The Family Practice

Quality Report

Western College
Cotham Road
Bristol
BS6 6DF
Tel: 0117 9466455
Website: www.fpwc.nhs.uk

Date of inspection visit: 11 May 2016
Date of publication: 10/08/2016

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Family Practice on 11 May 2016. Overall the practice is rated as good.

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

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- Risks to patients were assessed and well managed.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of and complied with the requirements of the duty of candour.
- The percentage of respondents to the GP patient survey who described the overall experience of their GP surgery as fairly good or very good was 95% compared to the clinical commissioning group of 86% and national average of 85%. Also 92% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 81% and the national average of 80%.

Summary of findings

The areas where the provider should make improvement are:

- The practice should review current good practice guidelines to ensure that clinical staff are trained to the appropriate level for their role for safeguarding children
- The practice should provide formal training for staff who carry out the chaperone role.
- The practice should review elements of the environment relating to risks to infection control management such as the wooden panelling and facilities, including floor surfaces in some consulting rooms.
- The practice should review how fire safety is managed so that fire risk assessments, fire drills, emergency lighting and safety checks are carried out in accordance to best practice and sustained.
- The practice should implement an effective system to identify carers in order to provide the most appropriate care for them.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

- There was an effective system in place for reporting and recording significant events
- Lessons were shared to make sure action was taken to improve safety in the practice.
- When things went wrong patients received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- Risks to patients were assessed and well managed. The practice should review current good practice guidelines to ensure that clinical staff are trained to the appropriate level for their role for safeguarding children.
- The practice had not provided formal training for staff who carried out the chaperone role.
- Elements of the environment raised the risks for infection control management such as wooden panelling and facilities should be reviewed.
- Most of the consulting rooms were fully carpeted; the floor surfaces around the area of examination couches were not the recommended floor covering, in order that these can be easily cleaned should there be a spillage of body fluids.
- The practice should review how fire safety was managed so that fire risk assessments, fire drills, emergency lighting and safety checks are carried out in accordance to best practice and sustained.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to the national average.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.

Summary of findings

- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- Improvements should be made as there were gaps in the system for checking referrals had been made in a timely way.
- Through discussion with GPs that written consent from the patients was not routinely taken for the fitting of contraceptive devices, although it is acknowledged in the patient electronic records verbal consent is obtained and recorded.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- However, privacy was limited in the large shared treatment room as although screening was provided it didn't provide privacy for conversations.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and the clinical commissioning group to secure improvements to services where these were identified.
- The practice offered Web-GP to patients that enabled consultation via email. In October 2015 this was being used on average three to five times per day and there had been a corresponding drop in appointments required.
- Telephone consultation appointments were available for patients who were not able to attend the practice or who needed advice in regard to their care and treatment.
- The nurse clinics were flexible to patients' needs and were able to combine activities in one visit, such as a blood test with regular health screening for a long term condition.
- The practice facilitated access to diabetic retinal screening, aortic aneurysm screening, and a weekly mental health clinic.

Summary of findings

- Patients had access to 24 hour blood pressure screening, ECG (heart monitoring) and tele-dermatology consultations at the surgery reducing the need to attend other services.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.
- The practice facilities did not meet good practice guidance as there were constraints, because of being a listed building, on providing appropriate door opening mechanisms and no lift to the first floor to support patient independence.

Are services well-led?

Good

The practice is rated as good for being well-led.

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings.
- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken
- The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active.
- There was a strong focus on continuous learning and improvement at all levels.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people.

- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and offered home visits and urgent 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 their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people.

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw positive examples of joint working with midwives, health visitors and school nurses.

Summary of findings

Working age people (including those recently retired and students)

Good

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

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- 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.

People whose circumstances may make them vulnerable

Good

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

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

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

- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice carried out advance care planning for patients with dementia.
- The practice was participating in a pilot with a mental health nurse available in the practice on a daily basis.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.

Summary of findings

- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results were published in January 2016. The results showed the practice was performing in line of above with local and national averages. Of the 292 survey forms that were distributed, 123 were returned. This was a 42% response rate; the national average was 38%.

- 97% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 90% and the national average of 89%.
- 99% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 98% and the national average of 97%.
- 96% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 92% and the national average of 91%.
- 95% of patients said they found the receptionists at the practice helpful compared to the CCG average of 88% and the national average of 87%.
- 96% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 87% and the national average of 86%.
- 87% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG and national average of 82%.
- The percentage of respondents to the GP patient survey who described the overall experience of their GP surgery as fairly good or very good was 95% compared to the clinical commissioning group of 86% and national average of 85%. Also

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. All of the 24 patient comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent and much valued service and staff were helpful, caring and treated them with dignity and respect. Patients commented that staff responded compassionately when they needed help, patients felt they were cared for and staff provided support when required. Patient feedback given directly to the practice highlighted patients had found that staff had treated them with kindness and understanding, were prompt in providing the care and support they needed and had reduced their apprehension.

We spoke with six members of the patient participation group (PPG). They also told us they were very satisfied with the care provided by the practice and said their dignity and privacy was respected.

Areas for improvement

Action the service SHOULD take to improve

- The practice should review current good practice guidelines to ensure that clinical staff are trained to the appropriate level for their role for safeguarding children
- The practice should provide formal training for staff who carry out the chaperone role.
- The practice should review elements of the environment relating to risks to infection control management such as the wooden panelling and facilities, including floor surfaces in some consulting rooms.
- The practice should review how fire safety is managed so that fire risk assessments, fire drills, emergency lighting and safety checks are carried out in accordance to best practice and sustained.
- The practice should implement an effective system to identify carers in order to provide the most appropriate care for them.

The Family Practice

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to The Family Practice

The Family Practice is located in a residential area of the city of Bristol. They have approximately 14,282 patients registered.

The practice operates from one location:

Western College

Cotham Road

Bristol

BS6 6DF

The Family Practice is situated in a Grade II listed building in a residential area of the City of Bristol. It serves patients from the Cotham, Kingsdown and Clifton areas of Bristol. The building was originally a theological college in 1903 and has many unique architectural features and has been used as a GP practice since 1993. The main patient areas of the practice are situated on the ground floor of the building with seven consulting rooms and a large treatment room with five patient areas. There is an additional consulting room, offices and meeting rooms on the first floor. There is no lift to the first floor. There is parking for approximately 30 vehicles at the side of the practice.

The practice is made up of seven GP partners and two associate GPs. Four female and five male. They have one nurse practitioner, three practice nurses and three healthcare assistants. They are supported by a practice business manager, reception and administration team. The practice is a training practice for GPs and a teaching practice for medical students.

The practice opening hours are from 8.15am until 6.30pm, Monday, Tuesdays, Thursdays and Fridays. Wednesday the practice opens at 8.15am and closes for staff training at 12 and reopens at 2pm until 6.30pm. The practice is open one evening per week from 6:30pm to 8pm for routine GP and nurse appointments and alternate Saturday mornings 8:30am to 11:45pm for GP appointments only.

The practice has a Personal Medical Services contract with NHS England. The practice is contracted for a number of enhanced services including extended hours access, improving patient's online access, supporting patients with a learning disability and unplanned admission avoidance.

The practice does not provide out of hour's services to its patients, this is provided by the 111 services and BrisDoc. Contact information for this service is available in the practice and on the practice website.

Patient Age Distribution

0-4 years old: 4.7% (the national average 5.9%)

5-14 years old: 9.1% (the national average 11.4%)

Total under 18 years old: 16% (the national average 20.7%)

65+ years old: 12.3% (the national average 17.1%)

75+ years old: 4.9% (the national average 7.8%)

85+ years old: 1.6% (the national average 2.3%)

Other Population Demographics

Detailed findings

% of Patients with a long standing health condition is 46.2% (the national average 54%)

% of Patients in paid work or full time education is 72.1% (the national average 61.5%)

Practice List Demographics / Deprivation

Index of Multiple Deprivation 2015 (IMD): is 13% (the national average 21.8%)

Income Deprivation Affecting Children (IDACI): is 7.8% (the national average 19.9%)

Income Deprivation Affecting Older People (IDAOPI): is 14.5% (the national average 16.2%)

Patient Gender Distribution

Male 48.7%

Female 51.3%

% of patients from BME populations 8.57%

Patient turnover 2015 14.1%, the national average 8.5%.

Why we carried out this inspection

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

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 8 October 2015.

During our visit we:

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

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

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

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

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

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

Good

Are services safe?

Our findings

Safe track record and learning

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

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice carried out a thorough analysis of the significant events.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, a patient attended for a contraception implant insertion without attending a prior appointment for counselling. The implant went ahead after counselling took place during the appointment as the patient insisted but then the patient raised concerns the next day wishing the implant to be removed. The actions and learning from this incident was that new protocols were put in place, a new patient advice leaflet was developed and reception staff now ensure that a counselling appointment is made pre-insertion appointment.

Overview of safety systems and processes

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

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and most had received training on safeguarding children and vulnerable adults relevant to their role. All but one of the GPs were trained to child protection or child safeguarding level three. Nursing staff had been trained to child safeguarding level two.
- Notices in the waiting room and consulting and treatment area which advised patients that chaperones were available if required. Nursing staff and health care assistants acted as chaperones had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). There was no information in the training records to show that formal training had been provided for the chaperone role.
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. One of practice nurses was the infection control clinical lead who liaised with the local infection prevention teams in order to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements they could address that were identified as a result. However, we saw from the environment, particularly in the treatment room area, it was difficult to maintain and keep to current infection control guidelines. This was because of the nature of the room facilities and the limitations that impede meeting appropriate standards. The treatment room is a large open room divided into two individual cubical and three treatment spaces with curtains for privacy. The walls, like most of the other parts of the building were decorated with wooden panelling and the practice was constrained by the Grade II listing parameters in being unable to change, alter, conceal or adapt the original features. There was limited space for storage and minimal work top space for staff to work from. It was evident that the wooden panelling presented a

potential of risk for the spread of infection because it could not be cleaned effectively. Most of the consulting rooms were fully carpeted; the floor surfaces around the area of examination couches were not the recommended covering to be easily cleaned should there be a spillage of body fluids.

- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat prescriptions which included the review of high risk medicines. The practice carried out regular medicines audits, with the support of the local clinical commissioning groups (CCG) pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored when received into the practice and there were systems in place to monitor their distribution around the practice. Nursing staff confirmed practice staff were following appropriate guidance in regard to removing or securing prescription paper from the printers when the rooms were unattended or at the end of the day. One of the nurses had qualified as a Nurse Practitioner and could therefore prescribe medicines for specific clinical conditions. She received mentorship and support from the medical staff for this role. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. Health Care Assistants were trained to administer vaccines and medicines against a patient specific prescription or direction from a prescriber.
- The practice did not hold stocks of controlled drugs (medicines that require extra checks and special storage because of their potential misuse).
- We reviewed three personnel files and records relating to the employment of nursing staff and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (DBS). DBS checks were carried out on those staff having direct personal contact with patients. Other roles, such as administration were risk assessed the exception was the driving volunteers engaged by the practice to provide support to patients to attend their appointments. The application form used for the recruitment of staff did not request the applicants full work history or evidence of any gaps explained. For the sample of recruitment records we reviewed all relevant information had been obtained as applicants had supplied CVs as accompanying documents. We saw information relating the interview processes and correspondence in regard to offer of employment. There was very little evidence of the decision making process, for example the employment of a new clinical staff member, to support the reasons why they would be appropriate for the role or the service. Minor amendments to the documented recruitment policy and procedure were needed to match what the practice actually carried out, for example the checks on professional registration, training and qualifications. Following the inspection we were provided with a copy of updated recruitment documents that supported that the required information would be requested from applicants and detail of the reason to employ recorded.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in a prominent place for staff which identified local health and safety representatives. Minor changes to the health and safety policy were required to ensure it met with current practices, for example the practice no longer kept liquid nitrogen on the premises. Following the inspection we were told these changes had been made. The practice had a fire risk assessment that had originally been undertaken in 2007 and updated and amended over time. However, the document was brief and did not necessarily reflect current fire safety standards, nor did it highlight the specific risks regarding the unique features such as the high ceilings, the method of storing paper records on open shelves (old library area), the wooden panelling and decorative wooden doors. During the inspection the practice manager engaged their contractor for fire safety to check the potential of risk on their behalf. A detail risk assessment was carried out on 24 May 2016 by an external organisation and the provider was given

information in regard to ensuring some aspects or monitoring were to be improved. For example, ensuring that the delay in providing evidence of the routine six monthly fire alarm checks, last check carried out eight months previously, was rectified as soon as possible. Other areas to complete were to set up and have carried out regular annual emergency lighting checks and to assess if a personal emergency evacuation plan was required for one member of staff. The provider was also given areas of suggested improvement which included carrying out checks to ensure that all staff are included in at least one fire evacuation drill once a year. Likewise, it was suggested that a similar system was in place to ensure that all staff attend a physical fire training exercise within a two year period. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health(COSHH) and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). However, we found that COSHH data sheets regarding the cleaning products used at the practice were not stored as routine with the products as per guidance. This was addressed during the inspection.

- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty. Members of the administration team were flexible in their roles to meet the demands of the service. Clinicians covered absences of their colleagues when they were able to and when needed regular locums were employed to fill gaps in the schedule allowing some continuity of care.

Arrangements to deal with emergencies and major incidents

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

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

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

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 99% of the total number of points available. Exception reporting was similar to other practices in the clinical commissioning group (CCG). (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014/2015 showed:

- Performance for diabetes related indicators was similar to the national averages. The percentage of patients on the diabetes register, with a record of a foot examination and risk classification within the preceding 12 months (01/04/2014 to 31/03/2015) was 90%; the CCG average was 90%, the national average was 88%.
- Performance for mental health related indicators was higher than the national average. For example, the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in their records, in the preceding 12 months (01/04/2014 to 31/03/2015) was 99%; the CCG average was 91%, the national average was 88%.
- There had been ten clinical audits completed in the last two years, all of these were completed audits where the improvements made were implemented and monitored. Five audits were on-going cycles of audits, one of which had been undertaken four times within a two year period. This was in response to a significant event raised through concerns about hormone replacement therapy.
- The practice participated in local audits, national benchmarking, accreditation, peer review and research.
- Findings were used by the practice to improve services. For example, following NICE guidance recent action taken as a result included the identification and on-going monitoring of women flagged as acquiring gestational (during pregnancy) diabetes who were at a higher risk of developing diabetes in the future. The practice staff identified the shortfalls in the monitoring and follow up processes for patients and had updated how they recorded information on a patient care plan template and improved their call and recall system to ensure patients were screening and checked appropriately.
- Another audit reviewed the minor surgery carried out at the practice. This looked at the information recorded such as consent and particularly the GPs decision making in regard the perceived necessity for the procedure to be carried out. The initial audit identified that recording processes could be improved to ensure that it is noted that the potential of risks in balance with the benefit had been discussed with the patient. The outcome was that GPs were reminded to complete the minor surgery template with greater detail and a re-audit was planned for later in 2016 to check this was being used effectively and patients have been provided with an informed choice to proceed with the treatment. There was also evidence that audits linked to reviewing patient experiences were carried out. This had included looking at the provision of consultation times and comparing times with consultation types. This had

provided the practice with information to review and restructure their appointment system to allow for slightly longer consultation times and the implementation of 'catch-up' slots in the scheduling.

Effective staffing

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

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. Nursing staff told us the induction programme was detailed and supportive and allowed them to be supernumerary for two weeks so that they could adjust and learn about their new role and the service. New staff had the opportunity to meet with their line manager on a regular basis and all staff undertook a probationary period.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions, nursing staff had been given the time to undertake diplomas in asthma and diabetes. One nurse was just completing an insulin adjustment course. GPs shared their individual training and development records which showed the training they had undertaken to take lead roles at the practice such as mental health including caring for patients with post-natal depression and the health benefits or physical activity for patients with depression, anxiety and dementia.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence.Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by attending training and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. All staff had received an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire safety awareness, and basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

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

- This included care and risk assessments, care plans, medical records and investigation and test results. We saw that care plans for admission avoidance were in place and we were informed following the inspection this had been extended to patients with complex or multiple health conditions so that there was a planned holistic approach to providing their care.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services. We did note that there were gaps in the system for checking referrals had been made in a timely way.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

Consent to care and treatment

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.

Good

Are services effective?

(for example, treatment is effective)

- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored through patient records audits. We did note through discussion with GPs that written consent from the patients was not routinely taken for the fitting of contraceptive devices, although acknowledged in the patient electronic records verbal consent obtained.

Supporting patients to live healthier lives

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

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, and smoking cessation. Patients were signposted to the relevant service.
- Patients had access to care and support at the practice for mild to moderate depression, including counselling services. Patients were directed to local support groups.

The practice's uptake for the cervical screening programme was 80%, which was comparable to the clinical commissioning group (CCG) average of 80% and the national average of 81%. There was a policy of recall carried out be staff for patients who did not attend for their cervical screening test. There were systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

The practice also supported its patients to attend national screening programmes for bowel and breast cancer screening. The uptake for screen was above or similar to the CCG and national average. For example:

- 62% of patients aged 60-69 years were screened for bowel cancer within six months of invitation which was above the clinical commissioning group (CCG) average of 49%, and the national average of 55%. We noted that 63% of patients aged 60-69 years were screened for bowel cancer in the last 30 months, which was above the CCG average of 53%, and the national average of 58%.
- 73% of females, aged 50-70 years were screened for breast cancer in the last thirty six months which is above the CCG average of 70%, and similar to the national average of 73%.

Childhood immunisation rates for the vaccines given were comparable to the CCG averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 80%.Meningitis C) to 100%, with the CCG from 81% to 97%. Childhood immunisations for five year olds ranged from 86% to 96%, which compared with the CCG range from 88% to 97%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

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

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and the main treatment room doors were closed during consultations; conversations taking place in the consulting rooms could not be overheard. However, privacy was limited in the large shared treatment room as although screening was provided it didn't provide any privacy for conversations. Nursing staff did ensure where possible that patients were seen when able within the two cubicles in the treatment room which offered greater privacy.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

All of the 24 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent and much valued service and staff were helpful, caring and treated them with dignity and respect.

We spoke with six members of the patient participation group (PPG). They also told us they were very satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help, patients felt they were cared for and staff provided support when required. Comments included in patient feedback given directly to the practice highlighted patients had found that staff had treated them with kindness and understanding, were prompt in providing the care and support they needed and had reduced their apprehension.

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

- 97% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 90% and the national average of 89%.
- 89% of patients said the GP gave them enough time compared to the CCG average of 86% and the national average of 87%.
- 99% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 98% and the national average of 97%.
- 90% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG and national average of 85%.
- 96% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 92% and the national average of 91%.
- 95% of patients said they found the receptionists at the practice helpful compared to the CCG average of 88% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Where patients made personal choices about their care this was accepted. Patient feedback from the comment cards we received was also positive and aligned with these views.

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

- 96% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 87% and the national average of 86%.
- 87% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG and national average of 82%.

Good

Are services caring?

- 88% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG and national average of 85%.

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

- Staff told us that telephone translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.
- Information leaflets were available in easy read format.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting areas which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 108 patients as carers (less than 1% of the practice list). The practice population was predominantly working age population 72%. They provide additional support for patients who were identified as carers including access to appointments a convenient time and provided influenza immunisation for 50%.Written information was available to direct carers to the various avenues of support available to them.

The practice had been providing community support to patients, not just carers and had a patients association that had been established for over 30 years. The association had a volunteer driving service as well as a weekly lunch club which was held in a local community building which provided to meet the social needs of their elderly and isolated patients.

Staff told us that if families had suffered bereavement, their usual GP contacted them or sent them a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and by giving them advice on how to find a support service. The practice had developed a bereavement pack for this purpose which included the practical aspects and also support with dealing with grief.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

- The practice offered extended hours one evening each week from 6.30pm to 8pm and alternate Saturday mornings from 8.30am until 11.45am on a Monday for working patients or those who could not attend during normal opening hours.
- Patients could book appointment three weeks in advance.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients could book appointments and order repeat prescriptions online.
- Patients were able to receive travel vaccinations that are available on the NHS as well as those only available privately.
- There weretoilet facilities for those less able on the ground floor, a hearing loop and telephone translation services available. However, there were constraints, because of being a listed building, on providing appropriate door opening mechanisms and no lift to the first floor to support patient independence. Staff ensured that patients' needs were met by checking with patients if they required support to enter and leave the building, appointments and meetings were accommodated on the ground floor.
- The practice had a focus on providing mental health support to people with mild and moderate depression with facilitating counselling services (IRIS, domestic violence counselling), access to a mental health nurse each day and involvement with external mental health teams.
- The practice were participating in a physiotherapy pilot where patients were able to self-refer reducing the timescales for receiving treatment.
- The practice accommodates temporary residents to obtain health care, treatment and support. This included people working and studying in the area but their primary residence was elsewhere. They were also the point of contact for a primary care service for families outside the area who were supporting children who were inpatients at the local children's hospital.
- The practice offered Web-GP to patients that enabled consultation via email. In October 2015 this was being used on average three to five times per day and there had been a corresponding drop in appointments required.
- Telephone consultation appointments were available for patients who were not able to attend the practice or who needed advice in regard to their care and treatment.
- The nurse clinics were flexible to patients' needs and were able to combine activities in one visit, such as a blood test with regular health screening for a long term condition.
- The practice facilitated access to diabetic retinal screening, aortic aneurysm screening, and a weekly mental health clinic.
- Patients had access to 24 hour blood pressure screening, ECG (heart monitoring) and tele dermatology consultations at the surgery reducing the need to attend other services.
- The patient participation group (patients association) who provided a volunteer service to meet the social and emotional needs of the elderly, housebound patients by providing a volunteer driving service and a Monday lunch club.

Access to the service

The practice opening hours are from 8.15am until 6.30pm, Monday, Tuesdays, Thursdays and Fridays. Wednesday the practice opens at 8.15am and closes for staff training at 12md and reopens at 2pm until 6.30pm. The practice is open one evening per week from 6:30pm to 8pm for routine GP and nurse appointments and alternateSaturday mornings 8:30am to 11:45pm for GP appointments only.

Good

Are services responsive to people's needs?

(for example, to feedback?)

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

- 83% of patients were satisfied with the practice's opening hours compared to CCG average of 82% and the national average of 78%.
- 86% of patients said they could get through easily to the practice by phone compared to the CCG average of 72% and the national average of 73%.

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

The practice had a system in place to assess:

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

This was carried out by telephone triage when patients first contacted the practice, the administration staff had a process of assessing each patients need and sought advice from the duty clinician. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice had an effective 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 who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system which was in the form of a leaflet, information on display and provided on the practice website.

We looked at a sample of the 24 complaints received in the last 12 months and found each complaint had been satisfactorily handled and dealt with in a timely way. Verbal complaints and suggestions made were investigated and responded to equally with those written. Lessons were learnt from individual concerns and complaints and also from analysis of trends and action were taken to as a result to improve the quality of care. For example, complaints ranged from the time waiting the phone to be answered to patient's experience of poor communication or issues with staffs manners. A patient had complained they were unhappy their phone call wasn't answered quickly at 6pm, it was identified that support administration staff were processing new registrations processes at the time away from the reception area and did not respond as quickly as they could. Changes were made in how administration processes were carried out, this included ceasing processing these applications after 6pm so that staff were readily available. Where patients had expressed concerns about staff manner or responses it was identified that communication skills should be addressed, staff needed to provide a greater explanation and ensuring that information was correct on the practice website regarding bank holidays.

The percentage of respondents to the GP patient survey who described the overall experience of their GP surgery as fairly good or very good was 95% compared to the clinical commissioning group of 86% and national average of 85%. Also 92% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 81% and the national average of 80%.

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 'maintain excellent all-round family health care.'

- The practice had a mission statement which was displayed in the waiting areas which outlined how the practice intended to deliver the service. This was through' providing and atmosphere for patients that is professional, welcoming and encourages full participation in their own health.' Staff knew and understood the values.
- The practice had a robust strategy and supporting business plans which reflected the vision and values and were regularly monitored.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff.
- A comprehensive understanding of the performance of the practice was maintained
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

Leadership and culture

On the day of inspection the partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. Members of the practice partnership and other staff had lead roles they were responsible and accountable for, such as safeguarding, complaints and the business management of the service. They told us they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment:

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

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

- Staff told us the practice held regular team meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. We noted team training days and engaged in social activities and events to support team building.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

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

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

- The practice had gathered feedback from patients through the patient participation group (PPG) or patients association and volunteers. They had also obtained feedback through surveys, compliments and

Are services well-led?

Good

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

complaints received. The PPG had approximately 15 to 20 regular participants who met four to five times per year. The PPG had assisted with practice patient surveys were consulted at some aspects of the service delivery and submitted proposals for improvements to the practice management team. For example, the implementation of Wi-Fi in the waiting area, promotion of self-care information and support and signage in the waiting and reception area. The PPG had made observations about confidentiality in the reception area and they had been involved in trials and monitoring of changes made to answering telephones away from this area to minimise conversations being overheard. When we spoke with representatives of the PPG they were very positive about their involvement in the delivery of the service and felt they were listened to and that their opinion was valued.

- The practice had gathered feedback from staff through meetings, team building days and individually through one to one and appraisals. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The partners had carried out a review of the service in April 2016 and they revisited their findings in line with The General Practice Review (May 2016) from NHS England. What this identified was the practice had already completed or was in the process of completing some of the key areas of development for GP services. For example, active signposting patients including an online portal and navigation to services, new types of consultations including e- consultations and their project to provide a service for texting results to patients directly was to 'go live' in June 2016. The practice had looked at increasing the variety of clinical support provided to patients including employing an advanced nurse practitioner in March 2016. They were in the process of joint employing an IT manager so that they could use their IT systems more effectively.

The practice was in the process of developing its participation in a federation that was formed in 2015 with two other practices in the local area. This was looking at shared systems such as administration and management, treatment and care provided and clinical support.

The practice had identified that they were not meeting the needs of the service in regard to their treatment area facilities. They were in the process of obtaining planning permission to build an extension in the car park area to accommodate new treatment areas that met with current good practice for infection control and patient access.

One GP had an interest in and worked with the local medical committee in promoting a GP support scheme in the Bristol area. This provided GPs, locums and practice managers with support and access to occupational health resources, support for managing professional relationships and advocate schemes. This meant they were able to signpost and support the clinical team at the practice.