Pilning Surgery

Quality Report

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Date of inspection visit: 7 May 2015
Date of publication: 06/08/2015

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Pilning Surgery (Montpelier Health) on Thursday 7 May 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, well-led, effective, caring and responsive services. It was also good for providing services for the care of older patients, those with long term conditions, families, children and young patients. In addition it was good at providing services for working age patients, including those recently retired and students, patients whose circumstances make them vulnerable and patients experiencing poor mental health including, patients with dementia.

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed, with the exception of those relating to recruitment checks.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

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

The provider should:

Summary of findings

- Ensure two written references are obtained when recruiting new staff to be satisfied they are suitable for employment.
- Provide staff with training in the Mental Capacity Act 2005 so they are fully aware of their responsibilities when patients lack the ability to give informed consent.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

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

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for staff. Staff worked with multi-disciplinary teams.

Are services caring?

Good

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

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Summary of findings

Are services well-led?

Good

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

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. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

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

Families, children and young people

Good

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

Working age people (including those recently retired and students)

Good

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

Summary of findings

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including patients from the travelling community and those with a learning disability. It had carried out annual health checks and offered longer appointments for people with a learning disability. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. 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.

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). People experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia. The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. Some staff had received training on how to care for people with mental health needs and dementia however, staff had not received training in relation to the Mental Capacity Act 2005.

Summary of findings

What people who use the service say

Patients we spoke with told us they were happy with the services provided at the Pilning Surgery. They said the staff treated them with respect and maintained confidentiality. GPs involved them in decisions about their care and treatment and they felt involved.

Patients who had been referred to secondary healthcare said the process had run smoothly and there was good communication between the practice and other services. Some of the patients told us they had been able to get a same day appointment and a parent told us the practice always provided a good response for their children.

Reception staff were referred to as polite and friendly and patients complimented them on the help they gave.

We sent comments cards in advance of our inspection and two were completed. Both patients were complimentary about the service they received. We looked at the NHS Choices website and there were no comments posted.

Areas for improvement

Action the service SHOULD take to improve

Ensure two written references are obtained when recruiting new staff to be satisfied they are suitable for employment.

Provide staff with training in the Mental Capacity Act 2005 so they are fully aware of their responsibilities when patients lack the ability to give informed consent.

Pilning Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Pilning Surgery

Pilning Surgery is one of the services provided by Montpelier Health. Its other services are at Montpelier Health Centre and the branch surgery at the adjacent Bath Buildings Surgery in Bristol. Montpelier Health commenced working collaboratively with Pilning Surgery in 2012 with the full merger taking place in 2014.

Montpelier Health Centre and the branch surgery were inspected in December 2014 and a report is available on our website.

Montpelier Health is a partnership of five GPs who employ a Practice Business Manager to oversee the strategic and business direction of the Partnership. This also includes the financial viability, practice development, strategic planning and overview of the day to day running of the business to ensure that all systems are in place to enable the delivery of care. There is also an operations manager who oversees the day to day operation of all its practices. The Pilning Surgery has a surgery manager who is responsible for the day to day management of the surgery. Montpelier Health also employs two GPs.

Pilning Surgery delivers a PMS contract to over 4,400 patients in the village of Pilning and surrounding areas. It was purpose built in 1995 and extended in 2010/2011 when a pharmacy (independent from the practice) was added during the refurbishment.

All patient areas are on the ground floor with level access throughout. The doors to the practice are electronically operated and open automatically to enable easy access. The practice administration team occupy first floor rooms.

There are four female and three male GPs and a clinical pharmacist (male) is employed to monitor prescribing. Two nurse managers are responsible for the provision of nursing services and there are three practice nurses and a healthcare assistant. In addition there are six reception/ administrative staff.

Pilning Surgery is open between 8.30 am and 6.30 pm on Monday Tuesday and Friday. It is open from 7.30 am until 6.30 pm on Wednesday and 7.30 am until 5.00 pm on Thursday. The surgery is closed at lunchtime from 1 pm until 2.30 pm most days however on Thursday it re-opens at 2.00 pm. Appointments are from 8.30 am to 6.30 pm daily. Extended hours surgeries are offered for pre-bookable appointments on Wednesday and Thursday mornings. The practice offers walk in, same day patient appointments between 8.30 am and 10.30 am each day.

The practice contract it's Out Of Hours GP service with BrisDoc for when it is closed. Patients can access this service through NHS 111.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was

planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We met with the South Gloucestershire Clinical Commissioning Group (CCG), NHS England area team and local Healthwatch. They had no concerns about Pilning Surgery. We carried out an announced visit on 7 May 2015. During our visit we spoke with a range of staff including GPs; the business, operations and surgery manager; nurses and administrative staff. We spoke with six patients who used the service. We observed how people were being cared for and talked with family members and reviewed records. We reviewed two comment cards where patients 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 are provided for specific groups of people and what good care looks like for them. The population groups are:

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

Good

Are services safe?

Our findings

Safe track record

The practice prioritised safety and used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, We saw there was an incident when blood test results were entered in the wrong patient record where two patients had the same name. As a result of discussing the incident it was agreed the patients date of birth and address would be verified along with their name before entries were made in patient records.

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

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of eight significant events that had occurred during the last 18 months and saw this system was followed appropriately. Significant events were a standing item on the practice meeting agenda and a dedicated meeting was held two monthly to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms and sent completed forms to the operations manager. A member of staff showed us the system used to manage and monitor incidents. We tracked eight incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result and that the learning had been shared. For example, when three patients' blood test results books went missing and were found to be held by a patient who had accidentally picked them up with their own without realising and later returned them to the surgery. The patients who had been affected were given an apology and informed of the actions taken to prevent the same thing happening again. The surgery manager told us they would look at the way other services handled the results of these tests and take action to improve the system.

National patient safety alerts were disseminated by the surgery manager to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at GPs or staff meetings to ensure staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details for reporting concerns in South Gloucestershire were easily accessible.

The practice had appointed dedicated partner GP's as leads in safeguarding vulnerable adults and children. The partner with lead responsibility for child safeguarding had been trained to level three as required. They could demonstrate they had the necessary competency and training to enable them to fulfil these roles. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments for example, children subject to child protection plans. There was active engagement in local safeguarding procedures and effective working with other relevant organisations including health visitors and the local authority.

Good

Are services safe?

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms and on the practice web site. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). Nursing staff acted as chaperone. One of the reception staff had undertaken training and would act as a chaperone if nursing staff were not available. Another of the reception staff told us they were planning to complete the training.

Attendance at the Accident and Emergency (A&E) was monitored and reviewed regularly for all patients. Any patients with high prevalence at A&E were added to the 'at risk' register to ensure they received regular reviews at the monthly safeguarding meetings.

If the practice was aware that a patient was at risk of domestic violence this was flagged on the electronic record system, to ensure all staff were aware and could offer support if necessary. The practice had an identified lead GP for domestic abuse. Practice staff had attended training in relation to domestic violence as part of participation in the IRIS scheme (Identification and Referral to Improve Safety for women

Medicines management

The practice employed a clinical pharmacist who was based at Montpelier Health Centre and reviewed medicines prescribing at Pilning Surgery. We saw an audit of prescribing carried out on 1 January 2014 with a re-audit as at 31 March 2015. It showed the actions taken and recorded outcomes for patients. We saw patient group directions (PGD) and patient specific directions were in place and observed. Patient group directions enabled nurses to administer vaccines for groups of patients and individuals. The health care assistant administered vaccines and other medicines using patient specific directions (PSDs) that had been produced by the prescriber. We saw up to date copies of these in the treatment rooms The practice nurse was able to prescribe certain medicines as they had completed enhanced training in this area.

We looked at the storage of medicines used for immunisations. They were stored in fridges and the temperatures of the fridges were checked and recorded to show the medicines were stored at the correct temperature and were safe to use.

Other medicines for use by the GPs were stored centrally in the treatment room. On the day of our visit there was some confusion about who held the key to the store and staff subsequently found out it was held by the practice nurse. GPs told us they carried certain medicines in their bags and replenished stocks themselves. During our visit it became apparent there was no access to these medicines between 4 pm and 6.30 pm on Thursday afternoons, when the nurse finished work early and unless the cupboard was left open. We spoke to the practice manager about this risk who told us they would address this by ensuring all GPs knew where the key was so the cupboard could be locked.

The practice had clear systems in place to monitor the prescribing of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse). They carried out regular audits of the prescribing of controlled drugs. We saw the protocol for prescribing controlled medicines was up to date.

We saw staff received training to enable them to prepare repeat prescriptions. All prescriptions were reviewed and signed by a GP before they were given to the patient. Repeat prescriptions could be ordered by telephone, by using the counterfoil from the last prescription or on line. The practice leaflet outlined how repeat prescriptions would be available within 72 hours. We saw there was a posting box in reception for people to request repeat prescriptions.

Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. We were told blank prescriptions were left in printers overnight and that consulting rooms were locked. However, consulting rooms were not secure at all times and this presented a risk to the security of blank prescriptions. When we brought this to the attention of the operations and surgery managers they took action to remedy this by researching suitable security arrangements and made temporary arrangements to minimise risk.

We saw a positive culture in the practice for reporting and learning from medicines incidents and errors. Incidents were logged efficiently and then reviewed promptly. This helped make sure appropriate actions were taken to minimise the chance of similar errors occurring again.

Good

Are services safe?

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a contract with an external cleaning company and cleaning arrangements were audited. The last audit was carried out in April 2015 and identified actions for the company's staff to complete.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff demonstrated how they used these to comply with the practice's infection control policy. There was also a policy for needle stick injury and staff knew and described the procedure to follow in the event of an injury.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. There was a risk assessment in relation to infection control and we saw evidence that the lead had carried out an audit of infection control arrangements in November 2014 and identified actions. They re-audited the practice in February 2015 to check improvements identified for action had been completed on time. The surgery met all the required actions. Minutes of practice meetings showed aspects of infection control arrangements were discussed.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. We saw sanitising hand gel in the reception area which invited patients and other visitors to participate in the practice commitment to good hand hygiene.

We saw there was a risk assessment in respect of clinical waste management. The practice had a contract with a collection company and we were shown collection slips to show this happened regularly.

The practice had undertaken a risk assessment for legionella (a bacterium which can contaminate water systems in buildings). It had decided that testing was necessary and we saw evidence that this was being arranged.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment took place on 16 February 2015 and evidence of completion in the form of an email dated 26 February 2015. This included spirometers and blood pressure measuring devices.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. It outlined how recruiting and selecting the right people to work in the practice was essential for the continued success of the organisation. We saw the policy was reviewed in November 2014 and was up to date. Records we looked at contained evidence that appropriate recruitment checks had been undertaken. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (These 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). We saw in some cases that although references had been requested they had not been received.

We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. Some staff worked at Pilning Surgery and at Montpelier Health Centre. Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the

Good

Are services safe?

building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see; included in the staff handbook and on the shared 'intranet'.

The practice identified, recorded and managed risks. It had carried out risk assessments where risks had been identified and action plans had been produced and implemented. For example, in relation to the use of display screen equipment, manual handling and clinical risks. The practice monitored risks to identify any areas that needed addressing.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. Risks associated with service and staffing changes (both planned and unplanned) were required to be included on the log. We saw risk assessments relating to clinical matters, manual handling, use of display screen equipment, infection control and waste management.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. Monthly multi-disciplinary meetings were held to discuss older patients and those with long term conditions that were considered to be 'at risk'. There was monitoring of falls and patients were referred to the 'falls clinic' as required so they could be assessed and provided with equipment to minimise the risk of falls.

The practice operated an 'open surgery' so patients could access same day appointments. The practice shared information as appropriate with the out of hours service so it had up to date information about patients when the practice was closed.

Attendance at accident and emergency departments (A&E) was monitored and children with high prevalence of attendance were added to the 'at risk' register to ensure they received regular reviews. Patients experiencing poor mental health who attended A&E were reviewed and followed up to ensure they had access to the relevant support.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that staff had received training in basic life support and use of the automated external defibrillator (used in cardiac emergencies). Emergency equipment was available including access to oxygen and an automated external defibrillator. Records indicated the equipment and medicines should be checked daily however showed there had been some days when it was not checked.

Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. The inhaler for assisting patients with breathing difficulties was not kept with the rest of the emergency medicines and on the day of our visit was hard to find. It was kept in a separate cupboard. The practice made arrangements for the inhaler to be kept with the medicines during our visit. Processes were in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Records showed staff practised fire drills and the fire alarm and intruder alarm systems were checked regularly.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners.

We discussed with a GP and nurse how NICE guidance was received into the practice. They told us this was the responsibility of one of the partner GPs based at Montpelier Health Centre who disseminated information to staff within the organisation. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines. The partner GP with responsibility for disseminating new NICE guidance was a member of the NICE 'fellowship' and involved in its research programme. Research findings were implemented in the practice so patients had benefits from being given the most up to date treatment.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with these national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example the practice had recently begun to offer specialist clinics for patients with asthma, chronic obstructive pulmonary disease and diabetes. Feedback from patients confirmed they were referred to other services or hospital when required.

The practice told us GPs lead in specialist clinical areas such as gynaecology, dermatology, cancer and paediatrics and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multi-disciplinary care plans were documented in their records and that their needs were being met to assist in reducing the need for them to go into hospital. We saw that after patients were discharged from hospital they were followed up to ensure that all their needs were continuing to be met.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate. The practice provided a service to members of the travelling community and enabled them to use the surgery address for health related correspondence. When it was received the practice contacted the patient to advise them it had been received.

Management, monitoring and improving outcomes for people

Information about patient's care and treatment, and their outcomes, was routinely collected and monitored and this information was used to improve their care. For example, in relation to medicines prescribing. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews,managing child protection alerts and medicines management. The information staff collected was then collated by the surgery manager and operations manager to support the practice to carry out clinical audits.

We looked at clinical audits that had been undertaken in the last two years. Each of these were completed audit cycles where the practice were able to demonstrate the changes resulting since the initial audit. For example we saw that an audit of medicines carried out in January 2014 were reviewed in March 2015 and showed where the practice had changed medicines prescribing in line with the NHS area team and National Institute for Health and Care Excellence (NICE) guidance. Another audit was carried out in response to a significant event analysis and related to the prescribing of medicines for erectile dysfunction and prostate cancer. The outcome of the audit was that the practice developed a protocol that male patients are given written information relating to prostate cancer testing if presenting with erectile dysfunction.

The practice also used the information collected for the Quality Outcomes Framework (QOF) to monitor outcomes for patients. (QOF is a voluntary incentive scheme for GP

Good

Are services effective?

(for example, treatment is effective)

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

This practice was not an outlier for any QOF targets. It achieved 98% of the total QOF target in 2014, which was above the national average of 94%. For example, performance for diabetes related indicators and the percentage of patients recalled for tests were similar to the national average.

We saw the practice regularly reviewed its achievements in relation to national and South Gloucestershire Clinical Commissioning Group (CCG) performance, at GPs meetings.

The practice's prescribing rates were also similar to national figures. There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. We saw the record of meetings identified actions to be taken to support these patients and who was responsible. Meetings involved the community matron, district nurses and a representative from the local hospice.

The practice also kept a register of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups such as patients with learning disabilities and patients with particular health conditions. Structured annual reviews were undertaken for people with long term conditions (e.g. Diabetes, COPD and Heart failure) and the electronic records system alerted staff so they knew when these were due.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support.

We noted a good skill mix among the doctors with two having additional diplomas in obstetrics and gynaecology. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

Records showed staff had annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed appraisals identified goals for the forthcoming year and identified role specific training and funding, for example for nurse practitioner training.

Practice nurses and health care assistants had job descriptions outlining their roles and responsibilities and we saw evidence that they were trained appropriately to fulfil these duties. For example, on administration of vaccines, wound care and diabetes.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had procedures for passing on, reading and acting on any issues arising from these communications including coding and scanning documents. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up.

Emergency hospital admission rates for the practice were relatively low at 8% compared to the national average of 14%. The practice maintained a register of patients who were at risk of admission to hospital who were reviewed at the monthly multi-disciplinary team meetings. For example, those with multiple long term conditions, mental health problems, people from vulnerable groups, those with end of life care needs or children on the at risk register. These meetings were attended by the community matron, district nurses, and palliative care nurses. Decisions about care planning were documented in a shared care record. Staff felt this system worked well. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate.

Good

Are services effective?

(for example, treatment is effective)

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner.

For patients who were referred to hospital in an emergency there was a policy of providing a printed copy of a summary record for the patient to take with them to Accident and Emergency. The practice had also signed up to the electronic Summary Care Record. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours). Patients could choose not to have their record shared if they preferred.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw the system alerted staff to certain issues such as, if a child had a protection plan or if patients were prescribed certain medicines.

Consent to care and treatment

We saw two staff had attended training with the Police and Crime Commissioning Service (PCCS) in relation to mental health and one of the healthcare assistants attended a dementia study day however there was no evidence staff had completed training in the Mental Capacity Act 2005.

We found that staff were aware of the Mental Capacity Act 2005 and understood issues of consent and recorded when patients were asked to give consent to treatment or examination.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions.

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the discussion about the relevant risks, benefits and possible complications of the procedure.

Health promotion and prevention

If a person lived within the practice area and wished to register as a patient, they were required to complete a registration form available to download from the practice website or from reception. There was a medical questionnaire, alcohol screening form and depression form included. They were required to provide two forms of identification, one as proof of identity and one to prove residency. It was practice policy to offer a health check to all new patients registering with the practice.

The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers.

The practice also offered NHS Health Checks to all eligible patients aged over 45 years. The practice told us the take up rate from patients at the Pilning Surgery were higher than the take up rate from its other practices.

The practice had many ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice had referred patients to dieticians, exercise on prescription and for weight management support. In addition it offered in house smoking cessation services or referred patients to the 'Smoke Free South Gloucestershire' service.

The practice's performance for the cervical screening programme was 88%, which was above the national average of 82%. The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance was above average for the majority of immunisations where comparative data was available. For example, flu vaccination rates for the over 65s were 79%, and at risk groups 65%. These were similar to national averages. Childhood immunisation rates for the

Good

Are services effective?

(for example, treatment is effective)

vaccinations given to under two year olds ranged from 89% to 100% and five year olds were 89%. These were comparable to the South Gloucestershire Clinical Commissioning Group (CCG) averages.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey 2013/2014 and a survey of more than 100 patients undertaken by the practice.

The evidence from these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'among the best' for patients who rated the practice as good or very good.

The practice survey was conducted in June 2014. It was specifically designed to consult with patients about the 'open surgery' arrangements at the practice. There were117 respondents and most patients indicated they did not go to the surgery to see a specific GP. Most patients said the open surgery worked for them. The practice listened to what patients said and retained the open surgery arrangements.

Patients completed CQC comment cards to tell us what they thought about the practice. We received two completed cards that were positive about the service experienced. Patients said they felt the practice offered a good, caring service and they were very happy.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk, upstairs, which helped keep patient information private. There was a sign at the reception desk advising patients to indicate if they wished to speak in a more private place. Additionally, 19% of respondents in the patient survey (2013/2014) said they found the receptionists at the practice helpful compared to the national average of 9%.

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

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. The practice was similar to the national average for its satisfaction scores on consultations with doctors and nurses. For example, 84% said the GP was good at treating them with care and attention and 81% said the GP was good at involving them in decisions about care and treatment. Both these results were average for the South Gloucestershire CCG area.

We spoke with six patients on the day of our inspection who told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive.

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

All patients over the age of 75 years, those with complex health conditions, patients with learning disabilities and those considered to be at risk because of their poor mental health had a named GP. Each of the patients had a care plan they agreed with.

The organisation had achieved the 'You're Welcome' accreditation for meeting the Department of Health quality criteria for offering young people friendly health services. This meant young people knew they would be treated with respect and confidentially.

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 84% of patients said the last GP they spoke to was

Good

Are services caring?

good at treating them with care and concern and 92% said the last nurse they spoke to was good at treating them with care and concern which were similar to the national average.

The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. They highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We saw the written information available for carers to ensure they understood the various avenues of support available to them.

As part of the annual screening check for those with long term conditions, patients are assessed for anxiety and depression. The practice offered a confidential service to young patients under the age of 16 years.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. For example the practice offered 'open surgery' so patients could access appointments the same day. It also made arrangements to receive hospital letters on behalf of members of the travelling community and was relaxed about their registration at the practice.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). For example, the practice provided a garden bench on the walkway into the practice at the suggestion of the PPG as patients felt it was too far to walk.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. This was evident in the way it responded to the needs of members of the travelling community. The majority of the practice population were English speaking patients but access to online and telephone translation services were available if they were needed. We saw the electronic 'arrival system' was available in a variety of languages. Information on advocacy services was available for patients.

The premises and services had been designed to meet the needs of people with disabilities. The practice and consulting rooms were accessible to patients with mobility difficulties as facilities for patients were all on one level. There were access enabled toilets and baby changing facilities and a large waiting area with plenty of space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence.

There was a system for flagging vulnerability in individual patient records.

There were male and female GPs in the practice; therefore patients could choose to see a male or female GP.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training.

Access to the service

The surgery was open from 08:30 am to 6:30 pm on Monday, Tuesday and Friday. On Wednesday it was open from 7.30 am until 6.30 pm and on Thursday from 7.30 until 5.00 pm. The surgery is closed between 1.00 pm and 2.30 pm except on Thursday when it is closed between 1.00 and 2.00 pm. During this time a GP was available for emergencies only and patients were encouraged to ring the doorbell for access. The early start on Wednesday and Thursday were for pre-bookable appointments particularly aimed at patients who worked. There was open surgery each day between 8.30 and 10.00am. The evening opening times enabled children and young people to be seen outside of school hours. Appointments could be made on-line, in person or by telephoning the practice.

Information relating to opening times was found in the practice leaflet and on its website. Information was also available about appointments with a nurse, telephone consultations and home visits. Out of Hours, emergency arrangements were listed in the practice leaflet and on the website.

Longer appointments were available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to two local care homes.

The patient survey information we reviewed for 2013/2014 showed patients responded positively to questions about access to appointments and generally rated the practice well in these areas. For example, 85% were satisfied with the practice's opening hours compared to the national average of 79%. In describing their experience of making an appointment 98% indicated it was easy compared to the national average of 75%. The proportion of respondents who said they always or almost always saw or spoke with a GP of their choice was similar to the national average at 39%.

Patients we spoke with were satisfied with the appointments system and said it was easy to use. They confirmed that they could see a doctor on the same day if they felt their need was urgent although this might not be their GP of choice. They also said they could see another

Good

Are services responsive to people's needs?

(for example, to feedback?)

doctor if there was a wait to see the GP of their choice. Routine appointments were available for booking in advance. Comments received from patients also showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. For example, one patient told us they had visited the practice earlier that day and was given an afternoon appointment and a parent told us they had telephoned the practice had a return telephone call from a GP who suggested they brought their child to the surgery and arranged an appointment.

Home visits were available when needed for older patients and those with long term conditions and complex health conditions.

The practice provided an on-line service for reporting blood pressure readings if patients had their own monitoring machine.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system. It was referred to in the practice leaflet and on the website. The leaflet explained how a copy of the procedure could be obtained from reception or by contacting the surgery manager. The complaints procedure clearly outlined the timescales for responding to complaints and identified who would take responsibility for handling the complaint and ensuring actions were followed.

Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice. One patient told us how they observed a patient who was unhappy and how the receptionist contacted the surgery manager who came to talk with them and led them to a private space to do so.

We looked at four complaints received in the last 12 months and found they were satisfactorily handled, and dealt with in a timely way. Complaints records showed the way the complaint was received and when, the name of the complainant along with a summary, response date, response and outcome including, action taken by the practice.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and there were no themes identified. However, lessons learned from individual complaints had been acted on and improvements made to the quality of care as a result.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were included in its statement of purpose. It stated that the practice aimed to provide high quality clinical care in a confidential and safe environment treating each patient with equal consideration and involving them in decisions about their care and treatment. It added that it would promote good health through education and information and work with the South Gloucestershire Clinical Commissioning Group to secure appropriate resources for patients. It aimed to involve patients in the practice by encouraging them to become involved in the patient participation group and would ensure staff had the right skills to carry out their roles.

Four of the staff we spoke with were asked about the practices vision and described it in various ways. They were clear that patient care was the main priority and that involvement and treating patients with dignity and respect was essential.

In 2013 the practice undertook a re-branding exercise with the assistance of an external agency and full involvement of practice staff. As part of the process staff were challenged to define what the practice did and arrived at the statement 'Wellbeing at the heart of the community'. Feedback from patients indicated the practice was delivering this. For example one patient told us the GP they saw printed internet information for them to help them understand their condition and they found this to be caring and helpful.

Governance arrangements

The practice had a range of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at ten of these policies and procedures that included clinical operational and prescribing protocols. We found they had been reviewed and were up to date.

There was a clear leadership structure with named members of staff in lead roles. There were four partner GPs and the practice manager reported to them. He was supported by an operations manager and there was a surgery manager. The GPs each had specific responsibilities such as child protection and adult safeguarding, asthma and chronic obstructive pulmonary disorder, gynaecology and responsibility for monitoring the Quality and Outcomes Framework (QOF).

Nurses and the healthcare assistant also had specific roles such as leading in infection control, management of long term conditions and providing smoking cessation advice.

The GP with responsibility for monitoring QOF and practice manager ensured the systems to monitor the quality of the service were consistently being used and were effective. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at GP meetings and actions were agreed to maintain or improve outcomes. The most recent data available to us showed the practice was performing in line with national averages or above.

The practice also had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, in relation to medicines prescribing. Evidence from other data sources, including incidents and complaints was used to identify areas where improvements could be made. Additionally, there were processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff.

The practice held weekly GP meetings where governance issues were discussed. We looked at minutes from these meetings and found that performance, quality and risks had been discussed.

The operations manager was responsible for human resource policies and procedures. We reviewed a number of policies, including the training and development protocol which were in place to support staff. We were shown the electronic staff handbook that was available to all staff, which included sections on equal opportunities and whistleblowing. Staff we spoke with knew where to find these policies if required.

Leadership, openness and transparency

The partners worked across all of the practice locations, at Pilning Surgery, Montpelier Health Centre and Bath Buildings. Staff told us that they were approachable and always took the time to listen to all members of staff. All

Are services well-led?

Good

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

staff were involved in discussions about how to run the practice and how to develop the practice. The partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

We saw from minutes that team meetings were held every two months. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and were confident in doing so and felt supported if they did.

We also noted that team away days were held with the most recent being in March 2015. The record of the away day showed there had been discussion regarding QOF, electronic systems, reception service, clinical services and staff training. The away day resulted in a 'to do' list. Staff said they felt respected, valued and supported, particularly by the partners in the practice.

Practice seeks and acts on feedback from its patients, the public and staff

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the patient participation group (PPG) and complaints received. It had an active PPG which met every three months. We spoke with the chairperson of the PPG and they were very positive about the role they played and told us they felt engaged with the practice. (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care).

Photographs and contact details for the PPG members were displayed in the practice. The practice actively encouraged patients to be involved in shaping the service delivered at the practice. For example, the PPG had some concerns about the on-line repeat prescription process, brought their concerns to the attention of the practice and they were being resolved. This related to the 'submit' function at the end of the process and the practice was looking into the possibility of changing the website so that it would not be missed.

The PPG was involved in health event talks that were provided in the community. The PPG chair told us about the event the practice held concerned with prostate cancer and how this was well received. They told us the next event would focus on dementia awareness.

The practice had also gathered feedback from staff through staff away days and generally through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us how the appraisal system identified future goals including training. Staff said they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

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

Montpelier Health was an established training practice and the practice manager told us it aimed to introduce training opportunities at Pilning Surgery in order to enable trainee GP's to be given the opportunity of working in a rural and inner city practice.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings and away days to ensure the practice improved outcomes for patients. For example one incident resulted in all staff being reminded that some patients can minimise their symptoms after a late cancer diagnosis and that cancer is a disease found in older patients.