The Old School Surgery

Inspection report

Manor Road
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Bristol
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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 location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Outstanding

Overall summary

This practice is rated as Good overall. The well led domain was rated as outstanding.(Previous inspection December 2014 - Good)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? - Outstanding

We carried out an announced comprehensive inspection at The Old School Surgery on 10 May 2018 as part of our inspection programme.

At this inspection we found:

- The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes. However, arrangements for medicines management did not always ensure the security of blank prescription stationery.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence-based guidelines.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Patients found the appointment system easy to use and reported that they were able to access care when they needed it.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.

We rated well-led as outstanding because:

- We saw evidence of effective leadership with a strong focus on innovation and improvement. For example, improvements to the services delivered to patients diagnosed with dementia, a true engagement of patients and staff to seek contributions and feedback to make improvements.
- The practice took a leadership role in its local health system to identify and proactively address challenges and meet the needs of the population. For example, taking a lead within the local transformation programme to improve access to patients and integrate care and improving student healthcare locally and nationally.

We saw some areas of outstanding practice:

- The practice was using innovative and proactive methods to improve patient outcomes, with services tailored to the needs of students including a dedicated mental health nurse employed by the practice; sexual health services for young people and through the Catheter Care pathway.
- A dedicated nursing team supported frail and older patients, including through urgent and routine home visits; management of long-term conditions; and care for patients with a diagnosis of dementia and their carers.
- The practice had continued to develop its practice based, prescribing clinical pharmacist role; and close working with the attached pharmacy, to enhance patient care. Both schemes had won national recognition from NHS England as case studies for innovation in primary care.

The areas where the provider **should** make improvements:

- Review and implement arrangements for the security of blank prescription stationery.
- Continue to monitor and improve the uptake of cervical screening, childhood immunisations and lower exception reporting for long term conditions and improve patient outcomes.

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

Population group ratings

Older people	Good
People with long-term conditions	Good
Families, children and young people	Good
Working age people (including those recently retired and students)	Good
People whose circumstances may make them vulnerable	Good
People experiencing poor mental health (including people with dementia)	Good

Our inspection team

Our inspection was carried out by a CQC lead inspector and a GP specialist adviser.

Background to The Old School Surgery

The Old School Surgery is registered with the CQC as the provider of regulated activities, carried out from the registered location at Manor Road, Fishponds, Bristol, BS16 2JD. Website: and also from a branch surgery within the campus of the University of the West of England (UWE) at:

The Health Centre, 23 Carroll Court, Frenchay Campus, Coldharbour Lane, Bristol BS16 1QY website: www1.uwe.ac.uk/students/healthandwellbeing/universityhealthcentre

We visited both the location and branch sites during the inspection.

The practice supports approximately 19,700 patients within Fishponds and the surrounding areas in the inner city east area of Bristol. Over 50% of patients are students and there is significant change to the registered patient list each year. For example, over 5,000 new patients, mostly students, were registered with the practice in the last year. This means the practice has a significantly higher than average patient population aged 15 to 44 years; and lower than average patient populations aged under 18 years or over 65 years old. Approximately 19% of patients are from black and minority ethnic (BME) groups. The practice catchment area scores in the fifth decile of the general Index of Multiple Deprivation (IMD). The most deprived score is the first decile and the least deprived score is the tenth decile. (An area itself is not deprived: it is the circumstances and lifestyles of the people living there that affect its deprivation score. Not everyone living in a deprived area is deprived and that not all deprived people live in deprived areas).

The provider is registered to carry out the following regulated activities:

Diagnostic and screening procedures

Family planning services

Surgical procedures and

Treatment of disease, disorder or injury.

There are six partners (three female GPs, two male GPs and a clinical pharmacist) and eight salaried GPs (seven female and one male). The GPs work alongside a clinical team including nurse practitioners, practice nurses, a mental health nurse, clinical pharmacists and health care assistants. Two of the nurse practitioners and one practice nurse form a frail and elderly nursing team supporting older patients. The clinicians are supported by practice management, reception and business support staff. The practice has been a registered GP teaching practice since April 2013, with two qualified GP trainers; and they also provide training for students at

UWE. A range of other services are hosted by the practice including: hearing aid clinics, substance misuse and alcohol services, carer's clinics, Age Concern and Marie Curie.

The practice has a General Medical Service contract with NHS England. The practice does not provide out of hour's services to its patients. This is provided via NHS 111 by BrisDoc when the practice is closed. Contact information is available in the practice and on the website.

Good

Are services safe?

We rated the practice as good for providing safe services.

Safety systems and processes

The practice had clear systems to keep people safe and safeguarded from abuse.

- The practice had appropriate systems to safeguard children and vulnerable adults from abuse. All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Reports and learning from safeguarding incidents were available to staff. Staff who acted as chaperones were trained for their role and had received a 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.)
- Clinicians had an application on their IT equipment/ telephones which linked directly to the local safeguarding reporting processes.
- A comprehensive library of safeguarding information had been developed which was available to all staff on the practice's intranet, including information on local safeguarding protocols, guidance on female genital mutilation, domestic violence and the Prevent programme.
- They were participants in the local Identification and Referral to Improve Safety (IRIS) domestic violence scheme. All staff had undertaken training for the scheme.
- Staff took steps, including working with other agencies, to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The practice carried out appropriate staff checks at the time of recruitment and on an ongoing basis.
- There was a thorough and an effective system to manage infection prevention and control (IPC). The practice IPC lead shared best practice and provided training to staff in other local practices.
- The practice had arrangements to ensure that facilities and equipment were safe and in good working order. However, we found that arrangements for fire drills and some electrical safety records were fully not up to date.
- Arrangements for managing waste and clinical specimens kept people safe.

Risks to patients

There were adequate systems to assess, monitor and manage risks to patient safety.

- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness, busy periods and epidemics.
- There was an effective induction system for temporary staff tailored to their role.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections including sepsis. We saw an information card available for patients regarding symptoms of sepsis and meningitis.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- The care records we saw showed that information needed to deliver safe care and treatment was available to staff. There was a documented approach to managing test results.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made timely referrals in line with protocols.

Appropriate and safe use of medicines

The practice had reliable systems for appropriate and safe handling of medicines. However, we found that arrangements for medicines management did not ensure the security of blank prescription stationery.

- The systems for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment, minimised risks.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with

current national guidance. The practice had reviewed its antibiotic prescribing and taken action to support good antimicrobial stewardship in line with local and national guidance.
- Patients' health was monitored in relation to the use of medicines and followed up on appropriately. Patients were involved in regular reviews of their medicines.
- Arrangements had not been implemented to record serial numbers of blank forms issued to clinicians, and there was no system to audit stocks of blank forms. We spoke to the practice who, within 48 hours of the inspection, provided evidence that improved security arrangements had been implemented.

Track record on safety

The practice had a good track record on safety.

- There were comprehensive risk assessments in relation to safety issues.
- The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture of safety that led to safety improvements.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice.
- The practice acted on and learned from external safety events as well as patient and medicine safety alerts.

Please refer to the Evidence Tables for further information.

Good

Are services effective?

We rated the practice and all of the population groups as good for providing effective services overall.

(Please note: Any Quality Outcomes (QOF) data relates to 2016/17. QOF is a system intended to improve the quality of general practice and reward good practice).

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- The provider had won an innovation bid for funds from the Prime Minsters Challenge Fund and had used the money to purchase a health promotion and monitoring equipment. It had been used by patients to monitor their blood pressure/weight/Body Mass Index.The results from the measurement were entered directly onto the patient record and an alert sent to their GP if measurements were outside of expected parameters.
- The practice had established, through close working with the on-site pharmacy, a medicines optimisation service that had won national recognition for innovation in primary care in 2016. Approximately 400 vulnerable patients with long term conditions were supported with monthly medicine reviews to ensure compliance and medicine optimisation. The pro-active patient contact and referrals had improved the safe use of medicines and reduced wastage.
- We saw evidence of comprehensive and effective arrangements for the management of patients prescribed high risk medicines.
- We saw that improvements to patient care within the practice had resulted from the lead contribution to the development of clinical pharmacist schemes both locally and nationally.
- Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.
- All new patients were encouraged to use the 'healthy promotions' area as part of the registration process and recorded their data on their new patient health questionnaire.

Older people:

- A dedicated nursing team was employed for frail and elderly patients. This comprised two nurse practitioners and a practice nurse who supported patients in the community, including urgent and pro-active home visits; and management of long-term conditions.
- Continuity of care was provided to patients living in Nursing or Care homes through weekly ward rounds by a dedicated clinician. Improved care was identified by monthly meetings with the practices clinicians and the care home managers and staff.
- Patients received a full assessment of their physical, mental and social needs. The practice used an appropriate tool to identify patients aged 65 and over who were living with moderate or severe frailty. Those identified as being frail had a clinical review including a review of medication. We saw positive feedback received from local care and nursing homes where patients were supported by the practice.
- Treatment Escalation Plans had been developed and used for patients in care and nursing homes. This document was more concise than admission avoidance plans and the initiative was being rolled out across the locality.
- Patients aged over 75 were invited for a health check. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and medicines were updated to reflect any extra or changed needs.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.

People with long-term conditions:

- We found that each disease group was led by a GP partner and other staff with specialist interest and additional training. This meant that the patients had access to specialist knowledge for their treatment.
- Vulnerable patients with long-term conditions were supported through a specific medicines optimisation scheme. Patients in nursing homes received medication reviews at least every six months.
- Patients with long-term conditions had a structured annual review to check their health and medicines

needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care. We saw that all the practice nurses were multi-skilled and trained to support patients with all long-term conditions.

- Staff who were responsible for reviews of patients with long term conditions had received specific training. For example, patients with long term conditions who are discharged from hospital had their discharge summaries reviewed by a clinical pharmacist. This included reviews of medicines and arrangements for appropriate care, to minimise further admissions.
- The practice demonstrated how they applied learning from involvement in projects such as the 'HG Wells pilot' aimed at delivering improvements in the management and treatment of diabetes. Identification of patients not on optimal therapy had a positive impact on the HBA1c (average blood glucose level) BP and cholesterol level for patients. The learning from this had been developed into a service wide strategy. The Practices results were positive with a 65% increase in the number of patients achieving a HbA1C at or below the NICE target of 58 mmol/mol, just over a 6% increase in patients reaching BP target of 140/80 and a 10% increase in patients achieving total cholesterol less than 4 mmol/l and LDL cholesterol less than 2 mmol/l.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice had arrangements for adults with newly diagnosed cardiovascular disease including the offer of high-intensity statins for secondary prevention, people with suspected hypertension were offered ambulatory blood pressure monitoring and patients with atrial fibrillation were assessed for stroke risk and treated as appropriate.
- The practice was able to demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.

Families, children and young people:

- The practice added an alert on the patient record system to remind clinicians to refer patients who meet the criteria to the National Diabetes Prevention Programme education course and had referred 32 patients since November 2017. This evidence was submitted by the practice after the inspection and we have been unable to verify the impact for the 32 patients.
- Childhood immunisations were carried out in line with the national childhood vaccination programme. The target percentage for immunisations of 90% or above was not met in three of the four indicators in 2016/17. However, the patient demographic at the practice had a lower than average number of children under the age of two and vaccinated the majority of these patients. See the evidence table for full details of percentages.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation. For example, we saw that regular meetings and liaison took place with health visitors and any safeguarding concerns were highlighted and discussed.

Working age people (including those recently retired and students):

- The practice had responded to higher than average rates of mental health diagnoses in the Bristol area with additional specific support services including a dedicated mental health nurse; and close working with the local universities counselling scheme.
- Services were tailored to meet the needs of the large proportion of patients who were students. For example, the needs of students were identified though annual surveys; a holistic registration event provided early access to support services; and the practice addressed priority needs relating to mental health and sexual health.
- The practice's uptake for cervical screening was 64%, which was comparable with local and national averages but below the 80% coverage target for the national screening programme. However, the patient population demographic had a lower than the average proportion of female patients in the age group eligible for cervical screening. We saw that the practice had in place arrangements to follow up patients with letters and phone calls to encourage participation in screening programmes.

Good

Are services effective?

- The practices' uptake for breast and bowel cancer screening was in line the national average.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time. We saw information on the meningitis (MenACWY) vaccinations included in the information for students.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

- Comprehensive support was provided to patients who were misusers of drugs, including hosting the Bristol Drug Projects for three sessions each week.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. The practice involved patients' families, carers and palliative care nurses to arrange the most appropriate support and care.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. Older and vulnerable housebound patients were supported by a dedicated nursing team.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice allocated a lead GP / Nurse Practitioner who supported each care home for people with complex learning disabilities.

People experiencing poor mental health (including people with dementia):

- The practice had employed a mental health nurse since 2016, full time since 2017, who provided eight clinical sessions each week, three based at the university health centre. We saw evidence that this had avoided approximately 1,650 face to face GP appointments and 2,100 GP telephone call each year.
- Longer appointments were offered to patients suffering from a mental health issue; and where appropriate, appointments were arranged in partnership with other health and social care professionals.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services. There was a system for following up patients who failed to attend for administration of long term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- 89% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This is comparable to the national average.
- 91% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This is comparable to the national average.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia and offered additional support or signposting when required.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- The practice offered annual health checks to patients with a learning disability.

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. For example, we saw improvements had resulted from clinical audits of contraceptive implants; and antibiotic prescribing. Where appropriate, clinicians took part in local and national improvement initiatives. For example, the clinical pharmacist and practice manager played key roles in the development of the NHS England clinical pharmacists pilot in 2016. The project was subsequently rolled out across England. The practice recruited other practices locally resulting in six clinical pharmacists appointed to nine other local practices. The practice also secured second phase funding to recruit three pharmacists for another three local practices.

Good

Are services effective?

- Quality and Outcomes Framework (QOF) results, including exception reporting, were in line with local and national averages. For several indicators, exception reporting rates were below the clinical commissioning group (CCG) averages.
- The practice used information about care and treatment to make improvements.
- The practice was actively involved in quality improvement activity. Where appropriate, clinicians took part in local and national improvement initiatives.
- The practice utilised the QOF prevalence toolkit designed by members of the practice, through the Prime Minsters Challenge Fund to identify wrongly coded patients for disease management. This ensured patients with long term conditions were correctly identified and received appropriate care and treatment.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

- Staff had appropriate knowledge for their role, for example, to carry out reviews for people with long term conditions, older people and people requiring contraceptive reviews.
- Staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.
- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. The induction process for health care assistants included the requirements of the Care Certificate. The practice ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing.
- CQC staff survey forms provided positive feedback. For example, staff reported they enjoyed good teamwork, good communication and felt supported to develop.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.
- Staff, teams and services were committed to working collaboratively and had found innovative and efficient ways to deliver more joined-up care. For example, the workflow coordinator reviewed discharge summaries for patients so that any identified actions needed were taken.'

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- Staff, teams and services were committed to working collaboratively and had found innovative and efficient ways to deliver more joined-up care. For example, the workflow coordinator reviewed discharge summaries for patients so that any identified actions needed were taken.
- The practice used tele dermatology which meant there was a quicker diagnosis and reduction for the need to refer to secondary care.
- We saw that other healthcare professionals and other community or charity organisations were invited to relevant clinical and educational meetings by the practice.
- The clinical pharmacist partner played a key role in the clinical commissioning group (CCG) relating to medicines optimisation.
- Regular liaison was carried out with the University of the West of England. For example, meetings were held with the Head of Student Services, the Healthy University Group; and University Health Board.
- During 2017/18 the practice offered 'winter pressure' priority appointments for patients aged 75 years or over, so these patients, who were potentially vulnerable or at risk of hospital admission, were seen more quickly to reduce potential pressure on hospitals.
- We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for people with long term conditions and when coordinating healthcare for care home residents. The shared information with, and liaised, with community

services, social services and carers for housebound patients and with health visitors and community services for children who have relocated into the local area. A dedicated nursing team was in place to support older and vulnerable patients in the community.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice had worked with patients to developed Treatment Escalation Plans for patients in care and nursing homes and these were shared with relevant agencies. These documents were more concise than typical admission avoidance plans and the initiative was being rolled out across the locality.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

- Staff were consistent in supporting people to live healthier lives, including identifying those who need extra support, through a targeted and proactive approach to health promotion and prevention of Ill-health.
- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers. Staff encouraged and supported patients to be involved in monitoring and managing their own health, for example through social prescribing schemes.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately.

Please refer to the Evidence Tables for further information.

Good

Are services caring?

We rated the practice as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from patients was positive about the way staff treat people.
- In the most recent GP patient survey (published July 2017) the practice received higher patient satisfaction scores for every indicator when compared to local and national averages. For example, 100% of patients reported having confidence and trust in the GPs; and 96% said the GP was good or very good at treating them with care and concern.
- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- Practice coordinators managed the handover and interface between primary (GPs) and secondary care (accident and emergency and local hospitals). This meant that patients being discharged from hospital were contacted to ensure support services had been arranged and the practice was able to resolve issues relating to discharge or admission. The care coordinator also arranged any follow up appointments or tests.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment. They were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information that they are given.)

- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment. For example, patient satisfaction scores were higher than average for GPs being good at explaining tests and treatments.
- The practice proactively identified carers, including during flu clinics, and supported them.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. The practice involved patients' families, carers and palliative care nurses to arrange the most appropriate support and care. Monthly palliative care meetings were held with multidisciplinary teams.

Privacy and dignity

The practice respected patients' privacy and dignity.

- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs. For example, we saw that both surgery site waiting areas had been modified to improve confidentiality.
- Staff recognised the importance of people's dignity and respect. They challenged behaviour that fell short of this.

Please refer to the Evidence Tables for further information.

Good

Are services responsive to people's needs?

We rated the practice, and all of the population groups, as good for providing responsive services.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs. For example, services for students were tailored to meet identified needs.
- Telephone and web GP consultations were available which supported patients who were unable to attend the practice during normal working hours.
- The Practice had invested in additional telephony technology and IT to aid and reduce waiting times on the phone for patients.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services.
- The practice provided effective care coordination for patients who are more vulnerable or who have complex needs. They supported them to access services both within and outside the practice. For example, the practice worked in collaboration with the on-site pharmacy to provide regular pro-active reviews and support to vulnerable patients with long term conditions.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.
- The practice utilised social media and used their practice information boards and TV to update patients regarding health campaigns and changes to the service. They also had access to an online library of materials to support patients with lifestyle choices and medical conditions.
- The practice hosted a range of services on their premises for patients to access. These included hearing aid clinics, substance misuse and alcohol services, carers clinics and clinics for voluntary support services.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme. For example, patients in nursing and residential homes could access clinicians via a dedicated phone line; and received weekly visits from a GP or nurse practitioner.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GP and practice nurse also accommodated home visits for those who had difficulties getting to the practice due to limited local public transport availability.
- A dedicated team supported frail and older patients. For example, a practice nurse provided home visits to help to manage patients with long term conditions.
- Nurse practitioners also provided urgent and routine visits for housebound patients.
- The practice worked with care and nursing homes so that they had access to patient's electronic records whilst on-site which meant records were completed contemporaneously.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- Patients with a long-term condition who were identified as vulnerable benefitted from monthly medicines reviews and support provided in collaboration with the on-site pharmacy.
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.

Families, children and young people:

- The patient population had a smaller than average number of children. However, we saw that a policy was in place giving priority for appointments for children under 6 years old. Same day face to face or phone appointments were available for children under 2 years old; and children aged 3 to 5 years old were offered a triage appointment.
- We found there were systems 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 accident and emergency (A&E) attendances. Records we looked at confirmed this and meetings were held every six weeks with health visitors to discuss any children at risk.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.

Working age people (including those recently retired and students):

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, extended opening hours in evenings and early mornings, Saturday appointments and phone appointments at convenient times to support continuity of care.
- We saw that the Times newspaper had shortlisted the practice for a 2018 award relating to outstanding services for patients who were University of the West of England (UWE) students.
- We saw evidence of regular health campaigns including through social media and a mobile phone app. For example, campaigns covered mental health, wellbeing; and sexual health.
- Healthwatch Bristol had published an impact report (March 2018) on UWE students' experiences of access to contraceptive services. Respondents praised the practice's university health centre site for ease of access to appointments by phone; and friendly and welcoming practice staff.
- The practice started and piloted Health and Social Care videos back in June 2017.Some of the practice clinicians wrote some of the scripts and starred in the videos, which were given as a link to patients to give them tips and advice and support to help them manage their condition. These videos shared with working age patients who were not easily able to attend the practice for advice. Patients could utilise the videos to help them understand their condition or how to use medical equipment.
- The practice and associated organisation are rolling the usage of these video's out to the Bristol locality. The practice has supported the development of communications and ways of utilising the use of the videos to help other locality practices.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode
- Practice staff had a good knowledge of vulnerable patients and were pro-active in responding to any concerns. For example, flags on the patient records system alerted staff and where necessary appropriate interventions were arranged including appointments made in partnership with other health and social care professionals; access to specialist services such as for domestic abuse, sexual health or social care.
- The practice hosted three sessions each week for the Bristol Drug Project to support patients with drug misuse issues.

People experiencing poor mental health (including people with dementia):

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia. For example, some staff act as dementia friends; and a dedicated full time mental health nurse was employed by the practice.
- The practice held GP led dedicated monthly mental health and dementia clinics. Patients who failed to attend were proactively followed up by a phone call from a GP.
- Social media was utilised to promote local health initiatives. For example, Meningitis promotions recorded 2711 interactions with patients and the mental health drop in appointments promotion recorded 2454 interactions. This increased awareness of the service and the support available.

Timely access to care and treatment

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- The latest national GP patient survey (July 2017) showed the practice scored higher than their clinical commissioning group (CCG) average in every question. For example, 93% of patients said they were able to get an appointment the last time they wanted to see or speak to a GP or nurse, compared with the CCG average of 78% and the national average of 76%.

Good

Are services responsive to people's needs?

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- Patients reported that the appointment system was easy to use.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care through a dedicated complaints lead.

- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. The practice learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care.
- The practice had a lead role for dealing specifically with complaints. The shared intranet was used to log/ track and share learning of complaints and each complaint has individual learning points and actions identified. The practice held a quarterly complaints review meeting.

Please refer to the Evidence Tables for further information.

Outstanding ☆

Are services well-led?

We rated the practice as outstanding for providing a well-led service.

The leadership, governance and culture are used to drive and improve the delivery of high quality patient care. A systematic approach was used to work with other local health and social care organisations to improve the care and outcomes across the local population. Leaders had a shared purpose of encouraging continuous improvement and innovation, seeking feedback from patients and staff to make improvements.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them. There was a clear focus on innovation and improvement. For example, this was demonstrated through services tailored to meet identified needs, especially addressing mental and sexual health; clinical audits; medicines management; practice away days focused on improvement; and responding to patient feedback.
- Leaders at all levels were visible and approachable, they had a shared purpose and worked hard to motivate staff to succeed. The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice. For example, we saw that succession planning of partners had been effectively planned and managed.
- The practice takes a leadership role in the local health system to identify and proactively address challenges and meet the needs of the population.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality, sustainable care.

- There was a clear mission statement and set of values in the form of 'cornerstone' statements. The practice had a realistic strategy and supporting business plans to achieve priorities. The practice developed its vision, values and strategy jointly with patients, staff and external partners.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them. There was strong collaboration with all staff groups on improving the quality of care and the patient experience
- The strategy was in line with health and social priorities across the region. The practice planned its services to meet the needs of the practice population.
- The practice monitored progress against delivery of the strategy.

Culture

The practice had a culture of high-quality sustainable care.

- Staff stated they felt respected, supported and valued. There was high levels of satisfaction and they were proud to work in the practice. We saw comprehensive opportunities to engage with the whole staff team. This was confirmed in independent staff surveys and when we spoke to staff during the inspection.
- The practice focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- The practice ran a mentoring scheme for salaried GPs who were aligned with experienced GP partners for support and training.
- The leadership of the service had an inspiring shared purpose, and worked hard to deliver and motivate staff to succeed. For example, three members of the team in the last twelve months had been mentored and supported through the prescribing qualification.
- All staff were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work.

Outstanding ☆

Are services well-led?

- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams. For example, daily meetings of staff involving different teams were held and staff told us that communication had improved as a result. The practice also held ongoing meetings with multi-disciplinary colleagues from external health and social care services in addition to weekly clinical meetings.
- The practice used innovative and proactive methods to improve patient outcomes, working with other local providers to share best service. For example, the service had worked in partnership with an associated company to develop integrated IT systems across the service. This included participating in the following pilots: Health and Social Care Videos – increased advice and support for patients; Electronic Prescription Service; Home visiting team for frail and elderly patients and Clinical Pharmacists in General Practice. The Old School Surgery was the first practice to have a clinical pharmacist role in England and led and supported eight other local practices to appoint a pharmacist.
- The practice has worked on and contributed to many projects to improve patients care in the locality.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control (IPC). Two IPC lead nurses were trained in the lead role and had provided training to all staff. We saw plans in place to provide IPC training to other practice nurses in the locality.
- Practice leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety. For example, the practice had employed a mental health nurse and we saw evidence of effective support and intervention to reduce risks to patients.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Practice leaders had oversight of national and local safety alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.
- The practice had plans in place and had trained staff for major incidents.
- The practice implemented service developments and where efficiency changes were made this was with input from both clinicians and non-clinical staff to understand their impact on the quality of care.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients. We saw a wide range of methods used to obtain feedback and performance data; and this was used to identify improvements and ensure services met identified needs.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The practice used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.

Outstanding ☆

Are services well-led?

- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice actively involved patients, the public, staff and external partners to support high-quality sustainable services. This included engagement approaches to ensure representation from patient groups who do not readily provide feedback.

- Innovation and improvement was being led by the governance team. For example, one GP partner is chair of the Locality Transformation Board, working to develop an integrated care system and develop a locality improved access plan. The practice had led the roll out of the NHS England pilot schemes to employ clinical pharmacists in local practices.
- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. There were active patient participation groups for both student and non-student patients.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

- The practice took a leadership role in its local health system to identify and proactively address challenges and meet the needs of the population. There was a strong focus on continuous learning and improvement.
- Staff knew about improvement methods and had the skills to use them.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.

Please refer to the Evidence Tables for further information.