Christchurch Family Medical Centre

Quality Report

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Date of inspection visit: 05 August 2014
Date of publication: 24/10/2014

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.

Contents

Summary of findings

Overall summary

Christchurch Family Medical Centre is located in North Street, Downend, Bristol, BS16 5SG and provides primary medical services to approximately 12,500 NHS patients. The practice is situated in a purpose-built building and is fully accessible for patients with mobility issues.

There were examples of practice that Christchurch Family Medical Centre had developed to meet the needs of its patients, which could be shared with other services. These included the substance misuse, learning disability and diabetes services and the accessibility of the practice.

We found the practice had systems that ensured their service was safe effective and caring for patients and staff. During our visit we spoke with six patients and reviewed 26 comments cards from patients who had visited the practice in the previous two weeks. Patients were complimentary of the staff and the care and treatment they received. Patients told us that they were not rushed and staff explained their treatment options clearly. They said all the staff at the practice were helpful, caring and supportive.

The practice proactively sought and responded to patient feedback to improve the service. The practice opened a variety of times throughout the week between 7:30 am and 6:30 pm, offered evening surgery twice a week until 8 pm and opened on Saturday mornings. This resulted in patients being able to access the practice at times that were convenient to them, including early mornings, evenings and at the weekend. There was also a system in place to ensure that patients who had an urgent need could be seen on the same day.

There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. The Out Of Hours service was delivered by another provider.

The practice was well led by a practice manager and the GPs. The staff team were engaged in the service and told us they were excited by the future direction of the practice.

We talked with most of the staff employed in the practice who worked on the day of our inspection. This included five GPs, two practice nurses and a nurse practitioner, a health care assistant and the practice manager and five administrative staff.

We spoke with the staff team about patient groups as defined by the NHS and used as part of the Care Quality Commissions new methodology. The patient groups were;

- Older People
- People with long-term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problem

We found that they provided services to all these groups of patients and the practice provided us with examples. These included employing a clinical co-ordinator to manage the health and social care needs of older patients, providing specialist clinics to meet the needs of patients with long-term conditions, offering extended hours to suit the working population, a specialist substance misuse service for vulnerable patients to improve access to services for patients experiencing a mental health problem.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice had systems in place to enable them to manage incidents and safety alerts. Staff told us the practice had an open and transparent culture which discussed incidents and significant events with all staff to improve services for patients.

The practice protected the safety of its patients because they had a lead GP for vulnerable adults and children. Some staff did not know who the lead GP was, although all the staff told us they would raise a concern with either a GP or the practice manager. Where abuse was suspected the practice took appropriate actions and worked in partnership with relevant agencies.

The practice managed medicines safely and had the correct equipment, training and emergency drugs to manage a medical emergency safely.

The practice was clean and tidy and there were arrangements in place to ensure appropriate hygiene standards were maintained.

Recruitment was carried out effectively to ensure that staff were suitable, and had the skills, knowledge and qualifications necessary to carry out their role safely.

Are services effective?

Care, treatment and support provided by the practice was effective and patients told us they were very satisfied with the treatment they received and the outcomes they experienced. GPs in the practice met twice daily to discuss the care and treatment of their patients. This enabled discussions about treatment options and ensured patients received care in line with national standards.

Patients' needs were assessed and treatment was provided in line with expected standards and guidance.

New patients were offered a consultation to identify long term conditions and explore their past medical history, family history, and other risk factors. This enabled the practice to identify where patients might be at risk of developing a long term condition. The practice also had programmes in place to support patients weight management, blood pressure checks, sexual health screening and advice, contraceptive and family planning services, minor surgery, alcohol related risk reduction, support-to-stop smoking and general health and wellbeing advice.

Summary of findings

The practice had a specialist diabetes service that enabled patients to choose to receive their care within the primary sector rather than attending hospital.

Nurses we spoke with told us they worked effectively together and their skills complimented each other. Most nurses could provide all treatments, however, nurses had specialist areas of knowledge and took lead roles with providing treatment to certain patient groups.

There were effective working relationships with other organisations and the practice had taken steps to ensure the service was appropriate for working age patients, patients with long-term conditions and vulnerable patients such as patients who misused substances or patients with a learning disability.

Are services caring?

All of the patients we spoke with were complimentary about the care and service that staff provided, and confirmed that care was provided with respect to patients' privacy and dignity. Patients told us that GPs and other clinical staff took time to listen to them and discussed their treatment options to ensure they were able to make informed choices.

The practice had a culture of providing a caring and family focused service. All the staff we spoke with told us patients were their priority, and providing a caring and supportive service was their aim. It was evident from our discussions with staff that they were striving to provide caring, empathetic compassionate care for patients.

The practice had a variety of ways in which they ensured patients were involved and understood their care and treatment. For example, patients with a learning disability told us they received a good service from the practice and appreciated having a designated member of staff to support them during their GP consultation if they required it.

The practice had a policy on confidentiality and staff described how they protected patient privacy. Staff we spoke with explained how they would respect patient privacy and dignity, for example ensuring that consultation room doors were closed and privacy curtains were drawn.

The practice understood capacity and consent and applied their knowledge of the Mental Capacity Act 2005 to ensure patients were able to make informed decisions, and they protected patients when they lacked capacity to make a decision about their care or treatment options.

The practice offered bereavement support to patients and families through either home visits or by telephone calls.

Summary of findings

Are services responsive to people's needs?

The practice was responsive to patient needs, understood the different needs of the population it served and acted on these to design effective and responsive services. For example, the practice had specialist clinics to support patients with long-term conditions and substance misuse patients.

The practice had a lead member of staff to support patients with a learning disability and employed a clinical co-ordinator to provide a link between health and social care services to ensure patients' needs were responded to quickly and appropriately. The practice also had a primary care diabetes service to enable them to identify patients at risk of diabetes and patients had regular reviews to ensure they received effective diabetes care.

The practice obtained and acted on patient feedback and learned from patients' experiences to improve the quality of care. For example, the practice had implemented a new telephone system to improve telephone access following feedback from patients.

The practice offered extended opening hours and patients told us the appointments system provided choice for them to access the right care at the right time.

Are services well-led?

The practice was well led by a dedicated staff team.

Our discussions with the clinical team highlighted how patients were put first, and all the staff we spoke with commented on the caring and open ethos of the surgery, and the democratic leadership style. Staff told us they felt listened to and valued and provided us with examples of where their feedback had led to changes in the practice to improve patient experiences. Staff commented to us that the open, caring and well-led nature of the practice meant that they felt happy to come into work and optimistic about the future direction of the practice.

Staff told us about a variety of meetings, where topics and issues were discussed and appropriate actions drawn up and carried out. Staff told us they were involved and engaged in the practice to improve outcomes for patients.

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

Patients over the age of 75 years had a named GP. Patients we spoke with were aware of who their named GP was. The practice told us that this ensured that links with other relevant health and care professionals were effective. Some patients said they always liked to see their named GP, whilst other patients told us they preferred to see other GPs in the practice and that their choice was supported by staff.

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

The practice employed a healthcare assistant as a clinical coordinator who provided a link between health and social care. They advised older patients and their families to support discharges from hospital. This included signposting new carers to services for support, organising occupational therapy referrals to ensure patient's homes were equipped and providing a point of contact at the practice.

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

People with long-term conditions

Patients we spoke with who had long term conditions told us they were well supported by the practice. Patients described attending for regular check-ups and always being informed of blood test results by a nurse or GP over the phone.

The practice had a lead GP for long term conditions who undertook audits to ensure that patients considered at risk were identified and newly diagnosed patients were monitored.

Summary of findings

Nurses described to us how they provided care and treatment to support people with long term conditions. For example, one nurse explained how they involved diabetes patients in developing their care plans. We saw that the practice used care plans which had been developed by the local clinical commissioning group (CCG). The nurse told us they asked patients to choose what they wanted to focus on and in consultation with patients set achievable goals. The practice ran diabetic clinics twice a week and regularly reviewed patients care plans. A nurse told us if patients were not able to achieve their health goals they would look to identify any barriers to achieving goals. They told us they worked with other local support services to improve the health of patients with diabetes. This included referral to a dietician or to a community exercise programme.

Another nurse described the care and treatment they offered to patients who had asthma. Patients attended for regular check-up appointments, these would generally take place annually but if patients were experiencing difficulties or concerns the appointment would be brought forward. The nurse explained how they followed the recommendation of an asthma charity and developed asthma action plans with patients. These plans provided patients with information about their medications and helped patients to recognise when their symptoms were getting worse.

Patients with long term conditions were recalled annually for an influenza vaccination and the practice used the opportunity to screen these patients for other health conditions.

Mothers, babies, children and young people

The practice had two GPs with a specialist qualification in paediatric medicine.

The practice offered women's health clinics including cervical cytology screening, contraceptive services and pre and post natal support. There were three female GPs who were trained in fitting IUCDs (contraceptive device) and other long acting reversible contraceptive methods.

The practice offered post-natal and child surveillance checks to all new mothers and babies and the health visitors we spoke with told us the practice worked in partnership to ensure children's health and welfare was protected. The health visitors used the practice facilities to offer weekly drop-in clinics for new mothers and their babies. The practice also had a dedicated telephone number for health care professionals to make contacting a GP straightforward, and held monthly meetings with health visitors to discuss vulnerable children.

Summary of findings

The practice offered a “No Worries!” service for young people in South Gloucestershire (both registered and unregistered patients) which aimed to make it easier for young people to get relationship and sexual health advice.

The practice provided a wide range of opening hours to suit young patients who attended school or college.

The practice was engaged with the national chlamydia screening programme, and sexually active young adults were offered chlamydia testing as a routine part of primary care and sexual health consultations at the practice.

The working-age population and those recently retired

The practice opened at times that were accessible to people who worked during the week. The practice opened a variety of times throughout the week between 7:30 am to 6:30 pm, offered evening surgery twice a week until 8 pm and opened on Saturday mornings. This ensured that patients could access both urgent (same-day) appointments and pre-bookable appointments. The practice employed nurse practitioners who were able to manage the needs of patients who presented with minor illnesses.

The practice information leaflet highlighted the practice offered health checks designed to identify and manage the risk of heart-related incident for patients aged 40-75 years old. Patients we spoke with who were of working age told us they had been invited in for a health check and had found it useful.

Patients could book appointments and make requests for repeat prescriptions online and the practice had a touch screen check-in terminal for patients to use in the reception area.

The practice offered health promotion clinics including weight management, blood pressure checks, support-to-stop smoking, sexual health screening and advice, contraceptive and family planning services, minor surgery, alcohol related risk reduction and general health and wellbeing advice.

The practice ran a private travel centre which was a registered yellow fever centre, and offered a range of vaccinations and immunisations for travellers. The practice told us that their clinical team monitored disease situations and outbreaks across the world to ensure that travellers could be made aware of any health risks of travelling to their destinations.

Summary of findings

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

The practice had a named member of staff who supported patients with a learning disability. This member of staff conducted patient's annual health checks and would visit patients in their own home if they were unable to attend the practice. Patients with a learning disability and staff described how they developed a health action plan as part of their annual health check-up and told us that often this appointment included relatives or carers. We spoke with staff about how they supported patients with a learning disability to be involved with decisions about their care and treatment. A nurse explained how they supported patients with a learning disability to manage their diabetes, when speaking with patients they used terms that the patient could understand and sometimes drew diagrams to assist with the communication. The nurse said they tried to educate the patient and their carer about the condition so that they could understand how they could manage it.

The practice offered support to patients who had caring responsibilities. A health care assistant and GP had a lead role for carers and arranged carers group meetings at the practice every six weeks. These meetings included activities and sometimes speakers from external organisations. External speaker topics had included dementia, fire safety and meals on wheels. The practice offered a flu clinic for carers during this meeting to avoid them having to return to the practice to have their flu vaccination at another time. A member of staff told us they highlighted to carers the support available from the local authority. The practice had a register of carers and contacted them to invite them to the carers meetings. There was a noticeboard in the practice highlighting the local support services available to carers. The practice information leaflet contained information about the carers group.

The practice told us about how they responded to individuals walking in without appointments needing immediate attention and how they recognised the sometimes chaotic circumstances of patients. They confirmed that the on-call GP system meant there was always a GP available to meet these patients' urgent healthcare needs. This included seeing unregistered patients as temporary residents to ensure that the most vulnerable patients had access to a GP.

The practice had a specialist service to support substance misuse patients. They had a dedicated GP who had additional knowledge and skills, and worked closely with the local substance misuse service to meet patient needs with an emphasis on recovery and improving health and independence. Our discussions identified the practice had a system in place that enabled them to provide

effective advice and information, identify and diagnose substance misuse issues, and provide caring and effective medical treatment including the support for patients to manage their substance misuse.

People experiencing poor mental health

We received written comments from some patients who were experiencing poor mental health. They said that the service they had received was supportive, sympathetic and helpful.

The practice told us they offered patients on medication regular checks to ensure that the correct therapeutic range was prescribed. The practice told us they worked closely with the Primary Care Liaison Service who provide care and support for patients with mental health problems and described this team as very reactive to same-day requests for assessment of patients with acute mental health issues.

For patients experiencing serious poor mental health the practice worked together with police, social workers and mental health coordinators to appropriately assess and admit patients to hospital in line with the Mental Health Act 2007.

Summary of findings

What people who use the service say

During our visit we spoke with six patients and reviewed 26 comments cards from patients who had visited the practice in the previous two weeks. Patients were complimentary of the staff and the care and treatment they received. Patients told us that they were not rushed and staff explained their treatment options clearly. They said all the staff at the practice were helpful, caring and supportive.

Areas for improvement

Action the service SHOULD take to improve
Action the provider SHOULD take to improve

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

Outstanding practice

The practice provided outstanding care and treatment for their patients.

- The practice had a specialist service to support patients who misused substances. They had a dedicated GP who had additional knowledge and skills, and worked closely with the local substance misuse service to meet patient needs with an emphasis on recovery and improving health and independence.
- The practice had a lead member of staff to support patients with a learning disability. Patients with a learning disability told us they appreciated having a designated member of staff to support them during their GP consultation if they required it.
- The practice employed a healthcare assistant as a clinical coordinator who provided a link between health and social care. They advised older patients and their families to support discharges from hospital. This included signposting new carers to services for support, organising occupational therapy referrals to ensure patients' homes were equipped and providing a point-of-contact at the practice for those families in need.
- The practice had a specialist diabetes service that enabled patients to choose to receive their care within the primary sector rather than attending hospital. The GP providing this had additional experience and training and was therefore able to manage more complex cases which might be more usually seen in hospital clinics.

Christchurch Family Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector, and a GP specialist advisor. The team included a second CQC inspector and a specialist advisor in clinical governance.

Background to Christchurch Family Medical Centre

Christchurch Family Medical Centre is located in North Street, Downend, Bristol, BS16 5SG and provides primary medical services to approximately 12,500 NHS patients. The practice is situated in a purpose-built building and is fully accessible for patients with mobility issues.

The practice has five GP partners and two salaried GPs. They are supported by two nurse practitioners, four practice nurses and two health care assistants. Clinical staff are supported by a team of ten receptionists and six administrative staff including medical secretaries and the practice manager and an assistant practice manager.

Outside normal surgery hours patients were able to access emergency care from an alternative out-of-hours service.

South Gloucestershire is a unitary district in the county of Gloucestershire, in south west England. Census data shows an increasing population and a lower than average proportion of Black and Minority Ethnic residents.

Why we carried out this inspection

We inspected this service as part of our new inspection programme to test our approach going forward. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

Before visiting, we reviewed a range of information we held about the service and asked other organisations to share what they knew about the practice. These included organisations such as the local Healthwatch, NHS England and the clinical commissioning group (CCG).

We carried out an announced visit on the 5 August 2014.

As part of the inspection we talked with six patients and reviewed 26 comment cards from patients expressing their views about the practice.

During our visit we spoke with a range of staff, including the practice manager, GPs, registered nurses and health care assistants, receptionists and other administrative staff.

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

- Is it safe?
- Is it effective?
- Is it caring?

Detailed findings

• 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

• Mothers, babies, children and young people

• The working-age population and those recently retired

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

• People experiencing a mental health problem

Are services safe?

Our findings

Safe Track Record

The practice responded to safety alerts and all the staff we spoke with confirmed they received safety alerts, that the system was effective and that they were able to act upon them as they needed to.

The practice also recorded minor incidents and we saw examples of how they had investigated incidents and used the findings to provide learning sets for staff. Staff told us they had found this training helpful.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. Significant events were recorded, investigated and discussed at a variety of practice meetings including the daily GP meetings at the point of occurrence. Significant events were also formally discussed at other meetings such as the monthly GP meetings and the bi-monthly whole practice meeting. We noted significant events were also subject to an annual review to enable the practice to detect any themes or trends. We saw that action plans were developed to ensure the practice changed their systems where necessary to promote patient safety. The senior GP provided us with an example where a medication error had occurred and been investigated as a significant event by the practice. From our discussion it was evident the practice had learnt from the incident and developed a new system to ensure the incident could not reoccur.

Reliable safety systems and processes including safeguarding

The practice had policies and procedures in place for safeguarding children and vulnerable adults. They set out how staff should respond when they suspected a child or vulnerable adult was at risk of harm. Staff were provided with details of agencies to report concerns to or which could give further advice about managing a concern. There was a lead GP for safeguarding, however, some staff did not know who the lead GP was, although all the staff told us they would raise a concern with either a GP or the practice manager. A small number of non-clinical staff had not received safeguarding vulnerable adults and children training. All the GPs had received safeguarding training and provided us with examples of how they had worked with other agencies such as the local authority to safeguard children and vulnerable adults.

We saw the practice had a chaperone policy and this was advertised to patients in a variety of formats. A chaperone is a person who, with their consent, accompanies an adult or child during their consultation or treatment. GPs we spoke with confirmed they used a chaperone where required or requested.

Monitoring Safety & Responding to Risk

The practice had health and safety and accident or incidents policies. A fire risk inspection of the practice had been completed in March 2014. We saw written communication to staff in April 2014 which updated them on changes to the fire procedure and gave details of a weekly fire test. We saw the practice had a fire procedure and that emergency lighting and fire extinguishers were checked on a regular basis. A record of these checks was kept. There were certificates of inspection of fire certificates which were in date.

The practice was in the process of introducing a system to identify risks associated with the premises. We saw copies of risk assessment forms. These had been completed for the staff room and staff offices. We saw that where risks had been identified action had been taken to reduce the risk. For example, flooring had been repaired.

Medicines Management

Safe management of medicines was in place. A health care assistant was responsible for the management of medicines within the practice. Medicines were kept securely in locked drawers and fridges. A stock check of all medication was undertaken every month. We looked at the most recent record which identified the amount of each type of medication and the expiry date. Fridge temperatures were checked twice daily to ensure medications were stored at the correct temperatures. We looked at records of these checks which showed satisfactory results.

There were clearly defined processes for the safe management of prescriptions that minimised the potential for errors. Records showed how the practice had assessed the risks posed by prescribing medicines and we saw the measures they had taken to improve their procedures. Staff confirmed that the new systems were effective and protected patients against the risks of prescribing errors.

Cleanliness & Infection Control

The practice was in the process of developing effective systems to reduce the risk and spread of infection. The

Are services safe?

practice had identified an infection control lead in March 2014. We saw that the infection control lead was in the process of writing appropriate infection control policies and procedures. The nurse, who was the infection control lead, had undertaken online training in infection control. An infection control audit had been completed. We saw that some of the actions from the action plan were completed, for example, changes to the availability and use of personal protective equipment and sharps bins.

Hand washing guidance was available above hand washing sinks in the treatment rooms and toilets. There were wall mounted soap dispensers and hand towels at every sink throughout the practice. Staff had a supply of gloves and other personal protective equipment and the infection control lead told us they had updated staff on when they should use it.

Patients were cared for in clean and hygienic environment. We noted all areas of the practice were visibly clean and tidy and the treatment and consulting rooms had clutter free work surfaces, which were easy to clean. We looked at the practice cleaning schedule and the treatment room cleaning schedules and found them to be in line with The Code of Practice for health and adult social care on the prevention and control of infections and related guidance (2009). Seats in the waiting room had surfaces which were easy to wipe clean. Cleaning records were completed on a daily and weekly basis and a monthly cleaning audit was completed by the practice manager.

We spoke with patients about the cleanliness of the practice. All of them told us they were happy with the environment and cleanliness.

Staffing & Recruitment

Appropriate checks were undertaken before staff began work. The practice told us that in the past they had not rigorously sought references for administration staff to assure themselves these staff were suitable, and some staff recruitment files we examined confirmed this. However, this risk was mitigated by ensuring all staff had received criminal records check undertaken by the disclosure and barring service (DBS). At the time of the inspection the practice manager confirmed that the practice checked the suitability of all staff by seeking appropriate references, in addition to the other recruitments checks they undertook such as confirming staff employment history and identity.

The practice described how they reviewed staffing needs on a monthly basis to ensure that they could keep patients safe and meet their needs.

Dealing with Emergencies

Appropriate equipment and medicines were available for use in a medical emergency. The emergency drugs were checked monthly by the health care assistant. The oxygen and automated external defibrillator (AED) were checked regularly by a nurse to ensure they were in date and in working condition. We saw evidence of these checks. All staff had received recent basic life support training.

Equipment

We saw records that confirmed that all equipment was tested and serviced in line with manufacturer's guidelines. The practice had one treatment bed and one treatment chair that were both height adjustable and had wheels for ease of use. However, some staff commented that most of the treatment beds were non-adjustable for height, did not have wheels and did not specify a weight limit. Staff were not sure of the safe weight limit for patients and the height of the examination beds could make it difficult for patients to access them.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care & treatment in line with standards

GPs in the practice met twice daily to discuss the care and treatment of their patients. This enabled GPs to discuss treatment options and ensure patients received care in line with national standards. All the GPs we spoke with described these meeting as invaluable and supportive. The practice took into account national guidelines such as those issued by the National Institute for Health and Care Excellence (NICE) and GPs were alerted to clinical updates because the practice had a system in place to share updates and ensure all staff had read them. GPs and nurses described how having GPs with specialist areas of interest promoted best practice. It was evident from our discussions that GPs felt they had an effective system in place, but also that they understood their individual professional responsibility to ensure they practiced in accordance with national guidance.

The practice screened patients for long-term conditions as part of their registration as a new patient, and through clinical reviews and health promotion programmes. The practice managed patients with long-term conditions and staff were aware of procedures to follow to ensure that patients on the Quality and Outcomes Framework (QOF) disease registers were contacted and recalled at suitable intervals.

GPs told us there was monthly care planning meetings. They confirmed the care plans were written by the GP who knew the patient best. A health care assistant had a lead role for working with GPs to develop care plans for patients requiring palliative care and for patients who were at risk of being admitted to hospital. This role involved identifying patients who may be at risk from the patient record system and highlighting these patients to the GP.

Care and treatment was delivered in line with recognised best practice standards and guidelines. For example, a GP described the system in place to ensure evidence based assessment, care and treatment of patients presenting with memory loss. This included a variety of tests and checks such as blood tests, brain scans and memory tests. The practice also had access to specialist memory nurses and clinics to seek advice for more complex patients. This ensured that the practice supported patients to maximise their health and well-being.

Management, monitoring and improving outcomes for people

Clinical staff were supported to take on lead roles in areas of clinical practice where they had an interest or specialist skill. For example, we were told that one GP who had recently joined the surgery had an interest in paediatric care and we noted they were being supported to become the lead for children's safeguarding. This ensured that staff could be guided by leads that had additional skills or knowledge in a specific area of clinical practice.

The practice had a system in place for completing clinical audit cycles. Examples of clinical audits included the use of specific medicines, the diagnosis of diabetes, and the identification of other health conditions. We saw that the practice developed action plans in response to the audit findings. The practice acknowledged they needed to ensure that actions resulting from clinical audits were reviewed to complete the audit cycle. Certain GPs undertook minor surgery in the practice and this had been the subject of internal clinical audit.

Effective Staffing, equipment and facilities

The practice had ensured they had appropriately qualified and competent staff with the right skills and experience. There was a staff skills, competency and training policy and clinical staff described an effective induction that enabled them to understand their role and the needs of the practice. Records of inductions we looked at confirmed this. The practice had recently set up a training system to enable them to easily recognise where further, or refresher training was required. The practice manager confirmed this was in the early stages and required further work to ensure the practice could easily identify when staff required training.

Nurses we spoke with told us they worked effectively together and their skills complimented each other. Most nurses could provide all treatments, however, nurses had specialist areas of knowledge and took lead roles with providing treatment to certain patient groups. For example, one nurse had completed a diploma in asthma management. Another nurse had completed a post-graduate qualification in diabetes management and another nurse took a lead role in wound care. Staff we spoke with told us how they would go to a member of the team who was more specialist for advice if they required it.

Are services effective?

(for example, treatment is effective)

Nursing staff told they were supported to attend regular update training which included; cervical screening, burns, contraception, childhood immunisations and travel vaccinations.

The practice had a lead GP for long term conditions who undertook audits to ensure that at risk patients were identified and newly diagnosed patients were monitored. The practice had developed a specialist diabetes service that enabled patients to choose to receive their care within the primary sector rather than attending hospital. The GP providing this had additional experience and training and was therefore able to manage more complex cases which might be more usually seen in hospital clinics. This enabled patients who wished to safely migrate by choice from the hospital to receiving their diabetic supervision in primary care. An example was given of a patient who whilst more typically might have been an attender at the hospital clinic actively requested transfer of care which was then arranged.

Working with other services

Patients we spoke with who had received a referral told us the process from the GPs perspective had been very good and they had received an appointment quickly. Patients told us the GP kept up to date with their care when they had been referred for treatment and chased up correspondence from secondary care service if it was not promptly received.

We noted the surgery worked effectively with other organisations such as substance misuse, social care and, community mental health services and health visitors. We spoke with two staff from another agency and they described an effective and caring working relationship. They told us that clinical staff at the practice knew patients and families well and were good at sharing information. They confirmed they worked in partnership including attending multi-disciplinary meetings to safeguard patients.

The practice proactively engaged with other healthcare providers to co-ordinate care and meet patient need. All referrals to secondary and acute care services were discussed informally at the daily GP meetings, and formally through weekly referrals meeting to confirm they were appropriate. GPs described their access to emergency care practitioners as helpful in preventing emergency admissions to hospital.

The practice had a GP buddy system in place to make sure test results or information received from other healthcare providers was acted upon quickly. The practice held monthly multi-disciplinary meetings to review end of life (palliative) patients and frail older patients at risk of falls or hospital admissions. They used these meetings to review management plans and ensure the practice provided joined up care for patients with complex physical or mental health needs.

Health Promotion & Prevention

The practice was accommodated in a purpose built building which the GPs had designed to be a one stop shop; staff described this philosophy as, what we can do for patients. We saw that patients could access other private healthcare services situated in the building such as a pharmacy, physiotherapy and osteopath services, a dental hygienist and a travel centre.

The practice offered health promotion clinics including weight management, blood pressure checks, sexual health screening and advice, contraceptive and family planning services, minor surgery, reducing alcohol consumption, support to stop smoking and general health and wellbeing advice.

Patients who attended for other treatment who were known to smoke were also offered the option of attending a smoking cessation clinic. A nurse described how they worked with patients who attended weight management clinics to identify achievable goals and regularly review those goals. Patients, if they wanted to be, were referred to local support services, such as exercise on prescription. The nurse explained this was a 12 week plan where the patient's weight was monitored. During this time the nurse continued to see patients to check on their progress.

The practice used appointment cards to deliver messages to patients. These changed regularly and we saw examples of cards that reminded patients about the flu vaccination and information about the chaperone service.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

Patients we spoke with described staff as friendly and very helpful. Patients told us they were able to request a male or female GP if they wanted.

The practice had a culture of providing a caring and family focused service. All staff we spoke with told us patients were their priority and providing a caring and supportive service was their aim. Patients were complimentary about the way staff treated them with dignity and respect. They also told us their privacy was respected during consultations. We observed staff treating patients with dignity and respect during our inspection and making sure patients were assisted as a priority before other business related tasks.

Staff we spoke with explained how they would respect patients privacy and dignity during intimate examinations through provision of towels to cover up and ensuring that consultation room doors were closed and privacy curtains were drawn.

The practice told us that reception staff were embarking on a variety of training including deaf awareness training, dementia care and support for patients with learning disabilities, to help them understand how to care and communicate with these patients better.

The practice offered bereavement support to patients and families through either home visits or by telephone calls.

Involvement in decisions and consent

Patients we spoke with told us they were involved in making decisions about their care and treatment. GPs described how they involved patients in discussions, including treatment options and risks, and told us about the resources they used such as conditions leaflets to ensure people had enough information and knowledge to make an informed decision.

Where patients did not have the capacity to consent to care and treatment staff told us how they would consult with other people to ensure that decisions were made in a patient's best interests. We were given examples of how the GPs had liaised with the patient, their family and hospital consultants to make decisions about care and treatment. The examples staff and patients described indicated that, where patients did not have the capacity to consent, staff were acting in accordance with the Mental Capacity Act (2005).

We spoke with staff about the communication needs of their patients and whether any communication aids were ever used. The practice had a lead member of staff to support patients with a learning disability. This member of staff told us they had created a card communication system for one patient who was non-verbal. This was provided to the patient to ensure that they were able to communicate their care and treatment needs clearly. Patients with a learning disability told us they received care and treatment from the practice and appreciated having a designated member of staff to support them during their GP consultation if they required it. Patients with a learning disability suggested the practice could consider providing more information to patients in an accessible format rather than in writing. Staff told us information could be printed in larger text format for patients with visual impairment.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to people's needs

The practice opened at times that were accessible to people who worked during the week. The practice offered appointments throughout the week between 7:30 am and 6:30 pm, an evening surgery was provided twice a week until 8 pm and the practice opened on Saturday mornings. This ensured that patients could access both urgent (same-day) appointments and pre-bookable appointments. The practice employed nurse practitioners who were able to manage the needs of patients who presented with minor illnesses. GPs described the triage system which ensured all patients could access a GP either by telephone or in person if they felt they needed to. Patients we spoke with were very complimentary about the practice opening hours.

The practice environment had been designed to accommodate a variety of patient needs. There was wheelchair access and accessible toilet facilities, and the waiting room offered seating that was accessible to patients with restricted mobility. All treatment and consulting rooms were situated on the ground floor. There was a lift should patients need to access the first floor of the building. Some signs within the practice had braille to support patients with visual impairments, for example signs on toilet doors. The practice had an induction loop system for patients who had a hearing impairment. However, staff were not aware of how to use this system and therefore it was not used to support patients. The practice acknowledged they needed to clarify how the loop system worked to enable staff to use it.

The practice confirmed that they had access to online and telephone interpreting and translation facilities. Not all staff were aware of local support services which could provide translation or signing services for patients and, therefore, did not always offer these services to patients. There was a risk that patients who did not speak English as their first language or patients who were deaf may not receive appropriate support to enable them to communicate with staff and understand their care and treatment.

There was a range of health-related information for patients available in the waiting room. For example, we found information explaining how patients could access out-of-hours care and information about a range of medical conditions. Patients we spoke with understood where they could access advice and support when the practice was not open.

The surgery had structured their partnership to ensure there was a mixture of male and female partners who mainly worked full-time. This promoted continuity of care and enabled patients to receive a responsive service from a GP who patients knew and who understood their healthcare needs.

The practice told us about their work with patients who misuse substances. They had a dedicated GP who had specialist knowledge in this area. The practice had patients on specific programmes and worked closely with the local substance misuse service to jointly meet patient needs with an emphasis on recovery and developing health and independence. Our discussion with the lead GP in this service identified that they were committed to recovery-oriented services which attempted to support patients in all areas of their lives in a co-ordinated way. We noted the practice had a system in place that enabled them to provide effective advice and information to patients, identify and diagnose substance misuse issues, and provide care and medical treatment including management of substance misuse.

The practice provided us with examples of where they had developed services to enable them to respond to patient needs. For example, the practice had staff who had received additional training in sexual health which meant that patients could receive appropriate and timely family planning services.

The practice ran a private travel centre which was a registered yellow fever centre, and offered a range of vaccinations and immunisations for travellers. The practice told us that their clinical team monitored disease situations and outbreaks across the world to ensure that travellers could be made aware of any health risks of travelling to their destinations.

Access to the service

Patients we spoke with told us if they were concerned about their health they could contact the practice and either get an appointment on the day or the GP would call them back that day. Patients in general told us it was easy to get an appointment at a time that suited them and that if they called with an emergency they would always be seen

Are services responsive to people's needs?

(for example, to feedback?)

that day. Some patients we spoke with told us it was difficult to get through on the telephone in the morning to make an appointment. However, they were aware they could make an appointment in person or online. 10% of appointments were available for patients to book online.

There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. The Out-Of Hour's service was delivered by another provider. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the Out Of Hours service was provided to patients in the practice waiting room and was also included in the practice leaflet and on the practice website.

Meeting people's needs

Patients we spoke with told us they never felt rushed during their appointments and had time to fully discuss their health concerns with the GP or nurses.

The health care assistant who worked with the GPs on developing care plans for patients ensured that patients' needs and wishes were taken into account. For example, patients who received palliative care were asked where they would prefer to receive their care and were involved in making decisions about how, where and when they would like to receive care and treatment.

Patients were able to choose the service where they wished to have further treatment. GPs told us they discussed the different treatment options with patients, such as services that could provide standard or more specialist services, in order to support them to make an informed choice.

Concerns & Complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. We reviewed the complaints the practice had received and found they had acted in accordance with their policies and procedures.

Patients we spoke with told us they had not needed to complain, but that if they did want to they would speak with the practice manager. There was a leaflet in the patient waiting area providing information to patients about how to make comments or complain. This leaflet explained the practice complaint procedure and provided patients with appropriate details of external organisations should patients wish to raise their complaint outside of the service. There was also a comments box in the practice waiting areas which patients could leave comments in about the service.

Are services well-led?

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

Our findings

Leadership & Culture

The practice had twice yearly strategy meetings to discuss business planning. As part of these GPs told us they considered succession planning to ensure the practice could continue to provide the high level of quality to patients as partners within the practice retired.

The practice was well-led and had a culture of open and supportive leadership. For example, we were told that partners supported each other and shared workloads to ensure the service operated effectively. The practice provided us with examples of how this happened. The examples included a partner returning from holiday to support the team when another GP needed to be away from work, and how the duty GP system was covered by other GPs when the duty GP became very busy. Our discussions with the clinical team highlighted how patients were put first, and all the staff we spoke with commented on the caring and open ethos of the practice, and the democratic leadership style, which they felt started with the GP partners' philosophy of leading by example and caring about the well-being of staff and patients. A significant number of staff commented to us that the open, caring and well-led nature of the practice meant that they felt happy to come into work and optimistic about the future direction of the practice.

The practice demonstrated the ethos of transparency at a high level by describing to us the actions they had taken to address poor practice which included mentoring and referrals to other regulatory bodies.

The practice communicated its values to patients. There were signs in the waiting area about the practice values of care, compassion, competence, communication, courage and commitment with information about what each value meant. This information was also contained in the practice guide to our service leaflet available to patients in the waiting area.

Staff we spoke with told us they felt valued by the practice and felt comfortable to raise any concerns or suggestions.

Governance Arrangements

Governance arrangements supported transparency and openness and staff had lead roles to ensure the practice had clear direction in specific areas such as information governance, safeguarding and human resources.

Throughout the inspection we observed staff followed information governance guidance such as using a clear desk rule to ensure confidential patient information was protected.

Staff told us the practice had reviewed and amended a significant number of their management and governance systems and confirmed they were kept up to date with changes through monthly meetings. They confirmed that the amended systems ensured they understood what to do in specific situations. We also saw there was a business continuity plan in place to ensure services continued running in the event of an emergency.

The practice had a strategy to mitigate risks to the service, such as staffing needs, by reviewing the anticipated demands on the service to ensure the continued delivery of high quality care.

Systems to monitor and improve quality & improvement (leadership)

The practice engaged in external auditing of their management systems and had received positive feedback about their governance.

The practice did not have a lead nurse. Nurses we spoke with felt that having a lead nurse would benefit the nursing team. For example, someone to have oversight of nurse training and development. We were told the practice manager had discussed appointing a lead nurse with the nursing staff and that this was being considered.

Patient Experience & Involvement

All of the patients we spoke with were complimentary about the care and service that staff provided, and confirmed that care was provided with respect to patients' privacy and dignity. Patients told us that GPs and other clinical staff took time to listen to them and discussed their treatment options to ensure they were able to make informed choices.

Practice seeks and acts on feedback from users, public and staff

There was a display board within the patient waiting area which highlighted feedback the practice had received through the patient survey and what they had done to address patient concerns. For example, patients had commented that the telephone system made it difficult to get through to the practice. The practice had introduced a

Are services well-led?

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

new telephone system to ensure that calls were directed to the appropriate member of staff. There was an information leaflet in the entrance hall providing detailed information to patients about how to use the new telephone system.

The practice had a 'virtual' patient participation group (PPG) and sought feedback from patients who belonged to this group through email or post. A PPG is a group of patients registered with the practice who have an interest in the services provided. The aim of the PPG is to represent patient views, to work in partnership with the practice, and to improve the services patients receive. The practice was making efforts to encourage patients to join the PPG. We saw the electronic notice and the electronic sign in screen in the reception area encouraged patients to join the PPG. Patients we spoke with told us they had been asked if they would like to join the PPG.

There was a comments box in the patient waiting area with comments forms for patients to write on.

Staff told us they felt listened to and valued. They provided us with a number of examples, such as changes to rotas, where the practice had acted upon their views and made changes to improve the service. If staff were concerned about the practice they told us they understood who they could express their concern to, and clinical staff were aware of the external organisations they could contact to report a concern about the practice. We noted the practice also had a whistle blowing policy; however it required amending to ensure staff had contact details for external organisations.

Management lead through learning & improvement

Staff we spoke with told us the historic appraisal system was not fit for purpose, but that it was changing and becoming more individualised and personal. The practice manager had told staff that future appraisals would be linked to a training and development plan. Staff we spoke with were looking forward to being able to highlight areas they wanted to develop in and have a plan to achieve this.

The staff team met regularly through a variety of single discipline and full team meetings. Records of these meetings showed a variety of topics were discussed and appropriate action drawn up and carried out. For example, nurses told us they held nurse meetings every three months. During these meetings they discussed updates from training courses they had attended and shared learning from reading. For example, an update on compression bandaging equipment and guidelines for wound care.

Identification & Management of Risk

The practice manager had risk assessed various processes including procedures for repeat medicines, training, booking urgent appointments and a protocol for identifying carers. We saw evidence of significant changes that had resulted from this to ensure patients were protected from identified risks to their care.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Our findings

Patients over the age of 75 years had a named GP. Patients we spoke with were aware of who their named GP was. The practice told us that this ensured that links with other relevant health and care professionals were effective. Some patients said they always liked to see their named GP, whilst other patients told us they preferred to see other GPs in the practice and that their choice was supported by staff.

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

The practice employed a healthcare assistant as a clinical coordinator who provided a link between health and social care. They advised older patients and their families to support discharges from hospital. This included signposting new carers to services for support, organising occupational therapy referrals to ensure patient's homes were equipped and providing a point of contact at the practice.

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

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Our findings

Patients we spoke with who had long term conditions told us they were well supported by the practice. Patients described attending for regular check-ups and always being informed of blood test results by a nurse or GP over the phone.

The practice had a lead GP for long term conditions who undertook audits to ensure that patients considered at risk were identified and newly diagnosed patients were monitored.

Nurses described to us how they provided care and treatment to support people with long term conditions.

For example, one nurse explained how they involved diabetes patients in developing their care plans. We saw that the practice used care plans which had been developed by the local clinical commissioning group (CCG). The nurse told us they asked patients to choose what they wanted to focus on and in consultation with patients set achievable goals. The practice ran diabetic clinics twice a week and regularly reviewed patients care plans. A nurse told us if patients were not able to achieve their health goals they would look to identify any barriers to achieving goals. They told us they worked with other local support services to improve the health of patients with diabetes. This included referral to a dietician or to a community exercise programme.

Another nurse described the care and treatment they offered to patients who had asthma. Patients attended for regular check-up appointments, these would generally take place annually but if patients were experiencing difficulties or concerns the appointment would be brought forward. The nurse explained how they followed the recommendation of an asthma charity and developed asthma action plans with patients. These plans provided patients with information about their medications and helped patients to recognise when their symptoms were getting worse.

Patients with long term conditions were recalled annually for an influenza vaccination and the practice used the opportunity to screen these patients for other health conditions.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Our findings

The practice had two GPs with a specialist qualification in paediatric medicine.

The practice offered women's health clinics including cervical cytology screening, contraceptive services and pre and post natal support. There were three female GPs who were trained in fitting IUCDs (contraceptive device) and other long acting reversible contraceptive methods.

The practice offered post-natal and child surveillance checks to all new mothers and babies and the health visitors we spoke with told us the practice worked in partnership to ensure children's health and welfare was protected. The health visitors used the practice facilities to offer weekly drop-in clinics for new mothers and their babies. The practice also had a dedicated telephone number for health care professionals to make contacting a GP straightforward, and held monthly meetings with health visitors to discuss vulnerable children.

The practice offered a "No Worries!" service for young people in South Gloucestershire (both registered and unregistered patients) which aimed to make it easier for young people to get relationship and sexual health advice.

The practice provided a wide range of opening hours to suit young patients who attended school or college.

The practice was engaged with the national chlamydia screening programme, and sexually active young adults were offered chlamydia testing as a routine part of primary care and sexual health consultations at the practice.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Our findings

The practice opened at times that were accessible to people who worked during the week. The practice opened a variety of times throughout the week between 7:30 am to 6:30 pm, offered evening surgery twice a week until 8 pm and opened on Saturday mornings. This ensured that patients could access both urgent (same-day) appointments and pre-bookable appointments. The practice employed nurse practitioners who were able to manage the needs of patients who presented with minor illnesses.

The practice information leaflet highlighted the practice offered health checks designed to identify and manage the risk of heart-related incident for patients aged 40-75 years old. Patients we spoke with who were of working age told us they had been invited in for a health check and had found it useful.

Patients could book appointments and make requests for repeat prescriptions online and the practice had a touch screen check-in terminal for patients to use in the reception area.

The practice offered health promotion clinics including weight management, blood pressure checks, support-to-stop smoking, sexual health screening and advice, contraceptive and family planning services, minor surgery, alcohol related risk reduction and general health and wellbeing advice.

The practice ran a private travel centre which was a registered yellow fever centre, and offered a range of vaccinations and immunisations for travellers. The practice told us that their clinical team monitored disease situations and outbreaks across the world to ensure that travellers could be made aware of any health risks of travelling to their destinations.

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

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Our findings

The practice had a named member of staff who supported patients with a learning disability. This member of staff conducted patient's annual health checks and would visit patients in their own home if they were unable to attend the practice. Patients with a learning disability and staff described how they developed a health action plan as part of their annual health check-up and told us that often this appointment included relatives or carers. We spoke with staff about how they supported patients with a learning disability to be involved with decisions about their care and treatment. A nurse explained how they supported patients with a learning disability to manage their diabetes, when speaking with patients they used terms that the patient could understand and sometimes drew diagrams to assist with the communication. The nurse said they tried to educate the patient and their carer about the condition so that they could understand how they could manage it.

The practice offered support to patients who had caring responsibilities. A health care assistant and GP had a lead role for carers and arranged carers group meetings at the practice every six weeks. These meetings included activities and sometimes speakers from external organisations. External speaker topics had included dementia, fire safety and meals on wheels. The practice offered a flu clinic for carers during this meeting to avoid them having to return to the practice to have their flu vaccination at another time.

A member of staff told us they highlighted to carers the support available from the local authority. The practice had a register of carers and contacted them to invite them to the carers meetings. There was a noticeboard in the practice highlighting the local support services available to carers. The practice information leaflet contained information about the carers group.

The practice told us about how they responded to individuals walking in without appointments needing immediate attention and how they recognised the sometimes chaotic circumstances of patients. They confirmed that the on-call GP system meant there was always a GP available to meet these patients' urgent healthcare needs. This included seeing unregistered patients as temporary residents to ensure that the most vulnerable patients had access to a GP.

The practice had a specialist service to support substance misuse patients. They had a dedicated GP who had additional knowledge and skills, and worked closely with the local substance misuse service to meet patient needs with an emphasis on recovery and improving health and independence. Our discussions identified the practice had a system in place that enabled them to provide effective advice and information, identify and diagnose substance misuse issues, and provide caring and effective medical treatment including the support for patients to manage their substance misuse.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Our findings

We received written comments from some patients who were experiencing poor mental health. They said that the service they had received was supportive, sympathetic and helpful.

The practice told us they offered patients on medication regular checks to ensure that the correct therapeutic range was prescribed. The practice told us they worked closely with the Primary Care Liaison Service who provide care and support for patients with mental health problems and described this team as very reactive to same-day requests for assessment of patients with acute mental health issues.

For patients experiencing serious poor mental health the practice worked together with police, social workers and mental health coordinators to appropriately assess and admit patients to hospital in line with the Mental Health Act 2007.