The Old School Surgery

Quality Report

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Date of inspection visit: 17 December 2014
Date of publication: 28/05/2015

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Old School Surgery on 17 December 2014. Overall the practice is rated as Good.

Specifically, we found the practice to be outstanding for providing effective services. The practice was good at providing caring, safe, responsive and well-led services including services for the working and student population, families and young patients, older patients, patients experiencing poor mental health and patients whose circumstances make them vulnerable.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The practice has a good working relationship with the attached pharmacy with the same aim to provide good quality patient care.

Summary of findings

- The practice had a proactive approach to understand the needs of the large student population registered with them including attending key student days and working with student forums to promote the service the practice could provide to them.

We saw several areas of outstanding practice including:

- The practice was the first to employ a full time clinical pharmacist in the area. They have developed this role to help support with patient medicine reviews and the management of long term conditions. This had assisted the practice in reducing unnecessary patient medicines alongside reducing the prescription cost per year.
- Dementia awareness and training of staff has proved successful due to increased patient diagnosis, recognising signs of dementia and better support and information for patients and their relatives.
- Young patients under the age of 25 years old were able to access the practice for confidential sexual health and relationship advice. The practice told us and the '4 young people' Bristol website, provided confirmation they had been accredited with the 'young people friendly' and 'you're welcome' award. This meant they were a welcoming place for young people to attend to gain information about their sexual health or relationships, aware of young people's health issues in the area, ability to work with other services and had the appropriate training and facilities for young people to use.

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

Importantly the provider should;

- Ensure all staff were risk assessed to determine their level of involvement with patients and whether they require a criminal background check alongside other recruitment checks to prevent unsafe patient care.

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. Risks to patients were assessed and well managed. There were good systems in place to monitor staffing levels, dealing with medical emergencies and anticipated events.

Are services effective?

Outstanding

The practice is rated as outstanding for providing effective services. Our findings at inspection showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence guidelines and other locally agreed guidelines. We saw evidence to confirm these guidelines were positively influencing and improving practice and outcomes for patients. The Quality and Outcomes framework showed that the practice was performing highly when compared to neighbouring practices in the CCG. The practice was using innovative and proactive methods to improve patient outcomes and it linked with other local providers to share best practice. The practice had worked alongside the attached pharmacy to achieve the national Pharmacy Business Optimisation Award. This had demonstrated excellence in community pharmacy and enhanced patient care in line with medicines prescribed.

The practice is an accredited research practice and currently had projects running for researching alternatives to adult female urinary tract infections, alternative ways to stop smoking, additional medicines used in resistant depression, choice of moisturiser in eczema treatment and the use of aspirin to reduce bleeding in over 60 year olds.

One of the GP partners was the National Champion for Autism with the aim to improve access for patients throughout the UK and in their own practice. We were told patients had registered from other practices due to the quality of service provided and the accessibly at the practice.

One of the salaried GPs was a committee member on the guideline development group for the National Institute of Health and Care Excellence guidance. They are involved in the working group for Sepsis in primary care and for sports medicine. This has benefitted

Summary of findings

patients through the GPs ability to update other colleagues with the latest findings and sharing best practice to enable more awareness of early diagnosis and early management of Sepsis. Also specialist sports medicine clinics are held for patients three times a year.

Are services caring?

Good

The practice is rated as good for providing caring services. National GP patient survey data showed patients rated the practice higher than others for the majority of aspects of care. Feedback from patients about their care and treatment was consistent and strongly positive. We observed a patient-centred culture. Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. We found many positive examples to demonstrate how patient's choices and preferences were valued and acted on. For example, braille was used in patient areas to improve accessibility for patients.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice reviewed the needs of its local population and engaged with the NHS England local area team and Bristol Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The practice acted on suggestions for improvements and changed the way it delivered services in response to feedback from the patient participation group (PPG). The practice and PPG had recently run a successful open day at the practice for patients to attend and learn about what services the practice and local area provided.

Patients told us it was generally easy to get an appointment with a GP. They did not always get an appointment with a GP of choice within a short timescale. However urgent appointments were available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. They had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held

Summary of findings

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 patient participation group (PPG) was active.	

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Good

The practice is rated as good for the care of older people. The Quality and Outcomes Framework showed outcomes for patients were good for conditions commonly found in older patients. The practice offered proactive, personalised care to meet the needs of the older patients in its population and had a range of enhanced services, for example, in dementia and end of life care. They were responsive to the needs of older patients, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of patients with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours. The premises were suitable for children and babies.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age patients (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

Summary of findings

The practice had a larger than national average 15 to 24 year old range and the majority of this age group registered were students at the local university. Approximately 45% of the student population registered were from minority ethnic backgrounds. The practice worked closely with the university to increase student knowledge of the services available of the service provided. For example, they held student forums and promoted service through key student days, such as 'freshers' week. This also provided an opportunity to inform students of where and which health services to use in the area for particular illnesses or problems. They also worked with the universities international faculty to inform overseas students of the NHS and what it could be used for.

The practice was accredited with a '4 young people' award for young people under the age of 25 years to attend the practice for sexual health matters and relationship advice.

The practice's performance for cervical smear uptake was 71.6%, which was lower than others in the CCG area and England average.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. They carried out annual health checks for patients with a diagnosed learning disability and 100% of these patients had received a follow-up from April 2013 to March 2014. The practice offered longer appointments for patients diagnosed with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patients. The practice had a dedicated community nurse to lead on hospital admissions avoidance for patients who were most at risk and worked closely with local community nursing teams to enable a joined-up approach.

Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

The practice had increased its accessibility to assist and support blind patients with braille writing on the toilet doors.

Summary of findings

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of patient's experiencing poor mental health (including patients with dementia). From April 2014 to December 2014 73% of people experiencing poor mental health had received an annual physical health check. National data showed us the practice an average of 90% completion rate for physical health checks being completed, which was higher than national average. The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups either locally or within the practice and referred to voluntary organisations. There was a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.

The practice provided facilities for a local drugs project to hold weekly sessions at the practice for its patients. The drugs project provided us with feedback pre-inspection and described a good working relationship with the practice. One of the GPs had specialist training in this field and staff at the drugs project found this invaluable to enable them to provide a supportive and approachable joined-up service.

The practice had an enhanced service for patients with a diagnosis of a dementia and also had a dementia identification scheme. They had improved their services for patients with a dementia on a number of levels. The practice had allocated a lead GP as a dementia champion they had completed dementia awareness training which had then been disseminated to all GPs. One of the nurses had also completed dementia training that had also been organised by the Clinical Commissioning Group (CCG). They had disseminated this to their peers in a team meeting. We were told before their additional training they had 60 patients diagnosed with a dementia and now they have 93 registered. This had proved that increasing staff knowledge had helped to assist in recognising signs and diagnosing patients leading to better information and treatment provided to newly diagnosed patients and their relatives. All newly diagnosed patients were provided with an information pack on dementia.

Summary of findings

What people who use the service say

During our inspection we met with the practice patient participation group (PPG) which was formed in 2012. We met with four of the eight PPG members. They told us the practice was committed to improving patient care and included the PPG in the decision making process when changes were planned. The four PPG members spoke very highly of the service provided and positive impact on the practice following suggestions made.

We received 22 comment cards. All patients who had commented were highly satisfied with the service received. We received one negative comment regarding how long the patient had to wait in the practice for their appointment.

During our inspection we spoke with six patients who were very complimentary about the practice. Four out of six patients commented that they could not always see the same GP without having to wait up to ten days. However, they did understand that it was not always possible to see the same GP and reasons for this but would like this area to be improved.

Prior to our inspection we reviewed other information sources of what patients experienced with the service provided. This included NHS Choices (a forum for patients to publicly provide their views about the practice and where the practice can respond to these views). We saw there had been no patient comments made about the practice in the last year.

We reviewed the national GP patient survey taken from patients for the periods of January to March and July to September 2014. This is a national survey sent to patients by an independent company on behalf of NHS England. We saw 112 patients had completed the surveys from the 448 sent. We saw 91% of patients surveyed said their overall experience of the practice was good with 98% of patients saying they trusted and had the confidence in the last GP they spoke with. We saw where patients were less satisfied were 30% of patients waited over 15 minutes for their appointment and 29% said they did not find it easy to get through on the phone.

Areas for improvement

Action the service SHOULD take to improve

Ensure all staff were risk assessed to determine their level of involvement with patients and whether they require a criminal background check alongside other recruitment checks to prevent unsafe patient care.

Outstanding practice

- The practice was the first to employ a full time clinical pharmacist in the area. They have developed this role to help support with patient medicine reviews and the management of long term conditions. This had assisted the practice in reducing unnecessary patient medicines alongside reducing the prescription cost per year.
- Dementia awareness and training of staff has proved successful due to increased patient diagnosis, recognising signs of dementia and better support and information for patients and their relatives.
- Young patients under the age of 25 years old were able to access the practice for confidential sexual health and relationship advice. The practice told us and the '4 young people' Bristol website, provided confirmation they had been accredited with the 'young people friendly' and 'you're welcome' award. This meant they were a welcoming place for young people to attend to gain information about their sexual health or

relationships, aware of young people's health issues in the area, ability to work with other services and had the appropriate training and facilities for young people to use.

The Old School Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to The Old School Surgery

We inspected the location of The Old School Surgery, Manor Road, Fishponds, Bristol, BS16 2JD, where all registered regulated activities were carried out.

The practice serves approximately 16,100 patients and sees patients who live in Stapleton, Clay Hill, Downend and Fishponds in the inner city east area of Bristol. The practice is based in an area that accommodates students for the University of the West of England. This means the practice has a higher than average age population of 15 to 24 year old patients. Practice register figures suggest approximately 7000 patients are students from the University and from the 7000 students approximately 45% were from a minority ethnic background.

The national general practice profile shows the practice has a significantly higher population of patients aged between the ages of 20 and 24 years old at 24% higher than the England average. They are also above the national and local average for 15 to 19 year olds. The majority of this age group were students at the local university. The practice is significantly under the national and CCG average for patients 0 to 14 years old and from 35 to 54 years old. The practice is just above average for deprivation in this practice catchment area.

Additional services are provided from the practice premises including Age Concern, first steps eating disorders, dietician service, retinopathy eye screening, next link (for domestic violence and housing advice), Bristol drugs project counsellor visits the practice on a regular basis to provide services to practice patients and others in the community. The practice provides specialist services such as your welcome and 4YP (for young people) a scheme set up by Bristol Clinical Commissioning Group for young people under the age of 25 years old to provide advise on sexual health matters.

There were six GP partners and six salaried GPs; four male and eight female. Each week all the GPs work the equivalent to seven and half full time GPs.

The practice has been a registered GP teaching practice since April 2013 with two qualified GP trainers. They provide training for students at the University of the West of England usually through tutorials and shadowing GPs whilst they work and post graduate training for qualified doctors requiring general practice training provided over a four month period.

The practice was the first practice in England to employ a full time clinical pharmacist eight years ago. They are a qualified independent prescriber and specialise in long term conditions and health promotion. They also lead on clinical auditing and reviewing patients' medicines. The clinical pharmacist is also a partner within the partnership of the practice.

There were ten female members of the nursing team which consisted of one nurse practitioner who was qualified to independently prescribe medicines, five practice nurses equivalent to three and half full time nurses, two health care assistants and a phlebotomist equivalent to one and

half full time workers. The practice also employed a long term condition community nurse who was the lead for the older population and reducing unplanned admissions to hospital.

The practice had a General Medical Service contract with NHS England. The practice referred their patients to Brisdoc for out-of-hours services to deal with urgent needs when the practice was closed.

Why we carried out this inspection

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

How we carried out this inspection

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 patient's needs?
- Is it well-led?

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We spoke with the Bristol Clinical Commissioning Group, NHS England local area team, Avon Local Medical Committee and local area Healthwatch. We carried out an announced visit on the 17 December 2014. During our visit we spoke with 15 staff including the five GP's, the practice manager, a clinical pharmacist, one nurse practitioner, one community nurse, one practice nurse, three administration staff and two receptionists.

We spoke with 10 patients including four members from the patient participation group and reviewed 22 comment cards where patients shared their views and experiences of the service prior to our inspection.

We heard from five members of the community team that were involved with the practice, such as Bristol community health, a member from Bristol Drugs Project, head of student services at the University of West of England, team leader from the health visitors and community team and first steps eating disorders.

We also spoke with one manager of a local nursing home who had residents who were registered at The Old School Surgery to gain their experience of the service provided.

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, a significant event was raised in November 2014 regarding a missed two week wait for a patient referral completed by a locum GP. The event was discussed in a practice meeting resulting in a change of protocol to reflect all referrals made by locum or trainee GPs should be checked by another GP in the practice before sending.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We saw records of 14 significant events that had occurred during the last year. Significant events were a standing item on the weekly clinical meeting agenda. There was evidence the practice had learned from these and the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. They showed us the system used to manage and monitor incidents. We saw incidents were logged and evidence of action taken as a result. For example, a patient with drug and alcohol problems complained about a GP, a chaperone was present. The practice had taken action to ensure there was an alert on the system and for this patient to have a named GP. Where patients had been affected by something that had gone wrong, they were given an apology and informed of the actions taken.

National patient safety alerts, such as from the Medicines and Healthcare Products Regulatory Agency (MHRA) were disseminated through the clinical pharmacist to relevant practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed together through educational meetings on a weekly basis, where necessary, to ensure all staff were aware of any 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 people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in vulnerable adults and children. They were aware of their responsibilities of sharing 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 via the practice safeguarding policy which was available for all staff on the intranet.

The practice had appointed a dedicated GP and deputy GP to lead in safeguarding vulnerable adults and children. All GPs had been trained in level three child protection training and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments. For example children subject to child protection plans.

We saw evidence of the practice advertising the use of a chaperone if a patient wanted one. There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). The majority nursing staff, including health care assistants, had been trained to be a chaperone except for the new nursing staff where their training was in progress. Reception staff would act as a chaperone if nursing staff were not available. Receptionists who carried out chaperoning were trained and understood their responsibilities.

Good

Are services safe?

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear procedure for ensuring that medicines were kept at the required temperatures and staff knew what action to take in the event of a potential failure.

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 audits had been completed to review prescribing of antibiotics and results were reviewed at a clinical meeting, to ensure learning was shared and appropriate checks were carried out following latest published guidance.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of patient group directions (PGD). One member of the nursing team was a qualified independent prescriber alongside the clinical pharmacist. The nurse practitioner told us they received regular weekly clinical supervision with a GP and support in her role as well as updates in the specific clinical areas of expertise for which they prescribed.

The clinical pharmacist took the lead on high risk medicine management and there were systems in place, which included regular monitoring in line with national guidance. Appropriate action was taken based on the results.

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. The clinical pharmacist lead on the repeat prescription service and was first point of contact for queries from administration staff and patients. They also rationalised repeat prescription lists and provided polypharmacy advice to avoid waste and disruption.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how these were managed. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. There were arrangements in place for the destruction of controlled drugs.

Cleanliness and infection control

We observed the premises to be clean and tidy. The practice employed a cleaning company and we saw there were cleaning schedules in place. The cleaning company carried out regular spot checks of rooms and audited the practice twice a year. We saw records of cleaning schedules and monitoring documents. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control and saw all nursing and administration staff had completed annual infection control training. GPs were in the process of completing the latest e-learning infection control update, three out of 11 GPs had completed the training so far. The lead for infection control was arranging for additional infection control training to be completed. We saw evidence the lead had carried out the last infection control audit in February 2014. Actions identified showed whose responsibility to complete and date action was completed. We noted some actions had not been completed. For example, treatment room curtains to be changed every six months. At the time of the inspection this was about to be addressed through the cleaning company.

We saw personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap and hand towel dispensers were available in treatment rooms.

The practice employed an external contractor to carry out regular checks in line with reducing the risk of legionella infection to staff and patients (Legionella is a bacterium that can grow in contaminated water and can be potentially fatal).

Equipment

Staff we spoke with told us they had 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

Good

Are services safe?

stickers indicating the last testing date. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometers.

Staffing and recruitment

We read four recruitment records from all levels of staff employed in the last year. We saw evidence recruitment checks had been undertaken prior to employment. For example, proof of identification, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). However, two administration staff employed in September and October 2014 had been employed without references taken. The practice manager informed us this was an oversight and had requested references for these members of staff the day after our inspection. We received evidence showing references had been received within 48 hours of the inspection. The practice had a clear recruitment policy, last reviewed in December 2014 which set out the standards it followed when recruiting clinical and non-clinical staff.

The practice used trained receptionists on occasions to carry out chaperoning. Two members of reception staff had not been risk assessed for the level of patient contact they had and whether they warranted a criminal background check and had not been risk assessed following the review of national guidance to determine if these were necessary.

The practice manager 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 there were enough staff were on duty at any one time. Each staffing team had provisions in place to cover sickness and annual leave within the team. Each team had all staff trained in every area to enable short notice cover. Part-time GPs would be called in to cover absence of another GP and often there was no need for locum GP use. The nursing team also worked in a similar way to cover absence.

There was a comprehensive checklist used for agreeing annual leave for GPs to ensure there was adequate cover. The practice manager and one of the GP partners met regularly to discuss annual leave arrangements alongside reviewing patient demand. This approach could improve the consistency of patients seeing the same GPs.

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 annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

There was a maintenance lead employed by the practice who addressed any concerns raised by staff promptly. A plan was in progress to update the facilities within the building and every weekend selected parts of the practice would be refreshed or refurbished. For example, consulting rooms would be repainted and flooring was replaced.

The practice had carried out a fire risk assessment in July 2014, which included actions required to maintain fire safety. We saw recommendations from the risk assessment had been completed. Records showed nursing and administration staff were up to date with fire training and weekly fire alarm tests were carried out.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed all GPs and nursing staff had received training in basic life support. The practice manager informed us all frontline administration staff including receptionists had received basic life support training. Other administration staff who did not have patient access received training if they chose to. The practice had risk assessed this and viewed the size of their staffing team of who were trained in basic life support outweighed of staff not being available to assist in an emergency. However, the practice had decided they would enrol all staff to complete basic life support training in April 2015.

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 they were checked on a weekly basis. When medical emergencies occurred, depending on the nature of the emergency, staff involved discussed the events in a practice meeting and any learning or changes were agreed.

Good

Are services safe?

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. We saw emergency medicines were checked within their expiry date and suitable for use every week. All the medicines we checked were in date and fit for use.

A business continuity plan, last reviewed in October 2014, was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. New guidelines were disseminated by the clinical pharmacist. We found from our discussions with the GPs and nurse's staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The implications for the practice's performance and patients were discussed and required actions agreed. For example, an audit had been completed in August 2014 following an alert from the Medicines and Healthcare Products Regulatory to ensure patients had their medicines reviewed in respect of advice received. Patients who were taking these medicines were now on lower doses for a shorter period of time.

New evidence based techniques and technologies were used to support the delivery of high quality care. One of the GPs was involved with NICE and was a committee member and formed part of the guideline development group. They were currently involved in Sepsis (a common and potentially life threatening condition triggered by an infection) and sports medicine. They had received additional training for Sepsis and been involved in raising public awareness of Sepsis through attendance on national television in September 2014. They have also provided awareness on diagnosis and early management of symptoms of Sepsis to junior doctors in North Bristol through presentations and written articles for the University of Bristol. The GPs have extensive knowledge in sports medicine and runs the sports medicines group in the South West. Patients benefit from their sports medicine expertise as three specialist clinics a year were run from the practice and also uses this as a teaching opportunity for junior doctors. All new guidelines and research were discussed with other relevant team members within the practice in allocated educational meetings to ensure learning was carried through and patient care was improved by all using the latest research and guidance.

Another GP was the National Clinical Champion for Autism for the UK and had provided autism awareness training to all practice staff and this has improved care and assessment for patients on the autistic spectrum. The practice flag on patient notes if the patient had a diagnosis on the autistic spectrum and made adjustments to allow equitable access. Patients from other practices have also joined this practice after hearing from others of the quality of service.

The safe use of innovative and pioneering approaches to care and how it is delivered were actively encouraged. The practice was a research practice and was currently involved in five active research projects and two others were about to be started. These projects included researching alternatives to adult female urinary tract infections, alternative ways to stop smoking, additional medicines used in resistant depression, choice of moisturiser in eczema treatment and the use of aspirin to reduce bleeding in over 60 year olds. One of the research projects included reducing the incidents of bleeding in patients over 60 years using aspirin. The initial trial had found patients who chose to participate in the trial felt more involved in their care, more regular contact and their opinion valued, 91% of patients who were suitable for the trial were successfully treated.

The clinical pharmacist told us they led in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the GPs to focus on specific conditions. GPs and nursing staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines.

The clinical pharmacist reviewed all patients who had been recently discharged from hospital. They highlighted suggested changes made by hospital and allocated to the appropriate GP to review and action any changes made to the patient's care package. All patients were contacted within 72 hours of being discharged from hospital to ensure they had the appropriate support and treatment. Patient risks were highlighted on the system to ensure staff were alerted of these changes. Any patients who were diagnosed with cancer were contacted by the GP.

We were told by one of the GPs that local CCG data showed the practice was average in comparison to other practices with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national and local standards for referral of patients with

suspected cancers were referred and seen within two weeks. We were told regular meetings were held to review referrals made, and improvements to practice were shared with individual staff. All trainee GPs had their referrals reviewed prior to submitting to avoid unnecessary referrals.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate. For example, we saw a case where a patient used an interpreter during a consultation with the GP to ensure they fully understood their treatment and provided the ability to discuss their options.

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 and managing child protection alerts and medicines management.

We saw 11 clinical audits had been undertaken in the last five months. All audits reviewed showed clear actions for staff to address and new procedures to follow. For example, a family planning cycle audit had been completed over the last two years for a type of contraception that the GPs prescribed. The results from the latest audit showed an increase this type of contraception and the attendance of follow ups after the procedure from 85% January 2013 to 88% in May 2014. The practice had implemented a new protocol for reception staff to highlight where a patient had cancelled their appointment so this could be followed up to further improve the procedure.

One of the GPs told us of a minor surgery audit which had confirmed GPs who undertook minor surgical procedures were recording patient verbal consent in line with their registration. We were told the previous audit had shown 100% consent had been recorded prior to minor surgery and the practice would re-audit again in a year to review if this was now established practice.

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 voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures.

The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. We saw the practice had higher than England and local CCG average for completion of their QOF outcomes with an exception rate of 98.9%. For example, 90% of patients with diabetes had an annual medication review including a foot and eye check. This practice was an outlier cervical screening national clinical targets. We were told part of the reason the figure could be lower was because the students and young patients had a choice to use the Contraception and Sexual Health service or the practice.

The team made use of clinical audit tools, clinical supervision and staff meetings to assess the performance of the GPs and nursing staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement.

Administration staff, who had been trained by the clinical pharmacist, regularly checked patients requesting repeat prescriptions had been reviewed by the GP. The IT 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 further tests were required they delayed the prescription until the patient had the necessary tests to ensure it was safe for the patient to continue using the medicine.

The practice had achieved and implemented the gold standards framework for end of life care. At the time of the inspection they had 28 patients on the palliative care register and had monthly internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

All staff were actively engaged in activities to monitor and improve quality and outcomes. The practice had an enhanced service for dementia and dementia identification scheme. They had improved their services for patients with a dementia on a number of levels. The practice had allocated a lead GP as dementia champion who had

completed dementia training which had then been disseminated to all GPs. One of the nurses had also completed dementia training organised by the Clinical Commissioning Group (CCG). They had disseminated this to their peers in a team meeting. We were told before their additional training they had 60 patients diagnosed with a dementia and now they have 93 registered. This had proved that increasing staff knowledge had helped to assist in recognising signs and diagnosing patients leading to better information and treatment provided to newly diagnosed patients and their relatives.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw most staff were up to date with completing mandatory courses such as fire safety. We noted a good skill mix among the doctors with three out of 11 GPs having additional diplomas in women's health and a number of GPs who had a specialist interest in particular subjects such as learning disabilities, family planning, ear, nose and throat, dermatology and mental health. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals identified learning needs from which action plans were documented. The practice manager informed us that some appraisals were overdue and there was a plan in place to ensure these were completed promptly. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. The nurse practitioner received weekly clinical supervision from their mentor GP to discuss their clinical practice.

The practice manger told us where poor performance had been identified appropriate action had been taken to manage this and provided examples of when this had been managed.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those patients with complex needs. They received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from 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 instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

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

The practice provides care and treatment to a number of patients who reside in two local nursing homes. We spoke with one of the nursing homes who provided us with positive feedback about the service provided. They said they had a good relationship with the practice and the practice involved families regularly in decision making, where necessary. The home had a dedicated GP who completed weekly 'ward rounds' at the home. If the nursing home required urgent attention then this would be dealt with promptly alongside any repeat prescription requests.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made referrals through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of

place, date and time for their first outpatient appointment in a hospital). Staff reported this system was easy to use and assisted patients, when requested, to help book their appointments using the system.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record in the patient record system to coordinate, document and manage patients' care. All staff were fully trained on 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.

Consent to care and treatment

We found staff were aware of the Mental Capacity Act 2005 (MCA), the Children Acts 1989 and 2004 and their duties in fulfilling it. We spoke with one GP about their understanding of the key parts of the legislation and were able to describe how they implemented it in their practice. For example, we heard of an example of when an advocate was used for a patient with no close relatives to make decisions about their treatment options. We spoke with the local nursing home which had patients registered at the practice who informed us the GPs included relevant parties when making decisions in the patients best interests, particularly through advanced decision making and initiating the 'do not attempt cardiopulmonary resuscitation' process.

We were told it was a practice policy to document consent for specific interventions, such as minor surgery and immunisations and vaccinations. For example, for all minor surgical procedures, a patient's written consent was documented through the use of a written consent form.

The practice had a consent policy, last reviewed in November 2014. This detailed clear procedures for staff to follow including a MCA assessment tool for completion if a patient's capacity was in question. There was also information on Gillick competence and what rights the child had for making their own decisions.

Health promotion and prevention

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, patients wishing to give up smoking were offered a 12 week programme with an advisor for smoking cessation. The practice had also identified the smoking status of 78% of patients over the age of 16 and 89% of these patients had been actively offered nurse-led smoking cessation clinics, which was above Bristol CCG and England average. We were told they had some success with the number of patients who had stopped smoking following smoking cessation.

Young patients under the age of 25 years old were able to access the practice for confidential sexual health and relationship advice. The practice told us and the '4 young people' Bristol website provided confirmation that they had been accredited with the 'young people friendly' award. This meant they were a welcoming place for young people to attend to gain information about their sexual health or relationships, aware of young people's health issues in the area, ability to work with other services and had the appropriate training and facilities for young people to use. The practice also had a confidential facility for patients and others in the community to collect free condoms from them as long as they had a 'c card'.

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. All 63 patients with a diagnosed learning disability were offered an annual physical health check. Since April to December 2014, 40% of the 63 patients had received an annual health check. The previous year April 2013 to March 2014, 100% of patients had received an annual health check.

The clinical pharmacist provided weight management clinics and was able to refer to local weight management services and provide treatment where necessary. Other services were available in the practice such as bi-weekly clinics for eating disorders and age concern and domestic violence and housing advice was provided once a week at the practice.

The practice's performance for cervical smear uptake was 71.6%, which was lower than others in the CCG area and England average. We were told this could be due to the student population using other local sexual health services and other patients chose not to have one. Patients were provided with advice on cervical smears and why it was necessary to have them. There was a policy to offer telephone reminders for patients who did not attend for cervical smear test and the practice audited patients who do not attend in order to increase attendance.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Child immunisations performance from April 2013 to March 2014 with two out of 16 showing they were below average for the CCG. The other 14 results were either higher or on average with the Bristol CCG area. We saw the uptake of flu vaccines was 78% from September 2012 to February 2013, which was slightly above England average. There was a clear policy for following up non-attenders by the named practice nurse.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national GP patient survey from 2014 gaining views from 112 patients and a survey of 196 patients undertaken by the practice's patient participation group (PPG) in March 2014. The evidence from these sources showed patients were satisfied with how they were treated and that they had been treated with compassion, dignity and respect. Data from the national GP patient survey showed the practice was rated above Bristol Clinical Commissioning Group (CCG) average for patients who rated the practice as good or very good. The practice was above the CCG average for its satisfaction scores on consultations with doctors with 95% of practice respondents saying the GP was good at listening to them and 96% saying the GP gave them enough time. We saw 99% of patients had confidence in the nurses and 95% of patients said nurses were good at treating them with care and concern.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 22 completed cards which were highly positive about the service experienced with only one negative comment about an appointment waiting time for their child. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. We also spoke with six patients visiting the practice on the day of our inspection and four members from the patient participation group. 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. Curtains were provided in consulting rooms and treatment rooms so patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted consultation and treatment room doors were closed during consultations and 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 confidential information was kept private. Patient calls were generally taken away from the reception desk by additional administrators. The reception desk had a lowered area for patient accessibility and also provided an additional area to talk to patients more confidentiality or additionally patients could be taken to another room.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or if 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. We were told of an example of a recent incident that showed appropriate actions had been taken.

Care planning and involvement in decisions about care and treatment

The GP national 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, 84% of practice respondents said the GP involved them in care decisions, 84% of patients said they were sufficiently involved in making decisions about their care and 87% felt the GP was good at explaining treatment and results. Results were significantly lower for patients seeing their preferred GP at 51%, four out of six patients spoken with on the told us this was often a problem. However, 91% said the last appointment they got was convenient and satisfaction with GPs seen was very high.

Patients we spoke with on the day of our inspection told us health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us 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.

Patient/carer support to cope emotionally with care and treatment

Patient's emotional and social needs were seen as important as their physical needs. Patients spoken with on

Good

Are services caring?

the day of the inspection provided us with examples of when they felt GPs had provided compassionate and supported patients in times of need emotionally and physically. For example, a patients relative went through end of life care, they commented the allocated GP was always there quickly when they needed them and when their relative passed away had visited them at their home to check on their wellbeing.

Patients told us that staff go the extra mile and the care they received exceeded their expectations. For example, a patient was awaiting results from hospital and their GP reviewed them when they were returned. They found the results did not present a good outcome. The GP visited the patient at their home to explain the results. Another occasion a patient told us their relative had passed away after a terminal illness and the GP and nursing staff involved in their care had attended the person's funeral.

Staff were fully committed to working in partnership with patients and making this a reality for each person. The practice had a carer's champion who had been trained and they had disseminated this training to the reception team. The practice encouraged carers to register and currently had 91 carers registered with them (not all necessary patients at the practice but known carers for registered patients were also highlighted). This enabled the practice to provide additional support to them when required. The practice asks patients who attend flu clinics if they were a carer, which had been successful increasing their carers register. They had arranged a practice open day and invited the local carers support to provide support to patients. The practice planned to do this again as this day had been a successful. If carers register with the practice then they receive a carers information pack, put an alert on the system to enable reception staff to prioritise their appointments. The practice also provide newsletter for carers every quarter and had a section on their website specifically for carers.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The NHS England local 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 were told meetings were held regularly for practice managers, practice nurses and GPs where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. Currently the CCG focus was on improving community services for patients. At a monthly primary care agreement meeting the practice had agreed to engage with another two practices to trial four district nurses working from three locations. This pilot was initiated to improve community multi-disciplinary care.

The practice had been funded for the enhanced service avoiding unplanned admissions. In response to this the practice had employed a care of the elderly community nurse in July 2014 with the main objective to reduce hospital admissions for patients and ensuring patients were cared for when returning home from hospital. This role was the first of its kind within the local area. The nurse acted as the care co-ordinator for the top 2% of patients who were 'at risk'. Admission avoidance meetings were carried out on a monthly basis with the community nurse and the other GPs to discuss 'at risk' patients. They also saw the community nursing team on a weekly basis to alert them of patients who were deteriorating to coordinate care to enable patients to stay at home. The top 2% of patients had care plans completed and these were monitored and reviewed at least every three months. The practice had not yet completed an audit to confirm if these changes had improved patient care and reduced admissions. Due to the success of the role of the care of the elderly community nurse the practice had recruited two nurse practitioners to care for their older and more frail patients.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). For example, they had helped the practice increase patient knowledge of the services provided by assisting with the organisation of a practice open day. This had proved to be successful with approximately 80 to 100 patients attended throughout the day.

Tackling inequity and promoting equality

There was a proactive approach to understanding the needs of different groups of patients to deliver care in a way that met these needs and promoted equality. They had a larger than national average 15 to 24 year old range and the majority of this age group registered were students at the local university. The average practice turnover each year was 1000 students de-registering and 2500 registering, which had an impact on the practice. Approximately 45% of the student population registered were from minority ethnic backgrounds. The practice worked closely with the university to increase student knowledge of the services available of the service provided. For example, they held student forums and promoted service through key student days, such as 'freshers' week. This also provided an opportunity to inform students of where and which health services to use in the area for particular illnesses or problems. They also worked with the universities international faculty to inform overseas students of the NHS and what it could be used for. Social media sites and mobile applications were also used by the practice to increase student interaction, education and involvement with the practice.

The practice provided facilities for a local drugs project to hold weekly sessions at the practice for its patients. The drugs project provided us with feedback pre-inspection and described a good working relationship with the practice. One of the GPs had specialist training in this field and the drugs project found this invaluable to enable them to provide a supportive and approachable joined-up service.

The practice also provided facilities for age concern, first steps eating disorders, dietician service, retinopathy eye screening, next link (for domestic violence and housing advice), counsellor visits the practice on a regular basis to provide services to practice patients and others in the community.

The practice had 63 registered patients with a learning disability. We were informed that from April to December

Good

Are services responsive to people's needs?

(for example, to feedback?)

2014 the practice had completed 40% of annual health reviews for patients with a learning disability so far and the previous year they had completed 100% of annual health checks.

The practice had a website language translator and access to telephone translation services. The practice provided equality and diversity training through e-learning. We saw from the information the practice provided staff had completed this in the last year.

The premises and services had been adapted to meet the needs of patient with disabilities. All patient areas in the practice were on the ground floor. Accessible toilet facilities were available for all patients. 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. Part of the reception desk had been lowered for patients who used wheelchairs. All patient door signs had braille for patients with poor sight and also had a type-talk service available for patients who were hard of hearing.

Access to the service

Appointments were available from 8:30am to 6:30pm on weekdays. The practice extended their opening hours on Monday evenings until 7:30pm. The practice had increased their appointment times to enable patients who could not easily attend within the normal working hours, such as for patients with work commitments. Patients were able to see a GP or nurse during this additional time and they would provide a normal service to patients, such as providing cervical smears checks for women and blood tests.

Appointment system information was available to patients 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 on the out-of-hours service was provided to patients.

The GPs had 15 minute routine appointment times for all 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, nurse or clinical pharmacist. Home visits were made to two local care homes on a specific day each week, by a named GP and to those patients who needed one.

Patients were generally satisfied with the appointments system. They confirmed they be seen the same day if required. Patients were less satisfied about being offered appointments which were over a week's wait to see the GP of their choice. They did say they were offered another appointment to see another GP if there was a wait to see the GP of their choice. Two patients out of six spoken with told us they thought they had to call the practice between 8am and 9am to book an urgent appointment otherwise you would not get an appointment. However, when we feed this back to the practice they informed us this was not the case and said they would consider how they could improve knowledge of the appointment system for patients.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. The complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The policy also included details for the patient to contact advocacy services, if wanted additional support. There was a designated responsible person who handled all complaints in the practice.

We saw information was available to help patients understand the complaints system in the practice leaflet and the complaints policy was available on the practice website and at reception. Patients we spoke with were generally aware of the process to follow if they wished to make a complaint.

We saw records of 16 complaints had been received from December 2013 to November 2014. We found complaints were around a number of areas, such as appointments and care received and there was no apparent theme. All complaints, where appropriate, were discussed in the weekly clinical meeting and relevant staff included where necessary. We saw two complaints in detail which had been discussed and learning identified.

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 five year business plan. The practice vision and values included;

- Modern innovative practice with patients at the heart of everything we do
- To get it right the first time every time
- Promote a team spirit to enable responsive caring attitudes amongst staff

We spoke with 15 members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. Staff could also review the practice values and behaviours in the staff room. The practice had monthly business meetings involving all of the partnership to discuss the business direction and drive the business forward. The practice also held an away day for all staff every 18 months. This enabled the practice to communicate their vision and ethos and to involve staff in decisions and how they were going to drive the practice forward.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We read seven of these policies and procedures and found they had all been reviewed in the last year and contained detailed information.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and one of the GP partners was the lead for safeguarding. We spoke with 15 members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

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 QOF data was regularly discussed at team meetings every quarter and action plans were produced to maintain or improve outcomes.

The GPs, nursing team and practice manager worked with other GP practices within the CCG area and attended CCG forum meetings to discuss future plans and local challenges. Within these forums was training of interest or opportunities to share learning, such as discussing new guidelines and how these could be implemented within the practice.

The practice had a one year business plan. This was not any longer due to anticipated increase and decrease of patient registrations due to the student population registered with them. One of their plans for the next year was to initiate a peer review system for the nurse practitioner to buddy with another nurse practitioner who was linked to another university. The outcome was to enable progression within their role and share learning.

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 to improve outcomes for patients. Part of the clinical pharmacist's role was to carry out audit and we saw a number had been completed for various medicines management. For example, an audit was carried out for nutritional supplements in October 2014. This had identified where patients had no Body Mass Index evidenced and had not recorded whether an advice leaflet had been provided to the patient. The pharmacist also reviewed whether supplements could be changed to a more cost effective version. All patients were reviewed where information was missing to ensure they were on the most appropriate medicine. From the other audits seen it was evident patient outcomes had been improved and where applicable patients had their medicines reduced or stopped. This had helped to reduce the cost of prescribing within the practice.

Leadership, openness and transparency

There were consistently high levels of constructive staff engagement. Staff told us there was an open culture within the practice and they had the opportunity and were happy to raise issues at various meetings, such as administration team meetings or whole practice meetings. The practice had a staff suggestion scheme to enable staff to anonymously submit comments to the practice manager of ways the practice could improve. This had improved systems in the practice. For example, a procedure was changed following patients receiving their prescriptions following their consultation. The practice had a whistleblowing policy which was available to all staff on the

Are services well-led?

Good

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

staff intranet. This set clear guidelines for the practice and staff member to follow when they wanted to raise concerns including information on whistle blowing charities that could be contacted.

The practice manager was responsible for human resource policies and procedures. We reviewed the recruitment and staff training policy, which were in place to support staff. Staff could access policies and procedures through the staff intranet.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received. We read the results of the annual patient survey which specifically looked at patient views of appointments and 29% of patients said same day appointments were most important to them and preferred later opening hours rather than earlier, which confirmed this was what the practice had in place. From patient comments the practice had increased the amount of disabled parking spaces within the practice car park. We heard from patients this had improved access to the practice.

The practice had an active patient participation group (PPG) of eight patients who were all over the age of 55 years old. The PPG had carried out annual surveys and met every four to six weeks. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys are available on the practice website. For the practice to gain a variety of views they worked closely with the university and had set up and run student forums to encourage the practice to hear their views. Social media sites and mobile applications were also used by the practice to increase student interaction, education and involvement with the practice.

The practice had gathered feedback from staff through staff away days and staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

Staff told us the practice supported them to maintain their clinical professional development through training and mentoring. We read four staff files and saw some appraisals were overdue but when they did take place they included a personal development plan. There was a plan for the practice manager to complete these as soon as possible. Staff told us the practice was very supportive of training and they attended regular meetings within the practice.

The practice has been a registered GP teaching practice since April 2013 with two qualified GP trainers. They provide training for students at the University of the West of England usually through tutorials and shadowing GPs whilst they work and post graduate training for qualified doctors requiring general practice training provided over a four month period.

The practice had completed reviews of significant events and other incidents and shared with staff at regular meetings to ensure the practice improved outcomes for patients.

The leadership drives continuous improvement and staff were accountable for delivering change. The practice was the first practice in England to employ a full time clinical pharmacist eight years ago who is a qualified independent prescriber and specialises in long term conditions and health promotion. They also lead on clinical auditing and reviewing patient's medicines. The clinical pharmacist is also a partner of the practice. The practice has a good working relationship with the attached pharmacy with the same aim to provide good quality patient care. This includes handling repeat prescriptions and highlighting any vulnerable patients to enable the practice to ensure the patients care needs were met. They jointly won the national Pharmacy Business Optimisation Award in 2014.