Christchurch Family Medical Centre

Quality Report

North Street,
Downend,
Bristol BS16 5SG
Tel: **0117 970 8950**
Website: www.
christchurchfamilymedicalcentre.com

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Christchurch Family Medical Centre on 9 August 2016. We had inspected this GP practice in August 2014 as part of our inspection programme pilot to test our approach going forward.

Areas identified for improvement in August 2014 were:

- The practice should ensure all staff understand what to do if they are concerned or worried about a vulnerable adult or child.
- The practice should ensure that actions resulting from clinical audits are reviewed to complete the audit cycle.
- The practice should ensure all staff are aware of translation or signing services for patients.
- The practice should ensure their whistle blowing policy contains contact details for external organisations.

From this inspection 9 August 2016 our findings were:

Overall the practice is rated as good.

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

- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- Patients said they could make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day. The practice managed its more vulnerable patients well and made specific support available to them to facilitate them to access health care.
- 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. Improvements were made to the quality of care as a result of complaints and concerns.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

Summary of findings

- There was a clear leadership structure and staff felt supported by management. The team had regular away days in order to review and plan the practice developments.
- There was a governance framework for the delivery of the strategy and good quality care, and the practice had a number of policies and procedures to govern activity.
- The provider was aware of and complied with the requirements of the duty of candour.
- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events, but we found the practice relied on their established verbal communication systems and informal meetings to share and cascade information.

We saw areas of outstanding practice:

- A clinical coordinator was employed by the practice to support vulnerable patients with learning disabilities. They offered the annual health checks for patients which had allowed them to develop a secure and trusting relationship and continuity of care. They also liaised with the care homes for people with learning disabilities and provided a point-of-contact for those patients living independently in the community by providing support, care, chaperoning and interpretation. They had been involved in developing a DVD to support training in other primary care organisations to raise awareness of learning disabilities. Patients could contact the clinical coordinator directly for support making appointments.
- The practice offered support to carers and held monthly meetings which provided social and health care opportunities to carers. These patients could also contact the clinical coordinator directly for support making appointments.

The areas where the provider should make improvement are:

- The practice should update their fire safety risk assessment.
- The practice should maintain clear records of clinical and other meetings where decisions are taken which impact on the work of the practice.
- The practice should monitor the cleanliness of the practice environment.
- The practice should monitor their patient group direction to ensure they are up to date.

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.

- There was a system in place for reporting and recording significant events. The meetings where actions and learning were reviewed were not always documented and did not provide assurance of how lessons were shared, or incidents reviewed, to identify any trends.
- When things went wrong patients received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- There was an open and transparent approach to safety however, we found that the practice fire safety risk assessment had not been recently updated.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to the national average.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits monitored the quality of the service and identified where improvement was needed.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.

Summary of findings

- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- The practice managed its more vulnerable patients well and made specific support available to them to enable them to access health care. A clinical coordinator was employed by the practice to support vulnerable patients and carers. These patients could contact the coordinator directly for support with making health care appointments and accessing community based services.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified. For example, they had a dementia specialist nurse shared within the practice cluster group.
- Patients said could make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues 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.

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management.
- There was a governance framework for the delivery of the strategy and evidence of good quality care; the practice had a number of policies and procedures to govern activity.
- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for notifiable safety incidents.

Summary of findings

- The practice proactively sought feedback from staff and patients, which it acted on.
- There was a strong focus on continuous learning and professional development at all levels. The practice had a strong core of staff with additional specialist qualifications and skills.
- The practice had reviewed their staffing establishment and had employed a wide range of health care professionals to meet the demand for services this included a nurse practitioner, a clinical pharmacist and at the time of our inspection the practice were advertising for a primary care paramedic in order to provide an acute home visiting service which would be available to patients throughout the day.

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 practice offered proactive, personalised care to meet the needs of the older people in its population.offered a direct line of access to the practice and their GP; with additional support and advice by signposting to the most appropriate health care professional.
- The practice was responsive to the needs of older people, and offered daily home visits and urgent appointments for those with enhanced needs.
- The practice undertook the enhanced service for hospital admission avoidance and held weekly meeting with the multidisciplinary health care team in order to have proactive care planning to prevent hospital admission.
- The practice used emergency care practitioners from the community healthcare services to undertake some home visits. This was initiated by the duty doctor who triaged requests for home visits.
- The practice provided support to 14 local care homes, with a nominated GP for six of the larger care homes. The practice provided primary medical services for the second highest number of care homes residents within the whole of South Gloucestershire. The lead GP visited weekly to provide a clinic which ensured continuity of care for patients. Care homes had direct email access to their named GP for non-urgent needs which improved their response to patients, and ongoing care. The practice were trialling multidisciplinary team reviews at one of their care homes to develop closer and collaborative working.
- The practice supported the “interim beds pilot project” with South Gloucestershire Council in nursing and residential homes. These beds were for patients who were medically fit for discharge from hospital, but who needed a further period of rehabilitation or recovery before they return home. The care the practice offered as part of the pilot included a weekly review, and the provision of responsive care if patients became acutely unwell, and the management of their medicines.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions.

Summary of findings

- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.
- Longer appointments and home visits were available when needed.
- Nursing staff had lead roles in chronic disease management
- A named GP acted as the lead for each long-term condition and met with the practice manager and lead nurse on a monthly basis to review the clinical and operational management of these patients.
- The practice had employed a clinical pharmacist to work with older patients and those with long term conditions to promote medicines .

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 able to they make informed choices about their care.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice offered access sexual health advice for both registered and unregistered patients.
- We saw positive examples of joint working with midwives and health visitors; they offered post-natal and child surveillance checks to all new mothers and babies offering flexibility of appointments to suit their needs. The on-site health visitors worked closely with the GP team offering integrated care for new mothers and babies until the age of 5 years old and a weekly
- The lead GP for safeguarding children and vulnerable adults met with the health visiting team on a regular basis for child protection meetings to review and discuss vulnerable families and children.

Summary of findings

- The practice had two GPs with specialist qualifications in paediatric medicine, a DCCH (Diploma in Community Child Health) and another GP had a DCH (Diploma in Child Health) which facilitated internal referral and acted as a valued resource.
- The practice actively encouraged young people to give up smoking with annual telephone contact to screen and offer smoking cessation advice and clinics.

Working age people (including those recently retired and students)

Good 

The practice is rated as good for the care of working-age people (including those recently retired and students).

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care such as daily phlebotomy clinics from 7.30am.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.
- The practice had a nurse practitioner who held minor illness clinics.
- The practice offered NHS Health Checks for patients aged between 40-74 years old, who had not already been identified and included on long-term disease registers. Over the past three months, the practice had promoted this service specifically to patients in often hard-to-reach groups including men, or those who have not attended the practice within the last 5 years, to ensure they were aware of the service.
- The practice offered a variety of health promotion clinics and social prescribing such as including weight management sessions.

People whose circumstances may make them vulnerable

Outstanding

The practice is rated as outstanding for the care of people whose circumstances may make them vulnerable.

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. The practice responded to chaotic circumstances of vulnerable individuals who arrived without an appointment by including them in the duty GP system and seeing unregistered patients as temporary residents to ensure they had access to health care.

Summary of findings

- The practice offered longer appointments for patients with a learning disability. The practice had a named member of staff who supported patients with a learning disability and who undertook conducted the patient's annual health checks.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients. The practice hosted a substance misuse service; they had a dedicated GP who had additional knowledge and skills, and who worked closely with the service.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.
- The practice employed a clinical coordinator who provided a link between health and social care. This included signposting new carers to services for support, organising occupational therapy referrals and providing a point-of-contact at the practice for those families in need.
- The practice had an active carers group with two staff acting as the practice carers champions. The group met every six weeks to support and provide some respite to patients, or their families. The lead GP for carers attended the meetings and offered health and social care advice where necessary. The meetings were hosted at the practice where tea, coffee and cake were provided; the meeting gave carers an opportunity to hear speakers on topics that may support and advise them on issues relating to caring and the opportunity to share their experiences.
- The reception and administration teams had undertaken a variety of training including deaf awareness, dementia care, and how to support patients with learning disabilities, so that they could better support these patients.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).

- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice carried out advance care planning for patients with dementia.

Summary of findings

- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. The practice could access the mental health primary liaison service which meant patient could be reviewed within a short timeframe.
- Staff had a good understanding of how to support patients with mental health needs and dementia, and signposted patient to the South Gloucestershire dementia prescription programme. The practice worked with others within their GP practice cluster and had obtained additional funding for a dementia specialist nurse who could provide therapeutic interventions at short notice.

Summary of findings

What people who use the service say

The national GP patient survey results were published on January 2016. The results showed the practice was performing in line with local and national averages. 274 survey forms were distributed and 110 were returned. This represented 0.9% of the practice's patient list.

- 47% of patients found it easy to get through to this practice by phone compared to the clinical commissioning group average of 70% and the national average of 73%.

  We saw the practice had acted on this survey in order to improve outcomes for patients and had sourced a new telephone system.

- 72% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the clinical commissioning group average of 81% and the national average of 76%.
- 90% of patients described the overall experience of this GP practice as good compared to the clinical commissioning group average of 86% and the national average of 85%.
- 81% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the clinical commissioning group average of 80% and the national average of 79%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 16 comment cards which were all positive about the standard of care received. Patients made favourable comments about being listened to and the time taken to discuss their illnesses and treatment options. Several patients had commented on the positive relationship between them and the staff at the practice.

We spoke with four patients during the inspection. All of the patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. The practice ran the friends and families test for June 2016 they only received seven responses, 71% of these respondents stated they would recommend the practice.

Christchurch Family Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Christchurch Family Medical Centre

Christchurch Family Medical Centre is located in North Street, Downend, Bristol, BS16 5SG and provides primary medical services to approximately 12,800 NHS patients.

The practice is situated in a purpose-built building and is fully accessible for patients.

The practice has five GP partners (male and female), two salaried GPs, a practice manager, five practice nurses, three health care assistants and a phlebotomist. Each GP has a lead role for the practice and nursing staff have specialist interests such as diabetes and infection control.

The practice is open between 7.30am and 6.30pm, Monday to Friday and offers an evening surgery twice a week until 8pm and Saturday mornings for open surgery.

The practice had a Personal Medical Services contract (PMS) with NHS England to deliver general medical services. The practice provided enhanced services which included facilitating timely diagnosis, support for patients with dementia and childhood immunisations.

The practice in line with other practices in the South Gloucestershire Clinical Commissioning Group is situated within a significantly less deprived area than the England average. However, the practice also covers wards in Kingswood and Staple Hill which are in the top five most deprived regions nationally.

The practice is a teaching practice, one of whom we spoke with during the inspection, and takes medical students from the Bristol University.

The practice has opted out of providing Out Of Hours services to their own patients. Patients can access NHS 111 or BrisDoc provide the out of hours GP service.

Patient Age Distribution

0-4 years 6.7 %

5-14 years 12.3 %

15-44 years 37.5 %

45-64 years 24.2 %

65-74 years 9.7 % - higher than the national average 18%.

75-84 years 6.1 % - higher than the national average 8.3%.

85 years + 3.4 % - higher than the national average 2.3%.

Patient Gender Distribution

Male

48.9 %

Female

51.1 %

% of patients from BME populations 5.45 %

Detailed findings

Patients at this practice have a higher than average life expectancy for men at 80 years and women at 85 years.

The practice hosted a variety of NHS and private health care service including:

Health visitors and community nurses.

Hosting substance misuse services for the Drugs and Homelessness Initiative (DHI) to provide advice and offer treatment within a structured care programme for all patients who seek help for drug dependency problems.

Midwifery drop in clinic.

GP Care Ltd who undertake deep vein thrombosis testing and working in conjunction with the practice to treat diagnosed patients; who also offer a private service for early pregnancy scans.

A private travel centre which was a registered yellow fever centre, and offered a range of vaccinations and immunisations for travellers. The practice is a specialist travel centre working in partnership with MASTA (Medical Advisory Service for Travellers Abroad).

Physiotherapy.

Dental practice.

On site pharmacy.

We inspected this GP practice in August 2014 as part of our new inspection programme pilot to test our approach going forward.

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. The 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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 9 August 2016. During our visit we:

- Spoke with a range of staff including GPs, nurses, community staff and practice management and spoke with patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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

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

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

- older people
- people with long-term conditions
- families, children and young people
- working age people (including those recently retired and students)
- people whose circumstances may make them vulnerable
- people experiencing poor mental health (including people with dementia).

Detailed findings

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

Good

Are services safe?

Our findings

Safe track record and learning

There was a system in place for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- There was a system in place for reporting and recording significant events. The meetings where actions and learning were reviewed were not always documented and did not provide assurance of how lessons were shared, or incidents reviewed, to identify any trends.
- We reviewed patient safety alerts and saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, all clinical staff had received information about the Zika virus and had confirmed they had read it.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. At our last inspection we found that not all staff understood what to do if they were concerned or worried about a vulnerable adult or child. During this inspection we spoke with the nurse team and they were able to demonstrate their understanding of safeguarding procedures and relate the processes followed to make referrals. We found staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs and nurses were trained to child protection or child safeguarding level three.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- The practice overall maintained appropriate standards of cleanliness and hygiene. We observed most of the premises to be clean and tidy in the clinical and waiting room areas, however, we saw that the patient toilets and nappy change area were not clean and brought this to the attention of the practice management team for action.
- One of the practice nurses was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat prescriptions which included the review of high risk medicines. The practice carried out regular medicines audits, with the support of the local clinical commissioning group (CCG) pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use.

Good

Are services safe?

- One of the nurses had qualified as an independent prescriber and could therefore prescribe medicines for specific clinical conditions. They received mentorship and support from the medical staff for this extended role.
- Patient Group Directions (PGD) were used by the practice to allow nurses to administer medicines in line with legislation. Health Care Assistants were trained to administer vaccines and medicines against a patient specific prescription or direction from a prescriber. We found that not all of the PGDs had been adopted by the practice (signed by the GP lead) such as the children's pre-school booster and not all of the nurse team had signed all of the PGDs for the vaccines they were administering. This meant that they were working outside of the required protocols. This was brought to the attention of the management team for action. Following the inspection the practice confirmed that all the nurses had signed the PGDs and for the specific PGD that was out of date (typhoid) they were using PSDs until the new PGD was available. The GPs had also signed the PGDs so that they had been fully adopted by the practice; the PGD that was no longer in use had been removed from the file.
- We reviewed five personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

Monitoring risks to patients

There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster on the premises. The practice had a fire safety risk assessment dated 2005, which had not been reviewed since then and we were told this was planned to be reviewed and updated by the practice. We observed there was fire evacuation information in all rooms in the premises that were used by the practice. The practice carried out regular fire drills and evacuation procedures. All electrical equipment was checked to ensure the equipment was safe to use. We saw the practice routinely recalibrated clinical equipment on a yearly basis, however, we found that not all equipment in GPs bags and the coagucheck (a machine for testing the anticoagulation property of blood last calibrated July 2013) had been checked to ensure it was working properly. This was raised with the practice for action. Following the inspection the practice told us they had now completed a review of all clinical rooms and GP bags, and had developed a full asset register of clinical equipment for the practice. Any equipment that was missed in the annual calibration test had been removed these instruments from use until calibration has taken place. In respect of the coagucheck machine they had found that the machine had in fact been calibrated and had been certified as such, but the appropriate advice notice had not been added to the machine to confirm this.

- The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.

The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs. We saw use of evidence based practice on the patient nursing records, for example, evidence of best practice treatment protocols, use of prescribing formularies and Diabetes UK best practice guidance.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results (2014 – 15) were that the practice achieved 96.7% of the total number of points available.

This practice was not an outlier for any QOF (or other national) clinical targets. Data from (2014 – 15) showed:

- Performance for diabetes related indicators was comparable to clinical commissioning group and the national averages. For example, the percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2014 to 31/03/2015) was 76% compared to a clinical commissioning group average of 77% and the national average of 78%.
- Performance for mental health related indicators was comparable to clinical commissioning group and the national average. For example, the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2014 to 31/03/2015) was 93%, the clinical commissioning group was 94% and the national average was 88%.
- At our last inspection we found a programme of clinical and internal audit was used to monitor quality and to make improvements. However, at that time the practice had not ensured that actions resulting from clinical audits were reviewed to complete the audit cycle. On this visit we saw the evidence of two re-audits undertaken in August 2016 to review how effective remedial action had been. These related to a hypertension audit which had identified patients not attending for review and an antibiotic prescribing re-audit which identified a reduction in prescribing and greater adherence to guidance. A review meeting to discuss the outcomes had been planned for 7 September 2016.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions who had completed specific diplomas and those undertaking minor injury treatments who had attended appropriate training.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. All staff had received an appraisal within the last 12 months.

Good

Are services effective?

(for example, treatment is effective)

- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services. We were told patient correspondence from other health and social care providers was scanned into patient records once the GPs had seen the results. This ensured the patient records were current and held electronically to be accessible should they be needed, for example, for a summary care record to take to the hospital.
- Community nurses teams could access a restricted area of the patient records remotely for any test results and to add details of their visits.

  Patients' blood and other test results were requested and reported electronically to prevent delays. GPs took responsibility to view their own results.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs. They had a dedicated line for health care professionals to make contacting a GP easier should they have any concerns about their patients.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- We saw the practice had clear protocols in place to consider best interest decisions such as the administration of covert medicines.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were signposted to the relevant service.

Information from the National Cancer Intelligence Network (NCIN 2013/14) indicated the practice's uptake for the cervical screening programme was 78%, which was higher than the national average of 74%.

Childhood immunisation rates for the vaccinations given were similar to clinical commissioning group (CCG) averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 86% to 100% compared to the CCG average from 84% to 99% and five year olds from 94% to 98% compared to the CCG average from 93% to 99%.

Patients over the age of 65 years were recalled annually for an influenza vaccination and the practice used this opportunity to screen patients for other health conditions such as atrial fibrillation, hypertension and general lifestyle risks. Patients who were unable to attend the practice for their influenza immunisation were visited at home to ensure they were vaccinated.

Patients had access to appropriate health assessments and checks. The practice information leaflet highlighted the practice offered health checks designed to identify and manage the risk of

Good

Are services effective?

(for example, treatment is effective)

developing long term conditions for patients aged 40-75 years old. These included health checks for new patients. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified. Over the past three months, the practice had promoted this service specifically to patients in often hard-to-reach groups including men, or those who have not attended the practice within the last 5 years, to ensure they were aware of the service. This had achieved an increased number of men attending for health checks (74) from the previous year (14).

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Same sex GPs were available for patients.

All of the 16 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with four patients who told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. They told us that they felt the practice exceeded expectations in the care and concern shown to them. We heard that patients had been contacted post consultation by GPs to make sure they were happy with their discussions and contacted directly with information about secondary care or results from tests. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 91% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 88% and the national average of 89%.
- 92 of patients said the GP gave them enough time compared to the CCG average of 87% and the national average of 87%.
- 96% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 94% and the national average of 95%.
- 88% of patients said the last GP they spoke to was good at treating them with care and concern compared to thenational average of 85%.
- 90% of patients said the last nurse they spoke to was good at treating them with care and concern compared to thenational average of 91%.
- 85% of patients said they found the receptionists at the practice helpful compared to the CCG average of 86% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients told us 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 available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

Patients who required palliative care were involved in making decisions about their care and treatment. The GP spoke with patients about their wishes and preferred location for their palliative care and treatment. When a patient consented to a 'do not attempt resuscitation' agreement (DNAR), the form to the patient at their home in person and checked again at this point if they were happy with the agreement and were happy to keep the form in their home.

A clinical coordinator was employed by the practice to support vulnerable patients with learning disabilities. They offered the annual health checks for patients which had allowed them to develop a secure and trusting relationship and continuity of care. They also liaised with the care homes for people with learning disabilities and provided a point-of-contact for those patients living independently in the community by providing support, care, chaperoning and interpretation. They had been involved in developing a DVD to support training in other primary care organisations

to raise awareness of learning disabilities. We met with a patient who had received this type of support who told us that they now felt able to visit the practice for appointments without assistance. They also told us how this had been a gradual process to build their confidence and trust but the practice had invested time to do this so they could take an active part in maintaining their health.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with or above local and national averages. For example:

- 83% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 84% and the national average of 86%.
- 85% of patients said the last GP they saw was good at involving them in decisions about their care compared to the national average of 82%.
- 90% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the national average of 85%.

The practice provided facilities to help patients be involved in decisions about their care:

- On our last inspection we found not all staff were aware of translation or signing services for patients. We saw on this visit that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.
- Information leaflets were available in easy read format.

Patient and carer support to cope emotionally with care and treatment

The practice managed its more vulnerable patients well and made specific support available to them to enable them to access health care. The practice employed a clinical co-ordinator to provide a link between health and social care services to ensure patients' needs were responded to quickly and appropriately. Patients could contact the coordinator directly for support making appointments. Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website.

The practice offered support to patients who had caring responsibilities; there was a noticeboard in the practice highlighting the local support services available to carers and information in the practice leaflet. The practice's computer system alerted GPs if a patient was also a carer. The practice had a register of carers (160) and contacted them to invite them to the carers meetings. The practice had an active carers group with two staff acting as the practice carer champions. The group met every six weeks to support and provide some respite to patients and their families. The lead GP for carers attended the meetings offering health and social care advice where necessary. The meetings were hosted at the practice and tea, coffee and cake were provided and gave carers an opportunity to hear speakers on topics that may support and advise them on issues relating to caring and the opportunity to share their experiences. Friendships had been made within the group, some of the carers continue to socialise outside of the practice. Each Christmas the practice held a Christmas party for the carers and the people they care for. The practice offered a flu clinic for carers at these meetings; carers were also signposted to other support organisations. The clinical coordinator acted as a point-of-contact should carers need to book appointments.

Staff told us that if families had suffered bereavement, their usual GP contacted them. This telephone call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. We were told that practice staff often attended funerals to support the bereaved.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and clinical commissioning group (CCG) to secure improvements to services where these were identified.

- Working in conjunction with the clinical commissioning group (CCG) they had developed a community "ophthalmology pilot" which gave patients rapid access to a trained optometrist (with support from a consultant ophthalmologist) for acute and stable chronic eye conditions.
- The practice was part of a pilot to develop a community deep vein thrombosis (DVT) treatment centre. They were contracted by the CCG and worked in partnership with a health care provider to provide treatment following a positive scan for a DVT. The practice provided community-based anticoagulation for patients supported by a GP and trained nurse who closely monitored patients' progress. Data indicated that 97% of patients who had a DVT diagnosed in the treatment centre did not require any secondary care.
- The practice hosted substance misuse services; they had a dedicated GP who had additional knowledge and skills, who worked closely with the local substance misuse service to meet patient needs with an emphasis on recovery and improving health and independence. A recent withdrawal of this type of treatment from a neighbouring practice meant that they registered an additional 22 patients on this programme and accommodated additional sessions within the practice from the substance misuse agency to meet patient need.
- The practice employed a nurse practitioner who was able to manage the needs of patients who presented with minor illnesses and minor injuries.
- There were longer appointments available for patients with a learning disability who could be supported by the clinical co-ordinator during appointments. The practice had participated in composing a DVD to inform patients what to expect during an annual health check. We saw the practice used accessible information for patients to support them making an informed decision.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that require same day consultation. The practice had two GPs with a specialist qualification in paediatric medicine which acted as a resource for internal referral.
- The practice is a specialist travel centre working in partnership with MASTA (Medical Advisory Service for Travellers Abroad). Patients were able to receive travel vaccinations available on the NHS as well as those only available privately.
- There were accessible facilities and designated parking bays for blue badge holders, with a passenger lift to the first and second floors.

Access to the service

The practice opened at times that were accessible to people who worked during the week. The practice opened a variety of times throughout the week between 7.30am to 6.30pm, and offered an evening surgery twice a week until 8pm. They offered an open access Saturday morning clinic with a GP and a nurse. This was this in addition to their contracted extended hours services. This ensured that patients could access both urgent (same-day) appointments and pre-bookable appointments.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was comparable to local and national averages.

- 73% of patients were satisfied with the practice's opening hours compared to the clinical commissioning group average of 78% and the national average of 78%.
- 47% of patients said they could get through easily to the practice by phone compared to the clinical commissioning group average of 70% and the national average of 73%.

We saw the practice had acted on this survey in order to improve outcomes for patients and had sourced a new telephone system. There was information on the waiting room wall where patients were invited to comment on what advisory recorded messages they would like to hear on the new telephone system due to be installed in October 2016.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Patients told us on the day of the inspection that they were able to get appointments when they needed them.

The practice had a system in place to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

This was carried out by telephone triage when patients first contacted the practice; the administration staff had a process of assessing each patients need and referred to the duty GP. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits. The practice used emergency care practitioners from the community healthcare services to undertake some home visits. This was initiated by the duty doctor who triaged requests for home visits.

Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns.

- Its complaint policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaint system on the website and a practice leaflet.

We looked at a selection of the 16 complaints received in the last 12 months and found these were dealt with in a timely way to achieve a satisfactory outcome for the complainant. For example, complaints were responded to by the most appropriate person in the practice and wherever possible by face to face or telephone contact. The information from the practice indicated at what stage the complaint was in its resolution. All complaints were followed through with a written response as well.

Lessons were learnt from concerns and complaints and action was taken as a result to improve the quality of care such as ongoing monitoring of the telephone system.

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

At a recent away day the team developed its mission statement, within this the practice had recorded:

"Together improving health and wellbeing with care and compassion"

The practice had a clear vision to deliver high quality care and promote good outcomes for patients.

- The practice had a mission statement which was displayed in the waiting areas and staff knew and understood the values.
- The practice had a strategy and supporting business plans which reflected the vision and values and were regularly monitored.

Governance arrangements

There was a governance framework for the delivery of the strategy and evidence of good quality care; the practice had a number of policies and procedures to govern activity. However, we found the practice relied on their established verbal communication systems and informal meetings to share and cascade information.

The overarching structures and procedures in place and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. All of the partners undertook responsibility in different areas of practice.
- Practice specific policies were implemented and were available to all staff.
- A comprehensive understanding of the performance of the practice was maintained through data searches and returns. For example, they monitored data on unplanned admissions to hospital as part of their involvement with the local clinical commissioning group (CCG).
- The practice had established communication systems and informal meetings to share and cascade information. For example, the GPs met at 8am and at noon to discuss patients and workload; however decisions and actions taken at these meetings were not recorded.
- There was a formal schedule of meetings to plan and review the running of the practice, for example, the GPs and practice manager met monthly for business planning. Some of these meetings were relatively new and were not fully embedded within the practice. There was limited availability of minutes from meetings and we found limited evidence of decision making, implementation of change and reviewing systems for effectiveness. For example, the practice policy for significant events was that each event would be discussed in detail and agreed actions documented in a significant event review or clinical meeting. We requested evidence for this but the practice was unable to provide it. Additional information was received at the factual accuracy stage in relation to the minutes from medicines management meetings.
- At our last inspection we found a programme of clinical and internal audit was used to monitor quality and to make improvements. However, at that time the practice had not ensured that actions resulting from clinical audits were reviewed to complete the audit cycle. We found the practice had prepared a new audit cycle intended to audit performance and monitor quality. We saw minor surgery was monitored for quality and had achieved a 100% no complications post-surgery rate. We read an audit for medicines which required the patient to be monitored through blood tests. Specifically an audit dated 4 August 2016 reviewed patients taking a medicine called lithium used to treat bipolar disorder. The 2016-17 quarter one data showed a compliance rate of attendance of 56% which was a reduction in compliance since the last review in 2012. We saw a second audit dated 4 August 2016 of patients prescribed methotrexate. The 2016-17 quarter one data showed a compliance rate of attendance of 65% which was a reduction in compliance since the last review in 2012. Additional information received at the factual accuracy stage showed that the audit information provided dated 4th August 2016 was incomplete and related to inaccurately obtained data from the EMIS search tool. Evidence was provided that annual audit has been performed on a range of medications since this time including amiodarone, methotrexate, lithium,

Are services well-led?

Good

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

contraception medication. Re-audit has been completed for methotrexate in 2011 and 2014 and for lithium in 2009 and 2012 using a standardised approach as the students are directed by University of Bristol guidance. The audits demonstrated benchmarking across local practices and provided evidence that the practice was providing a good service for patients.

Leadership and culture

The practice had five partners who worked full time and had worked together for a significant length of time. This meant they had established good working relationships and provided a strong leadership team for the practice. This was commented on by both patients and staff members we spoke with throughout the inspection. The partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable and always took the time to listen to them.

We observed strong leadership within the nursing team with examples of support for clinical work and professional development; monitoring and allocation of workload and delegation of tasks appropriate to level of skill. We saw the nursing team had regular, minuted meetings which promoted information sharing and team involvement.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment.

- The practice gave affected people reasonable support, truthful information and a verbal and written apology
- The practice kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure in place and staff felt supported by management.

- Staff told us the practice held regular team meetings; we saw minutes for reception staff meetings and nurse meetings but other meetings were not always minuted.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. The team had regular away days in order to review and plan the practice developments.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- The practice had gathered feedback from patients through surveys and complaints received. The patient participation group (PPG) was a virtual group who although received regular information did not always engage and respond. The practice were in discussion with various local community groups with a view to linking with them to develop patient feedback. The carers group who met monthly at the practice also gave feedback when asked. We saw in the waiting room a 'You Said…We Did' display with several items highlighted by patients which had been actioned such as telephone access.
- The practice had gathered feedback from staff through staff meetings, appraisals and discussion. 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 to improve how the practice was run.
- The practice had a suggestion box and ran the family and friends test.
- The practice updated patients with a regular newsletter and a news section on the website.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice

Are services well-led?

Good

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

team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. The practice had successfully applied with their cluster practices for the funding of a dementia specialist nurse to be shared for patients within the cluster group.

- Medical students were regularly attached to the practice.
- Using the NHS 'Productive General Practice' Improving Quality initiative (designed to help general practice continue to deliver high quality care whilst meeting increasing levels of demand and diverse expectations) the practice had reviewed their staffing establishment and had employed a wide range of health care professionals to meet demands for services this included a nurse practitioner, a clinical pharmacist and were advertising for a primary care paramedic to provide an acute illness home visiting service available throughout the day.
- Additional information received at the factual accuracy stage indicated the practice had been compliant with ISO 9001:2008 for a number of years and had recently had this renewed after assessment. Reports from 2016 and 2015 were submitted as evidence to support good management and continuous improvement.
- In conjunction with the clinical commissioning group (CCG), one GP had developed the first national waiting times application tool on the web that their offered patients up-to-date feedback on when they could expect to be seen by various service providers in the local area for secondary care.
- The practice participated in the One Care Consortium (an integrated approach to the delivery of primary care across GP practices in Bristol, North Somerset and South Gloucestershire) and were involved with programmes such as the rapid physiotherapy assessment. Patients with new presentations of problems with their muscles, joints or spine were offered a same-day telephone assessment from a physiotherapist.
- Additional information received at the factual accuracy stage the practice provided evidence that they had been successful in receiving NHS funding for in-house clinical pharmacist support. The pharmacist will specifically focus on the auditing and monitoring of disease modifying drugs at the practice.