within the health centre and the local children and adolescents mental health services was accessible. The GPs were also aware of the specialist mental health services for maternal mental health, although midwifery services were not based at the health centre.

Two GPs at the practice were able to run family-planning clinics and had specialist training for insertion of intrauterine contraceptive devices and provision of emergency contraception.

The practice adhered to and purchased equipment according to National Institute for Health and Care Excellence (NICE) guidance. For example, they had purchased a 24-hour blood pressure monitor. The practice also offered health screening programmes and was involved in the Child Health Surveillance programme.

GPs had undertaken training in the Mental Capacity Act 2005 and had completed further research and reading relevant to safeguarding issues. They recognised the need to work closely with the community learning disability team and community mental health teams to ensure patients were given the opportunity to make informed consent, or when competence to make informed consent was impaired, then decisions made in the best interests of the patient. We were told Do Not Attempt Resuscitation statements completed for patients at end of life care were reviewed if circumstances change or at the request of the patient or their representative.

We were told by the practice manager that the practice had a large number of patients of Eastern European origin registered with them but who generally spoke English well and had no language requirements or specialist cultural issues regarding the practice.

Some staff at the practice were involved in specialist training to be involved in a variety of research projects through the Research Ready programme, which ultimately benefitted patient care. For example, the nurse prescriber told us about a research project which had reviewed the effectiveness of prescribing of antibiotics to children whose presenting symptom was a cough. Patients were informed about the research programmes.

The practice established a patient forum in February 2014 to obtain feedback and inform the practice about patient expectations. The practice had worked with this group when carrying out patient surveys and had jointly identified areas of practice improvement. We met with the chairperson of the patient forum to discuss how the forum

Are services responsive to people's needs?

(for example, to feedback?)

influenced the day-to-day running of the practice. The group had identified an issue with accessing appointments by telephone, and some older patients had raised concerns about not being able to have an appointment with their GP of choice within a reasonable time. Patients completed suggestion forms and returned them to the practice manager for action via the forum. The practice met regularly with the forum and the chairperson met with the practice manager monthly. The forum told us that they felt the practice was responsive to patient suggestion and provided effective and responsive patient care. Information about the forum was available in the practice and on their website.

The patients we spoke with told us services were planned in a way that promoted person-centred and coordinated care, including for patients with complex or multiple needs. Patients told us referrals for diagnostic tests or specialist health care were timely and that their own GP followed up on these appointments and implemented prescribed treatment. Referrals were monitored against the South Gloucestershire Clinical Commissioning Group (CCG) average. Patients were asked about their preferences and specifically whether there were any cultural or religious beliefs that would affect some procedures, for example gynaecological procedures or the gender of the consultant. We were told that it was practice policy to make contact with every patient who had been discharged from hospital. This ensured patients had sufficient support for their recovery and to highlight any significant changes in care or treatment that may require input from the practice or linked services such as the community nurse service.

Information available in the practice promoted good health and wellbeing and the teams worked with patients to promote self-care and independence. Follow up telephone calls were made to patients with long-term conditions to ensure they were following clinical guidance and to remind them to attend their appointments.

The practice had suitable facilities to meet patients' needs. All of the consulting rooms were on the ground floor as there was no lift access to the first floor. The practice ensured the environment and facilities were appropriate and that the required levels of equipment were available in all consulting and treatment rooms. An ongoing maintenance programme was in place. There was information at the reception desk for staff to use should they need to access an interpreter for a patient whose first language was not English. We also saw information for patients about accessing interpreters. The practice advertised information on notice boards about chaperones being available for patients.

Access to the service

Patients who used the practice told us they were able to contact the practice to make an appointment. Appointments could be made by telephone, in person or by using the practice's online appointment booking system. Patients were offered a choice of GP and the practice ensured GPs and nurses of both genders were available.

Opening hours were clearly stated on the entrance to the practice, in the practices brochure and their personal and NHS Choice website and had been amended to be flexible and meet the needs of the practice's population. The appointments system was monitored to check both how it worked and where non-attendance occurred. Patients were able to be assessed by a GP, including urgent appointments if needed or telephone consultations and home visits for patients that would benefit from them. A range of appointment slots were available, from short telephone conversation consultations to 10minute single and 20minute double appointments. Longer appointments were also available when minor surgery was being provided.

There were two urgent care clinics in the practice on working days and these appointments were for acute medical problems and not for review of chronic illnesses. Appointments were prioritised by asking patients why they wished to see a GP. For example, staff who took telephone calls or worked on reception were trained to understand the symptoms of a stroke or chest pain and could therefore identify when more urgent care may be needed. This was part of the basic life support training provided every year for all staff.

We spoke with staff from the reception team who told us the practice was very busy, and challenging but enjoyable. They confirmed that an audit of telephone calls had been undertaken in January 2014 and, as a result, more staff were available at peak times to answer calls. Staff booked patients with their choice of GP wherever possible, however on occasions this could not be accommodated. There was a system in place to enable requests for same-day

Are services responsive to people's needs?

(for example, to feedback?)

appointments to be met. We spoke with three patients who had phoned up the morning of our inspection and were offered appointments to see a GP the same day. They were all satisfied with this situation.

The practice had a small group of travellers who lived locally and attended the practice for health care. We were told they accessed the primary and secondary care in the same way as any other patient. Where the practice had experienced issues because of literacy for some patients, for example, if an appointment letter was sent then the appointment may not be kept. However, where this was noted, the practice used other forms of communication or identified an advocate or intermediary to share information with. The practice also had links to the local authority lead officer for the travelling community.

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 and there was a designated responsible person who handled all complaints in the practice. The specialist practice manager reviewed two complaints and found they had been recorded and responded to in a timely manner. The complaints were investigated appropriately and the partners had discussed the complaint and formulated a response. The practice explained in writing in an open and honest way what had happened as a result of the issues being raised. The management team at the practice told us they learnt from complaints and made changes to prevent any reoccurrence.

Patients told us they knew how to raise concerns or make a complaint about the practice. The practice's complaints procedure was promoted on the patient noticeboard and on their website. Where patients were unsure of the policy, they told us they felt that if they complained to the GP or receptionist their complaint would be listened to and acted on.

All the patients we spoke with told us they had no concerns about the practice.

Are services well-led?

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

Our findings

The practice was well-led. Staff felt they were well led and supported by the GPs, practice manager and each other. Patients also felt the practice was well led and there was a positive culture of patient care. The practice had a range of governance policies and protocols that covered all aspects of the services it provided. We saw these were routinely reviewed and updated to reflect current guidance. The practice was proactive in gaining patient feedback. A patient survey that was carried out by the practice in October 2013 showed high levels of patient satisfaction with the services provided. Risks were managed and monitored effectively and the practice learned from day-to-day occurrences and incidents or complaints to improve the practice. The practice had a well-established staff team. All staff were clear about the values and aims of the practice.

Leadership and culture

The practice had a clear structure of leadership and accountability. The three members of administrative staff we spoke with all told us there was good communication within the practice, with feedback accepted by the partners and the practice manager. Staff confirmed the senior partner and the practice manager were very approachable and actioned any issues that had been raised with them. We were told by the GPs there was good communication between the team and the staff had an informal meeting each morning where any issues or concerns could be raised. The health visitors and community nurses confirmed to us they were aware of this meeting and they could attend if necessary. The practice supported new GPs by informal mentoring by a colleague who provided support and feedback when needed.

The practice manager took lead responsibility for the day-to-day management of the practice and acted as a link between the GPs, staff and patients. The lead practice nurse had responsibility for the nursing team. All the staff we spoke with felt they were well led and supported by the GPs, practice manager and each other, and this made them more confident about proposing new ways of working. For example, the nurses we spoke with told us about the initiatives they had implemented for patients with long-term chronic obstructive pulmonary disease, which had resulted in fewer attendances at the practice and a reduction in hospital admissions for patients.

The practice manager showed us the vision and objectives of the practice. Staff were able to tell us about the values and philosophy of the practice, which included key concepts such as compassion, dignity and respect, equality. This placed the patient at the centre of their own decision making. The priority of the staff was to maintain a good standard of care to patients and to continue to develop additional services to support patient health. We found that staff were encouraged to develop additional clinical skills and roles. For example, one GP took the lead on a project with Thornbury Hospital and attended the hospital for a weekly ward round and review of patients' treatment. We were told involvement in this project promoted continuity of care for patients, and ensured an inpatient resource remained in the local community. This brought additional finance to the practice, which was used to fund other development such as training and employing a nurse practitioner.

The practice did not have a business plan but had monthly minuted practice meetings where developments and new guidance were discussed. We found that responsibility and accountability was very clear among the partners of the practice. One GP had taken part in an initiative called "progressive general practice" which was about the inclusiveness of staff in the process of change in general practice for example reviewing repeat prescribing and telephone triage.

The GPs in the practice told us they operated an informal monitoring and mentoring system through their daily meetings. This allowed a safe forum to challenge diagnoses and treatment however processes were in place to address issues if something was seen to be incorrect. The senior partner shared responsibilities with the other GPs and the partnership was democratic, with all partners having equal influence. The GPs told us they felt complaints were dealt with following the agreed protocols and they tried to work with the patient and be honest when things went wrong so both patient and practice could learn together. One GP took a lead on complaints and followed up patients to ensure they were satisfied with the outcome of their complaint.

Governance arrangements

We saw the practice had a range of governance policies and protocols which covered all aspects of the services it provided and these were routinely reviewed and updated to reflect current guidance.

Are services well-led?

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

The GP specialist reviewed the arrangements for clinical governance with the doctors. They found that governance was seen as a universal responsibility and there was an expectation staff would share the responsibility for difficult situations through discussion with others. To facilitate this, the GPs had an informal meeting each morning. The practice had a GP who lead in dementia and who also had responsibility for the nursing homes that used the practice. The practice used the mini cognitive dementia screening tool opportunistically or where higher risk was observed or indicated by other comorbidity (presented with more than one medical condition). If results of this test indicated a need, a further detailed assessment to identify dementia was used. Staff were aware of the local initiative to increase diagnosis of dementia and that local specialists and a memory nurse (a nurse who specialised in dementia) were available, however, they were also aware that there was a delay of several months before patients were seen by specialists so during this period the practice ensured diagnostic tests were arranged.

The staff we spoke with were clear about what decisions they were required to make, knew what they were responsible for and fulfilled their role. For example, one nurse took responsibility for checking emergency medicine expiry dates and we saw this check was carried out.

The practice defined clear lines of responsibility for making specific decisions about the provision, safety and adequacy of care at practice level. The practice nurses we spoke with told us that they always referred patients back to the GPs where medical conditions changed and collectively agreed the best course of action to involve and support the patient.

The practice ensured any risks to the delivery of high-quality care were identified and mitigated before they became issues that would adversely impact on patients. The practice actively sought information in order to improve. We saw the practice routinely gathered feedback from patients via suggestions and questionnaires and used this information to improve. We were told by the practice manager that they used audits to inform their own governance reporting and practice improvement action plans. The practice's website was well maintained and informative, and provided current and potential patients with information about the practice and improvements.

The GPs we spoke with told us they continually reviewed their patient lists, and individual patient records were reviewed at each appointment. GPs supervised and appraised the nursing team and patient care formed part of these reviews. We observed how the reception staff greeted patients which ensured they received appropriate support on their arrival at the practice. All staff were made aware they had a responsibility to ensure patient safety was maintained and where concerns were observed in relation to vulnerable patients, these were reported to relevant organisations, including the local authority.

Systems to monitor and improve quality and improvement

The practice was proactive in gaining patient feedback. A Client Focussed Evaluation Programme for Improving Practice (CFEP) was carried out in October 2013. The survey showed high levels of patient satisfaction with the practice. The survey had been made available to all patients on the practice's website alongside the actions agreed as a consequence of the feedback.

Patient experience and involvement

Patients spoke highly of the practice and about how they were involved in their care and treatment. Patients told us they were offered choice and were given information about their preferred course of treatment or support. The practice had established a patient forum which was used to inform the improvement and development of the practice. The patients we spoke with reported excellent care and treatment from all staff.

Staff engagement and involvement

We spoke with a range of staff including four GPs, three practice nurses, the practice manager, the assistant practice manager and the nurse prescriber, reception staff and the administrative team. All the staff we spoke with told us they felt involved in the day to day running of the practice, as well as the longer term functions of the practice. We saw records which showed staff were involved in staff meetings and discussed a range of practice issues. The minutes from these meetings showed staff were involved in the planning and changes in practice delivery.

Some of the receptionist team had multiple roles in the practice, for example assisting with phlebotomy. Staff in these roles told us this enabled them to be more involved with patient care and could pass on observations to the teams.

Are services well-led?

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

Learning and improvement

The practice routinely considered improvements to their services and used feedback from the patient forum. There were effective measures in place to learn from any incidents that occurred within the practice. We saw that this learning was passed on at staff meetings.

Where complaints were received about staff or other aspects of the practice, the practice manager spoke with those involved and offered them support to improve their performance. Performance was also discussed and reviewed at annual staff reviews.

Staff training included mandatory subjects such as basic life support, fire training and safeguarding children and vulnerable adults. Staff told us they felt supported by the practice manager and the partners in the practice, and that the team were approachable and responded well to any queries raised by administrative staff. We were told there were sufficient staff on duty at all times to meet the demands of the patient group. We were told that the practice manager and the senior partner led the management team well.

Identification and management of risk

The practice managed risk through policies and operating procedures. We read in staff training records that these policies formed part of the induction programme for newly recruited staff. The staff we spoke with demonstrated a good knowledge of these policies. The practice manager told us that any changes to policies and procedures were communicated to staff both informally and at staff meetings to ensure they were implemented as soon as possible. The practice manager told us they monitored adherence to these policies.

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 was accessible for wheelchair users and had hearing loop facilities for the hard of hearing and patients with disabilities.

The practice maintained a list of patients who were also carers and ensured this was considered when patients attended for appointments.

The practice worked closely with the community services who had a nominated nurse for older patients, and the mental health team memory nurse for older patients with dementia.

The practice offered vaccination services, diabetes services, specialist clinics for patients with long term conditions, extended opening hours and patients could access a GP of their choice and preferred gender.

The practice supported residential care homes and nursing homes by making visits to patients living in these types of homes. This was overseen by a nominated GP which gave patients a continuity of care.

The practice also provided medical cover for the adjoining Thornbury Hospital inpatient service, which could be accessed for local patients and provided a continuity of care.

The older patient population at the practice was higher than the national England average.

Each patient over the age of 75 years old was allocated a specific GP as their point of contact. This GP took overall responsibility for meeting the patients' needs with an agreed plan of care. Patients were allocated to GPs based on who they had seen the most to ensure consistency of care.

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

They held a weekly multidisciplinary meeting with other professionals, such as community nurses and health visitors, to discuss patients who were vulnerable due to medical conditions. The purpose of the meeting was to ensure there was an integrated care approach to patients with complex healthcare needs so they received the best care possible. The meetings also highlighted patients who were likely to be admitted to hospital in the near future and how to reduce this possibility, such as increasing the community support for the patient and informing the out of hours service.

Nurses and GPs advised patients, and provided them with information, on the management of their long-term condition and signposted them to relevant support organisations.

Patients with long term conditions, such as diabetes, asthma and chronic obstructive pulmonary disease (COPD) made up 41% of the practice list. The nurse team had specialisms that allowed the practice to monitor patients throughout the year, with each patient having an individual care plan. The plan took into account how the patient took responsibility for their own care. The nursing staff coordinated annual check-ups and followed up any missed appointments with individual patients.

The practice had winter initiatives, which involved patients who were aware of the triggers for poor health self-monitoring and being provided with 'just in case' medicines for use. This had impacted on the number of admissions to hospital for these patients.

Patients with long term conditions also accessed vaccination and screening services, extended opening hours and could access a GP of their choice and preferred gender.

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

GPs met regularly with midwives and health visitors to discuss any patients at risk or vulnerable families. There were established communication pathways between the healthcare professionals, to assess and reduce risks for mothers and babies.

The practice was equipped to welcome children and babies into the practice. We saw there was space in the waiting area for pushchairs and prams.

Children with special educational needs were identified by the practice and this highlighted any additional healthcare needs they had and included annual health checks.

Patients could access family planning and sexual health services through the practice.

The practice offered a range of services for mothers and babies. This included a baby clinics and giving advice to expectant mothers throughout their pregnancy. Health visitors were based in the practice during normal working hours. Health visitors provided advice and checks for mothers and babies after the baby was born.

The practice offered vaccination services for children and younger adults. We saw that training for immunisations and vaccines was completed annually.

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

The practice had extended its opening hours on Monday to Friday and opened Saturdays mornings when a GP was always available. There was capacity within the appointment system for all patients to be seen the same day at the urgent care clinics if necessary. Pre-bookable appointments were also available for patients who found it difficult to visit the practice at short notice due to work commitments. The practice had made it easier for patients to book appointments by introducing an online appointment booking.

Patients could access family planning and sexual health services through the practice.

Lifestyle advice and information was available to patients in all the population groups.

Patients could access vaccination and screening services, such as health checks, through extended opening hours and could access a GP of their choice and preferred gender.

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

Information provided about the practice showed it was based in a low deprivation area. There were also a low number of patients whose ethnicity was not white British (1.8% of patients).

The practice had 47 patients registered with them who had been diagnosed with a learning disability. The practice had patients registered from local learning disability care homes and supported living homes. Patients with a learning disability were asked to attend an annual health check in line with national guidance. 63% of patients had received an annual health check in the last year. The practice nurses encouraged attendance for these checks by sending reminders and contacting the patient by telephone. The practice liaised with the local learning disability nurse to ensure that where risks were identified they were communicated with appropriate professionals.

The practice area covered a community of travelling people. The practice had no special measures in place for patients in this population group but told us that they applied the same principles they used to provide safe and effective care to all their patients.

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

The practice had a small number (less than 1%) of its patients who were experiencing a mental health problem, 77% of whom had attended the practice for an annual health check-up. This reviewed health checks such as, blood pressure, alcohol intake monitoring, cervical smear checks and a medicines review.

The practice worked closely with the local mental health crisis team. The practice also attended multidisciplinary meetings to discuss particular patients at risk. Where possible the practice tried to ensure the patient saw the same GP for continuity of care.

Where the practice was based, there was also a facility in the building for patients to receive counselling for drug and alcohol misuse and smoking cessation.

We were told by the GPs about the partnership working arrangements with other professionals, for example, direct referral processes for patients experiencing a mental health problem.