The Crest Family Practice

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Crest Family Practice on 31 March 2015. Overall the practice is rated as good. We did not inspect their branch surgery in St Johns Lane Health Centre located at Bedminster.

Specifically, we found the practice to be good for providing safe, well-led, effective, caring and responsive services. It was also good for providing services for patients 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 and people experiencing poor mental health (including people with dementia).

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored appropriately, reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a GP or nurse and that there was continuity of care. Urgent appointments were available the same day and 97% of patients said they had confidence and trust in the last GP they saw or spoke with.
- The practice was purpose built with 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 sought feedback from staff and patients, which it acted on.

Summary of findings

We saw there were areas of practice where the provider needs to make improvements. Importantly, the provider should:

- Review their system for recording actions taken following significant event investigations.
- Review their policies to ensure clear processes are available for staff for example, to manage cold chain procedures.
- Review their policies to ensure clear recruitment processes are stated and followed for all new employees, personal staff safety is maintained and written patient consent are gained for minor surgery.
- Review their process for how verbal or informal complaints are managed.
- Review risks in regard of staff safety.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and concerns. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were reliable systems in place to keep patients safe these included; the safe management of medicines, appropriate infection control measures, a programme of building maintenance and a programme of equipment monitoring and replacement. There were enough staff to keep patients safe and there was a skilled team to manage unforeseen emergencies within the practice.

Are services effective?

Good

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

Are services caring?

Good

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

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice had initiated positive service improvements for its patients that were over and above its contractual obligations. It acted on suggestions for improvements and changed the way it delivered services in response to feedback from the patient participation

Summary of findings

group (PPG). The practice reviewed the needs of its local population and engaged with the NHS England Local Area Team and Bristol Clinical Commissioning Group (CCG) to secure service improvements where these had been identified.

Patients told us it was easy to get an appointment and could request appointments with a named GP or a GP of choice, with continuity of care and 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 the practice responded appropriately when issues were raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy which was made available to patients and staff in communal areas. Staff were clear about the vision and their responsibilities in relation to this with the majority having lead roles for different aspects of service delivery. 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 governance meetings to review and discuss their development. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions and attended staff meetings and events with a new programme of appraisal about to begin.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a 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 on the at risk register. Immunisation rates were around average for all standard childhood immunisations with some at 100%. 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 and heard about good examples of joint working with midwives, health visitors and school nurses.

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

Summary of findings

a full range of health promotion and screening that reflects the needs for this age group. There were strong links with a charity organisation on the same site providing services aimed at tackling health inequality and promoting health and well-being.

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 and those with a learning disability. It had carried out health checks for people with a learning disability and the majority of these patients had received a follow-up. It offered longer appointments for people with substance misuse or mental health problems. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and local 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). Most patients experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out care planning for patients with dementia. The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND and other locally based organisations. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

We spoke with six patients visiting the practice and three members of the patient participation group during our inspection. We received nine comment cards from patients registered at the practice. The practice also shared their initial findings from their current 'friends and family' survey. We looked at the practice's NHS Choices website to look at comments made by patients (NHS Choices is a website which provides information about NHS services and allows patients to make comments about the services they received). We also looked at data provided in the most recent NHS GP patient survey and the Care Quality Commission's information management report about the practice.

The majority of comments made or written by patients were positive and praised the GPs and nurses who provided their treatment. For example, about the caring nature of the clinical staff; about seeing a named GP when they requested to do so and about being treated with kindness and consideration. A common theme from the comments received was about the friendliness of all the staff at the practice.

We heard and saw patients generally found access to the practice and appointments easy and how telephones were answered after a brief wait. However, a very small minority indicated it was not always easy to get through to the practice during the first hour of the practice opening. The most recent GP survey showed 93% of patients found the appointment they were offered was convenient for them. Patients also told us they used the practice's online booking systems to get appointments and liked the early and Saturday morning appointment options.

Patients told us their privacy and dignity was respected during consultations and they found the reception area was generally private enough for most discussions they needed to make. Patients told us how GPs supported them at times of bereavement and provided extra support to carers. A significant number of patients had been attending the practice for over 15 years and told us about how the practice had grown and that they were always treated well. The GP survey showed 89% of patients said the last GP they saw or spoke with was good at giving them enough time and treating them with care and concern.

Patients told us the practice was always kept clean and tidy. Improvements included the process for requesting repeat prescriptions. They told us during intimate examinations GPs and nurses wore protective clothing such as gloves and aprons and that examination couches were covered with paper protective sheets. 88% of patients describe their overall experience of this practice as good.

Areas for improvement

Action the service SHOULD take to improve

- Review their system for recording actions taken following significant event investigations.
- Review their policies to ensure clear processes are available for staff for example, to manage cold chain procedures.
- Review their policies to ensure clear recruitment processes are stated and followed for all new employees, personal staff safety is maintained and written patient consent are gained for minor surgery.
- Review their process for how verbal or informal complaints are managed.
- Review risks in regard of staff safety.

The Crest 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 and other specialists including, a practice manager and a practice nurse.

Background to The Crest Family Practice

The Crest Family Practice William Budd Health Centre, Knowle West Health Park, Downton Road, BristolBS4 1WH is located about 3 miles from the centre of Bristol. The premises are purpose built and are shared with another GP practice and a privately run pharmacy. The health park also includes the Bristol (Brisdoc) out of hours service and a charity organisation providing services aimed at tackling health inequality and promoting health and well-being across the south Bristol area.

The Crest Family Practice has approximately 6,200 patients registered over the two locations. The Practice is situated in Knowle West, one of the most deprived areas of the South West. The population is predominantly poorly resourced with many patients having multiple physical, social and psychological problems.

There are three partners who are complimented by one salaried GP and a locum GP; there is a salaried GP vacancy. The GPs were complimented by a small team of clinical staff including a lead nurse, a practice nurse, a health care assistant and a practice pharmacist who was employed by the Clinical Commissioning Group one day a week with some additional hours being commissioned by the practice.

Two partners are female and one is male, the hours contracted by GPs including the salaried and locum GP are equal to 4.1 whole time equivalent employees. Collectively they provide 29 GP sessions each week. Additionally the three nursing staff employed are equal to 2.2 whole time equivalent employees. Non-clinical staff included a medical secretary, a lead receptionist, support staff and a practice manager.

The practice population is predominantly White British with an age distribution of male and female patients predominantly in the working age population group. The average male and female life expectancy for the practice is 78 and 83 years respectively, the male figure is slightly below the national average and reflects the high level of deprivation in the area. The patients come from a limited range of income categories with patient population being in the most deprived category. The practice has one of the lowest numbers of patients over the age of 85 years in Bristol and about 23% under the age of 15 years. Over 79% of patients said they would recommend the practice to someone new to the area in the most recent National GP patient survey 2013/14.

The practice has a Personal Medical Services (PMS) contract to deliver health care services; the contract includes enhanced services such as extended opening hours, online access and diabetes services. This contract acts as the basis for arrangements between the NHS Commissioning Board and providers of general medical services in England.

The practice has opted out of providing out-of-hours services to their own patients. This service is provided by BrisDoc and patients are directed to this service by the practice during out of hours.

Detailed findings

Why we carried out this inspection

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

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.

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations such as the Bristol Clinical Commissioning Group and Healthwatch Bristol to share what they knew. We asked the provider to send us information about their practice and to tell us about the things they did well. We reviewed the information for patients on the practices website and carried out an announced visit on 31 March 2015.

We talked with the majority of staff employed in the practice who were working on the day of our inspection. This included three GPs, the lead nurse, the practice nurse, the practice manager and four administrative and reception staff. We also spoke with the pharmacist from the adjacent pharmacy, and a midwife and community nurse located in the practice. We spoke with six patients visiting the practice during our inspection, three members of the patient participation group and received comment cards from a further nine patients.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, reporting an incident involving a patient during a consultation.

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

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last year and we were able to review these. Significant events were a standing item on the practice meeting agenda and a meeting was held monthly to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. She showed us the system used to manage and monitor incidents. We tracked four incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result such as taking following up actions where a patient was identified as hepatitis B positive and replacing examination couches following an incident. However, where actions were taken they were not always recorded on the significant events form. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated by the partners and lead nurse to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed in clinical meetings to ensure all relevant staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

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

The practice had appointed a dedicated GP with lead responsibility for safeguarding vulnerable patients. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who the lead was and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans or young people who misused substances. .

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone.

GPs were using the required codes on their electronic patient record system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies

such as health visitors, the police and social services. The practice staff attended child protection case conferences and reviews and serious case reviews where appropriate. Reports were sent if staff were unable to attend.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a procedure for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the procedure however, there was not a practice specific cold chain policy for the handling of medicines requiring refrigeration. The practice manager told us they would arrange for a specific policy to be made available to the nursing team within the next few weeks.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses had received appropriate training to administer vaccines in line with these sets of guidance. (patient group and patient specific directions are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment and an instruction to administer/supply a medicine written in the patient's notes respectively).

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance; these were tracked through the practice and kept securely at all times.

Cleanliness and infection control

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

The practice had a nurse with lead responsibility for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about basic infection control specific to their role and received planned updates. We saw evidence that the lead had carried out an audit since taking on this role and that any improvements identified for action were completed on time. Minutes of clinical and treatment room meetings showed that the findings of the audits were discussed.

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

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. However some waste bins were not foot operated, the practice manager arranged for these to be replaced when this was highlighted to them. There was a policy for replacing disposable privacy curtains in the consulting rooms, we saw the curtains were replaced in line with the policy. The last change having taken place on 28 November 2014. Where portable screens were required we saw the practice had purchased wipe clean screens to ensure hygiene standards were maintained.

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal).We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All

portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer. Other equipment such as fire extinguishers were also serviced and tested annually in line with fire safety requirements.

Staffing and recruitment

Records we looked at contained evidence that recruitment checks had been undertaken prior to employment. For example, proof of identification, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). DBS checks were in place for all staff employed by the practice as they felt this approach ensured patient safety. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. However the policy did not clearly state the number of references required or the process for recording how verbal references should be recorded and stored.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. The rota for the day of our inspection was as stated. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed and provided us with records to demonstrate actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative. However the policy did not cover all risks to staff such as personal safety in the workplace or for staff carrying our patient visits outside of the practice.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at GP partners' meetings and within team meetings. For example, the practice manager had shared the recent findings from an infection control audit with the team.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment, shared with the other practice in the health centre, was available and included access to oxygen and an automated external defibrillator (AED) (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. The notes from a staff meeting showed that staff had discussed a medical emergency concerning a patient and the practice had learned from this incident.

Emergency medicines were available in a secure area of the health centre and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may have impacted on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a utility company to contact if the heating, lighting or water systems failed. Details were also provided for the Bristol Clinical Commissioning Group so they could be informed of emergency occurrences.

Good

Are services safe?

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. The policy covered joint arrangements with the other practice in the health centre. Records showed that staff were up to date with fire training and that they practised fire drills and alarm testing.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of clinical meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of respiratory disorders. Our review of the clinical meeting minutes and audits confirmed that this happened.

One of the partners explained to us about data from the local Clinical Commissioning Group (CCG) of the practice's performance for antibiotic prescribing, which was comparable to similar practices. The practice had also completed a review of case notes for patients with coronary heart disease or hypertension which showed all were receiving appropriate treatment and should have an electrocardiogram (ECG) on their records (an ECG records the electrical activity of the heart). The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital, which required patients to be reviewed within two weeks by their GP according to need.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of suspected cancers where patients were referred and seen within two weeks. We saw minutes from meetings where reviews of elective and urgent referrals were made, and that improvements to practice were shared with all clinical staff.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to carry out clinical audits and patient reviews.

The practice had a system in place for completing clinical audit cycles. The practice showed us six clinical audits that had been completed recently. Following each clinical audit, changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved. For example, following guidance from the Bristol Clinical Commissioning Group regarding patient use of oxygen, a clinical audit was carried out. The aim of the audit was to ensure that all patients prescribed this treatment were clearly identified as receiving clinical benefits. The first audit demonstrated 164 patients were identified who might fulfil the National Institute for Health and Care Excellence (NICE) criteria for home use of oxygen. Eight patients were identified as meeting the specific criteria for oxygen use. The information was shared with GPs and patients were called for a medication review; three patients stopped using oxygen at home. A second clinical audit was completed one year later with a further three patients having stopped using oxygen at home.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common

Good

Are services effective?

(for example, treatment is effective)

long-term conditions and for the implementation of preventative measures). For example, we saw an audit regarding the prescribing of analgesics and nonsteroidal anti-inflammatory drugs. Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 90% of patients with diabetes, on the register, had a record of an albumin creatinine ratio test in the preceding 12 months. The practice met or exceeded all the minimum standards for QOF in diabetes, asthma and chronic obstructive pulmonary disease (lung disease).

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all clinical staff should undertake at least one audit a year.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long-term conditions such as diabetes and the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the doctors with one having additional diplomas in sexual and reproductive medicine, and one with diplomas in children's health and obstetrics and one with further qualifications in Mental Health. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff were due to undertake annual appraisals in May 2015 to identify learning needs from which action plans could be documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example diabetes and chronic disease management. As the practice was a training practice, doctors who were training to be qualified as GPs were given extended appointments and had access to a senior GP throughout the day for support.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology and holiday immunisations. Those with extended roles who saw patients with long-term conditions such as asthma, diabetes, chronic obstructive pulmonary disease (COPD) and coronary heart disease were also able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we

Good

Are services effective?

(for example, treatment is effective)

spoke with understood their roles and felt the system in place worked well. There were no instances identified recently of any results or discharge summaries that were not followed up appropriately.

The practice was commissioned for new enhanced services for example, a process to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the process for actioning hospital communications was working well in this respect. The practice undertook a yearly audit of follow-ups to ensure inappropriate follow-ups were documented and that no follow-ups were missed.

The practice held multidisciplinary team meetings monthly to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, midwives and where required palliative care nurses, decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Other examples of where the practice worked with other service providers included supporting patients with drug or substance dependencies through joint working with a local drug project worker who held clinics in the practice. The pharmacist in the adjacent pharmacy also commented to us about the positive working relationship they had with the practice and how appropriate prescribing took place.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data, including care plans for the most vulnerable patients, to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made the majority of referrals last year through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that this system was easy to use.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. One GP highlighted the importance of this communication with A&E. The practice has also signed up to the electronic Summary Care Record and planned to have this fully operational by 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record (EmisWeb) to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified. Information was shared with other organisations in line with the practices clinical governance and data protection policy.

Consent to care and treatment

We found staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling them. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff for example, with making do not attempt resuscitation orders.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. The practice kept records and showed us the majority of care plans had been reviewed in the last year. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

Good

Are services effective?

(for example, treatment is effective)

There was a practice policy for documenting consent for specific interventions. For example, completing a detailed checklist with the patient for all implants and intrauterine devices (IUD or coil), a patient's verbal consent was gained following an explanation of the relevant risks, benefits and complications of the procedure. However, patient consent was not recorded for the examples provided to us. The practice recognised the lack of written patient consent was an issue and told us they would add a patient signature section to their checklist

Health promotion and prevention

The practice had met with the Public Health team from the local authority and the CCG to discuss the implications and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the local area. This information was used to help focus health promotion activity.

It was practice policy to offer a health check with the health care assistant or practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering diabetes blood screening and offering smoking cessation advice to smokers when they attended other appointments.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed about half of patients in this age group took up the offer of the health check. A nurse showed us how patients were followed up within two weeks if they had risk factors for disease identified at the health check and how they scheduled further investigations.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and all were offered an annual physical health check. The practice had also identified the smoking status of all patients over the age of 16 and actively offered nurse-led smoking cessation clinics to these patients. There was evidence these were having some success as the number of patients who had stopped smoking in the last 12 months was increasing. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs at the adjacent health and wellness centre.

The practice's performance for cervical smear uptake was 82.5%, which was better than others in the CCG area. There was a policy to offer reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend. There was also a named nurse responsible for following up patients who did not attend screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was average for the CCG, and again there was a clear policy for following up non-attenders by the named practice nurse.

The practice kept a register of older patients who were identified as being at high risk of admission to hospital or who were nearing the end of their life. All had up to date care plans and these were shared with other providers such as the out of hour's service. All older patients discharged from hospital had a follow-up consultation where this was clinically advised. Older patients who were prescribed multiple medicines all received a structured annual medicines review. 100% of older patients diagnosed with dementia had a face-to-face review in the preceding 12 months.

The clinical team worked closely with the community nurse for older people (CNOP) district nurse and palliative care teams and Bristol Community Health to provide a holistic and multidisciplinary approach to the care of older patients. One of the GPs is currently leading on a South Bristol project to support the health and wellbeing of their elderly population in the community. This includes the development of a community facing frailty team, the development of step up beds at a local Nursing home and the development and delivery of a rapid access clinic for older people (RACOP) at the local community hospital. The aim is to provide a safe alternative to hospital admission. The pilot of this clinic started in January 2015 and to date the practice has made four referrals to this service which has had a significant impact on the care and service provided to this patient group.

Good

Are services effective?

(for example, treatment is effective)

The practice provided annual reviews for patients diagnosed with various long term conditions such as diabetes, chronic obstructive pulmonary disease (COPD) and coronary heart disease. Data from the 2013/14 Quality and Outcomes Framework (QOF) showed 91.2% of patients diagnosed with diabetes received annual foot checks. The practice had adopted the use of summary care records for their most vulnerable patients in this category. We saw the lead nurse had been proactive in promoting healthy lifestyles with patients. Structured information boards were maintained in prominent areas of the waiting areas, leaflets were available in the consulting rooms and advice offered was recorded in the patient's notes. We were provided with evidence of multidisciplinary case management meetings and saw a named GP was provided for patients diagnosed with long term conditions.

Nursing staff have been trained or are in the process of being trained for chronic disease identification and management and long term conditions. The practice offers a range of long term clinic appointments at various times throughout the day to try to encourage patient to engage with and manage their long term health condition. Clinical staff follow and promote National Institute for Health and Care Excellence (NICE) guidelines.

All staff actively encouraged self-care, education and management. The lead clinical nurse had developed a range of detailed display boards to promote healthy lifestyles. All nurses were trained to provide smoking cessation and support and refer patients to weight management programmes where appropriate. The practice had signed up to support the CCG programme of self-care and promote the House of Care and 'ask me three questions' campaign which we saw actively promoted in the patient waiting areas.

Housebound patients were supported to manage their health by the community matron with whom regular meetings were held. The practice also arranged joint visits to these patients as appropriate. The community matron also had access to Telehealth (Telehealth is the delivery of health-related services and information via telecommunications technologies) which some patients told practice staff they found exceptionally useful in managing their diagnosed conditions.

Immunisation rates for all standard childhood immunisations were average for the CCG and up to 100% for many common illnesses such as polio and diphtheria and measles, mumps and rubella. We saw evidence of signposting young people towards sexual health clinics and contraception advice in information around the practice. The practice also signposted younger patients to the 4YP Bristol service which provided confidential, young people friendly services and advice on all aspects of growing up, relationships and health. The practice was in the process of applying to become a 4YP practice and had recently signed up to the IMPACT Study for which the practice was in the intervention arm (An impact study is research done on a topic to determine how a certain action would or is affecting other issues).

The midwives we spoke with told us about multidisciplinary team working involving practice staff and other organisations and were provided with minutes of meetings which were held. Mother and baby and post natal clinics were provided each Tuesday afternoon with an immunisation clinic also available that afternoon. The mothers we spoke with were complimentary about the clinics and the nurses and GPs involved.

Patients of working age had access to services from 7:30 am on Thursday mornings and between 6:30 and 7:00 pm on Tuesday evenings. Additionally the practice provided appointments on three Saturday mornings each month for pre-booked appointments. The Practice introduced a weekly drop in blood clinic in October 2014. This had proved so successful that daily drop in blood clinics were being made available from the beginning of April 2015. The uptake rate for cervical smears for women aged 25 to 65 whose notes recorded that a cervical screening test has been performed in the preceding 5 years was about 82.5%. A range of additional in-house services including, phlebotomy (blood tests), spirometry (a test that can help diagnose various lung conditions), international normalized ratio (INR) blood tests monitoring, NHS health checks and minor surgery were provided.

Patients were able to request repeat prescriptions in a number of ways including email, online, in person, over the telephone and via the pharmacist. Prescriptions were available within 48 hours but in an emergency they will be ready on the day after 6pm. This was confirmed by the patients we spoke with.

The practice held a register of patients whose circumstances may make them vulnerable for example, those who may be homeless, couch surfers (people who move between friends' houses sleeping on their sofas) or

Good

Are services effective?

(for example, treatment is effective)

those with diagnosed learning disabilities. We were provided with evidence of multidisciplinary team working and case management of vulnerable patients and saw the practice provided drug project worker led clinics each week. Additionally we saw evidence of signposting patients to various support groups and third sector organisations such as, Bristol specialist drug and alcohol service, addiction recovery agency and Alcoholics Anonymous.

Vulnerable patients were offered vaccination against Hepatitis B and screening for all forms of Hepatitis and HIV for higher risk patients. Patients were offered continuity of care with GPs trained in management of substance abuse.

Further support was offered by a benefits adviser from Citizens Advice Bureau who attended the practice one day a week and could advise patients on benefit queries.

Patients who experienced poor mental health were provided with a range of services through referrals to locally based services, for example, Child & Adolescent Mental Health Services (CAMHS) and adult mental health services. The practice carried out joint patient consultations with local mental health teams where relevant. This helped ensure greater continuity of treatment for the patient and improved information sharing for the professionals involved. For example, in the types and choices of treatment available to the patients.

Carers of these and other patients were identified and referrals were made to a local carers organisation to enable them to receive support if they required it, as well as the Carer's National Association. Carer identification had increased from 56 to 126 over an 18 month period.

A named accountable GP was available to patients who experienced poor mental health with flexible appointment times including same day emergency appointments and telephone consultations. Staff were trained to be sensitive to patients distress and offered extended appointment times when appropriate. GPs and nurses were informed immediately of any undue distress shown by patients so they could speak with the patient and provide an earlier appointment.

The practice had signed up to the dementia local enhanced service (LES) to improve the case finding and management of dementia. The practice increased the number of patients on the register from nine to 16 and also identified some patients with mild cognitive impairment. The clinical team met monthly with the dementia teams and the practice pharmacist carried out yearly reviews for this patient group.

The practice worked closely with the services provided at Knowle West Health Park which offered a range of support services, counselling and courses for a range of mental health issues.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey published on 8 January 2015. We also looked at the last survey of patients undertaken by the practice's patient participation group (PPG) and patient satisfaction questionnaires sent out to patients by each of the practice's partners. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'among the best' for patients who rated the practice as good or very good. The practice was also average or better for its satisfaction scores on consultations with doctors and nurses with 89% of practice respondents saying the GP was good at listening to them and 87% saying the GP gave them enough time.

Patients completed CQC comment cards to tell us what they thought about the practice. We received nine completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations. However the curtained areas of the treatment area meant conversations taking place in these spaces could be overheard by patients going into other treatment rooms.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk which helped keep patient information private. In response to patient and staff suggestions, a system had been introduced to allow only one patient at a time to approach the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it generally enabled confidentiality to be maintained.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff.

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

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 87% of practice respondents said the GP involved them in care decisions and 85% felt the GP was good at explaining treatment and results. Both these results were in line with other Bristol Clinical Commissioning Group (CCG) practices.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices on the practices website informing patents this service was available.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the

Good

Are services caring?

practice and rated it well in this area. For example, members of the Patient Participant Group we spoke with said they had received help to access support services to help them manage their treatment and care when it had been needed. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. The practice had a member of staff with lead responsibility for carers. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Staff told us if families had experienced a bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and or by giving them advice on how to find a support service. Patients we spoke with who had experienced a bereavement or who struggled emotionally confirmed they had received this type of support and said they had found it helpful.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. We saw one of the practices GPs was involved at a Clinical Commissioning Group (CCG) level for urgent care.

The NHS England Area Team and Bristol CCG told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. For example, improving health awareness – what can help us feel well, preventing illness, helping people manage their own care effectively, reducing hospital admissions and providing more community support to help people remain at home.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). For example, booking appointments up to six months in advance, promoting access to appointments and providing a GP led triage service.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, those with a learning disability, vulnerable patients, the unemployed and carers.

The practice had access to online and telephone translation services to support patients if English was not the patient's main language.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training and that equality and diversity was regularly discussed at staff appraisals and team events.

The premises and services had been adapted to meet the needs of patients with disabilities There were parking spaces for patients with disabilities and level access into the practice. Automatic opening doors assisted access into the building and there was sufficient space for wheelchair users and parents with pushchairs to manoeuvre safely. There were accessible toilets and baby changing facilities. All consulting and treatment rooms had level access and were only a short distance from the waiting area. A privately run pharmacy was located adjacent to the practice and enabled patients to access prescribed medicines easily.

The practice actively supported patients who had been on long-term sick leave to return to work by referring them to other services such as physiotherapists, counselling services and by providing 'fit notes' for a phased or adapted return to work.

Access to the service

Appointments were available from 8.30am-12.15pm and 1.15pm-6.30pm on weekdays. Additionally the practice opened from 7:30 to 8:00 am on Thursday mornings and from 6:30 to 7:00 pm on Tuesday evenings for pre-booked appointments. The practice also opened on three Saturday mornings a month from 8.30 until 10.30 am for pre-booked appointments at their branch surgery.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients. Self-help information was also available on the practices website.

Longer appointments were available for patients who needed them and those with long-term conditions. This included appointments with a named GP or nurse. Home visits were made to those patients who needed one.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their

Good

Are services responsive to people's needs?

(for example, to feedback?)

choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system both on the practice website and on waiting area notice boards, information was also in the practice brochure. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at five complaints received in the last 12 months and found these were satisfactorily handled, dealt with in a timely way, with openness and transparency when dealing with the compliant.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, actions from lessons learned from individual complaints were not always recorded despite evidence of the complaints being discussed in staff meetings. There was no process for recording how verbal or informal complaints were managed.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's strategy and business plan. These values were clearly displayed in the waiting areas and in the staff areas of the practice. The practice vision and values included; providing the highest quality care, treating patients with courtesy, dignity and respect,

supporting patients to make informed decisions, promoting best practice**,** putting patients at the centre of service delivery along with, responding in a forward looking and adaptable way.

We spoke with eight members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. We looked at minutes of the practice meetings and saw that staff had discussed and agreed that the vision and values were still current and they worked towards these aspirations.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop of any computer within the practice. We looked at eight of these policies and procedures and most staff confirm they had read the policy as part of their induction when starting work in the practice. All policies and procedures we looked at had been reviewed annually and were up to date. However, some policies such as those relating to recruitment, health and safety and minor surgery needed a further review to ensure they covered steps in more detail. For example, how many references to request and how they should be recorded.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and a partner GP was the lead for safeguarding. We spoke with six members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes. One of the GPs, the practice manager and their deputy had responsibility for overseeing QOF performance.

The practice nurse told us about a local peer review system they took part in with neighbouring GP practices and about the support and supervision provided by the partners. They shared with us minutes of nurses and clinical meetings where patient care and their diagnosis was discussed.

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, infection control audits which brought about changes to cleaning routines and an insulin initiation audit which enabled patients to be monitored locally. Other audits carried out included, A&E attendances, referral audits and emergency admissions to secondary care audits.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us risk assessments which addressed a wide range of potential issues. For example, ensuring the premises maintenance was managed appropriately. We saw the risks were discussed at relevant staff and health centre meetings and were updated. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. For example, we saw a 'Practice Pharmacist' employed by the clinical commissioning group had been commissioned to work with the practice to review prescribing so that medicines were prescribed therapeutically and risk to patients was minimised. However, risks in regard of staff safety such as lone working and display screen usage had not been carried out for all staff.

Leadership, openness and transparency

We saw from minutes that management team meetings were held regularly, at least monthly. These meetings involved GP partners, the lead nurse and the deputy and practice manager. Staff who attended these meetings told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. GPs held continuous professional

Are services well-led?

Good

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

development meetings and ensured the registrar GP was included in these meetings to ensure they were informed of the most up to date clinical information. Similar meetings were held for the nursing staff.

Administrative 'office' meetings were also held regularly to plan and deliver the practices services and to reflect on the positive work done by this team of staff. For example, adapting to using the electronic patient record system. Other subjects discussed included, managing patient discharge summaries, completing spreadsheets, medical reports and new patient cards. The minutes showed these meetings were well attended.

Overall the staff we met spoke positively about the leadership within the practice and how they were accessible, open and transparent in the way they supported all employees in the practice. We saw that staff with lead responsibility within the practice took their roles seriously and ensured staff were kept informed of improvements in the way they worked. We observed the office functions within the practice were well led by an engaged management team who communicated effectively with staff at all levels.

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

The practice had gathered feedback from patients through patient surveys, the NHS Choices website and complaints received. The practice had an active patient participation group (PPG) which was small but engaged with helping the practice improve services for patients. The PPG included representatives from various population groups such as the recently retired. The PPG had carried out annual surveys and met two or three times a year or communicated via email. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys were available in the practice.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss concerns or issues with colleagues and the management team. We heard from staff how they had requested additional training about safeguarding vulnerable patients and this had been provided. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at six staff files and saw that appraisals had been planned for May 2015 and would include a personal development plan. Staff told us that the practice was supportive of training and that they had staff training sessions where guest speakers and trainers attended.

The practice was a GP training practice with one registrar GP in post at the time of our inspection. The registrar had experience in hospital medicine and was spending a year with the practice to gain experience in family medicine. The registrar was supported by one trainer GP in the practice and could always access a GP for advice or opinion.

The practice had completed reviews of significant events and other incidents and shared the findings with clinical staff at meetings which ensured the practice improved outcomes for patients.