Northville Family Practice

Quality Report

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Date of inspection visit: 2 February 2017
Date of publication: 24/03/2017

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 Northville Family Practice on 2 February 2017.

Overall the practice is rated as good.

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

- 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.
- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Risks to patients were assessed and well managed; further attention was needed to ensure all vulnerable patients records were coded correctly. However, we found the practice was proactive with identifying risks to patients and had reviewed the notes of all female patients aged over 65 who had not had contact with the surgery in the last year and planned to do the same for the comparable males. The register was reviewed quarterly at multidisciplinary practice meetings and patients who had no contact with the practice in the previous quarter were telephoned and services offered.
- 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 could make an appointment with a named GP; 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.

Summary of findings

The areas where the provider should make improvement are:

- The practice should further develop processes and systems and embed them with the staff team, for example, medicine monitoring processes, a protocol for hospital discharge medicine changes and timely viewing of results.
- The practice should ensure that the information accessible by the public on the website is kept up to date.
- The practice should address the coding issues to ensure all vulnerable patients are identified.
- The practice should obtain an electrical installation certificate for the premises.

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; further attention was needed to address the coding issues to ensure all vulnerable patients are identified and coded correctly. The practice should also obtain an electrical installation certificate for the premises.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Staff assessed needs and delivered care in line with current evidence based guidance.
- There was evidence that the quality of clinical care was audited and demonstrated quality improvement. However, the practice should further develop processes and systems and embed them with the staff team, for example, medicine monitoring processes, a protocol for hospital discharge medication changes and viewing of results.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- 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.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey (July 2016) showed patients rated the practice higher than others for several aspects of care. For example, the percentage of respondents to

Summary of findings

the GP patient survey who stated that the last time they saw or spoke to a nurse, the nurse was good or very good at treating them with care and concern was 98% compared to the clinical commissioning group average of 93% and the national average of 91%.

- 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 was available, however we found the web site was not always current with the details of the staff team and services offered such as the minor injury service.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

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 liaised with the NHS England area team and clinical commissioning group to alert them where improvements to services were identified. For example, we found there were clinical audits undertaken to assess the patient group needs. Where deficits in the service were identified such as patients not having their medicines reviewed effectively, funding had been sought to employ a practice pharmacist for this work.
- Patients said they could make an appointment with a named GP; 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.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions, including patients with a condition other than cancer and patients with a diagnosis of dementia.
- 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.

Are services well-led?

Good

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

Summary of findings

- 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 provider 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 formation of a patient participation group was in progress.
- There was a strong focus on continuous learning and improvement at all levels.
- Staff had received inductions, annual performance reviews and attended staff meetings and training opportunities. Staff training was a priority and time was built into staff rotas.

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.

- Staff were able to recognise the signs of abuse in older people and knew how to escalate any concerns.
- 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.
- Where older patients had complex needs, the practice shared summary care records with local care services; the practice had a fortnightly meeting with the multi-disciplinary team including hospice care, district nurses and health visitor for older people.
- Older patients were provided with health promotional advice and support to help them to maintain their health and independence for as long as possible.
- Two staff members were booked to attend 'Frailty Friday' training which would provide training and guidance for identifying and addressing frailty in older patients.

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 long-term disease management and patients at risk of hospital admission were identified as a priority.
- The practice proactively identified patients at risk of developing long-term conditions and took action to monitor their health and help them improve their lifestyle. For example, the percentage of patients with diabetes, in whom the last blood test (HbA1c) to look at diabetes control was 64 mmol/mol or less was 57% compared to the clinical commissioning group average of 74%. The practice had employed a nurse practitioner with specialist knowledge to address this issue.
- Patients identified with raised blood glucose levels were phoned by the GP and advised that they were pre-diabetic. Patients were then asked to make an appointment with the practice nurse to discuss their lifestyle factors. 31 patients with prediabetes were seen this year and given advice.

Summary of findings

- 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.
- There were emergency processes for patients with long-term conditions who experienced a sudden deterioration in health. The respiratory nurse reviewed the records of housebound patients looking at which chronic obstructive pulmonary disease (COPD) patients may require home visits.
- The respiratory nurse was part of a pilot scheme with a specialist nurse to look at step down care in patients with milder disease and infrequent or no exacerbations. For patients this meant a reduction in use of triple inhalation therapy and maximal achievable bronchodilation supported by exercise and pulmonary rehabilitation, as this improved lung function, aiding daily activity and enhancing quality of life.
- The practice had a plan in progress to follow up on patients with long-term conditions discharged from hospital and ensured that their care plans were updated to reflect any additional needs. For example, patients with a hospital admission for asthma or COPD are highlighted to the respiratory nurse who will contact the patient.
- All appointments were for 15 minutes however, longer appointments and home visits were available when needed.
- The practice undertook monthly record searches for patients needing a repeat blood test and contacted those who had not attended.

Families, children and young people

Good

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

- There were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. 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.
- The percentage of women aged 25-64 whose notes record that a cervical screening test has been performed in the preceding 5 years was 88% compared to the local average of 84%.
- Appointments were available outside of school hours and the premises were suitable for children and babies.

Summary of findings

- We saw positive examples of joint working with midwives, health visitors and school nurses. The practice had a list of all patients who were pregnant with their expected delivery date and monitored patients to ensure the babies are registered with the practice and attend for their immunisations. The practice followed up non-attendance and highlighted to the GP any patients who failed to attend.
- Minor illness clinics were offered twice weekly.
- There was a minor injury drop in service.

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. For example, staff had attended NHS Health Checks training in January 2017 and will be sending out invitations to the target patient group. There was a protocol in place to act on findings.
- There was a risk register developed for patients who had limited or no interaction with the practice; they were contacted directly by the practice as a monitoring exercise.

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.
- 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.

Summary of findings

- 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.
- The practice had a system in place for sharing child protection information and responded to MARAC) requests was shared. The practice sent a list monthly to the Bristol and South Gloucestershire team of health visitors that covered the practice advising them of any newly registered patients under the age of five.

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).

- 72% of patients diagnosed with dementia had been reviewed in a face-to-face review in the preceding 12 months.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- Patients at risk of developing a dementia were identified and offered an assessment.
- The practice specifically considered the physical health needs of people with poor mental health; for example, the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in the record was 73%.
- The practice had a system for monitoring repeat prescribing for patients receiving medication for mental health needs. For example, there was a system to identify patients who requested prescriptions early and they planned to monitor patients so that those who fail to renew their prescription for medicines are identified.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- 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.

Summary of findings

What people who use the service say

The NHS England GP Patient Survey was published in July 2016. This contains aggregated data collected from July-September 2015 and January-March 2016. The survey reflected patient views when the previous providers as well as the current provider were running the practice. The results showed the practice was performing in line with local and national averages. 252 survey forms were distributed and 110 were returned. This represented 2% of the practice's patient list.

- 82% of patients found it easy to get through to this practice by phone compared to the national average of 73%.
- 75% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the national average of 76%.
- 90% of patients described the overall experience of this GP practice as good compared to the national average of 85%.
- 81% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the national average of 79%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 17 comment cards, all but one were positive about the standard of care received. Some comments highlighted specific members of staff where patients felt they had received and exceptional service.

We spoke with four patients during the inspection. All of the patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. Patients commented on improvements to the service and told us that clinicians never rushed them and always listened.

The practice operated the NHS Friends and Families test. A patient commented in December 2016 that the management failed to see to routine maintenance, as the door to the treatment room continually bangs when used. This criticism had been reviewed and acted on, and a regular maintenance programme had been arranged for the site. In response to some of the comments that had been mentioned on more than one occasion the practice put together a "You Said, We Did" poster in the waiting room.

Northville 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 second CQC inspector.

Background to Northville Family Practice

Northville Family Practice is part of BrisDoc Healthcare Services Limited. BrisDoc is a limited company whose shareholders are the current employees. The provider BrisDoc has an Alternative Provider Medical Services (APMS) contract to deliver primary health care services which it took on at short notice from 15th January 2016 for a two year period when the previous GP contract holders resigned.

It operates from one site:

521 Filton Avenue,

Bristol

BS7 0LS

The practice is sited in a converted house. All patient services are located on the ground floor of the building. The practice has a patient population of approximately 5200.

The contract includes enhanced services such as childhood vaccination and immunisation scheme, facilitating timely diagnosis and support for patients with dementia and minor injury services. An influenza and pneumococcal immunisations enhanced service is also provided.

The practice is open between 8am and 6.30pm Monday to Friday. Appointments are available from 8.30am and emergency telephone access is available from 8am. The practice operates a mixed appointments system with some appointments available to pre-book and others available to book on the day. The practice also offers telephone consultations. GP appointments are 15 minutes each in length and appointment sessions are typically 8.30am until 11.30am and 3pm until 6pm. The practice offers online booking facilities for non-urgent appointments and an online repeat prescription service. Patients need to contact the practice first to arrange for access to these services.

The practice has six salaried GPs (male and female), a practice manager, two practice nurses who were prescribers, two treatment room nurses and two health care assistants.The practice also has an Operations Manager, one practice secretary, prescriptions clerk and seven receptionists. Each GP has a lead role for the practice and nursing staff have specialist interests such as diabetes and infection control.

The practice is not a teaching practice.

The practices patient population is stable but has slightly more patients between the age of 20 and 29 years than the national average. They have a lower than national average number of patients over the age of 65 years at 16.7% compared to a national average of 27.2%.

The general Index of Multiple Deprivation (IMD) population profile for the geographic area of the practice is that the practice is in one of the most deprived areas of South Gloucestershire. (An area itself is not deprived: it is the circumstances and lifestyles of the people living there that affect its deprivation score. It is important to remember that not everyone living in a deprived area is deprived and that not all deprived people live in deprived areas).

Detailed findings

The national GP patient survey (July 2016) reported that patients were more than satisfied with the opening times and making appointments. The results were above local and national averages.

Patient Age Distribution

0-4 years old: 5.21%

5-14 years old: 9.55%

15-44 years old: 49.1%

45-64 years old: 19.35%

65-74 years old: 9.06%

75-84 years old: 5.41%

85+ years old: 2.31%

Patient Gender Distribution

Male patients: 50.96 %

Female patients: 49.04 %

Other Population Demographics

% of Patients from BME populations: 15.53 %

The practice has opted out of providing Out Of Hours services to their own patients. Patients can access NHS 111 and BrisDoc provide the Out Of Hours GP service.

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 2 February 2017. During our visit we:

- Spoke with a range of staff which included the clinical team, the practice manager and administration team, and the medical director for BrisDoc and spoke with patients who used the service.
- Observed how patients were being cared for and talked with patients and family members
- Reviewed a 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).

Detailed findings

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, we saw a significant event had been raised following three emergencies at the practice when it was found that the emergency equipment and medicines were not in a single accessible place. Following this event there was a debrief session and a team decision to purchase a bespoke emergency medicines and equipment unit which we observed was kept in an accessible place. National guidelines and medicines administration guidance had been added to the emergency medicines.

We saw any incidents that were not significant events were also recorded and that learning from these were disseminated to the team. We spoke with the practice manager who was confident that this was a learning process for a relatively new team and established good practice.

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 all had received training on safeguarding children and vulnerable adults relevant to their role. GPs and the lead nurse were trained to child protection or child safeguarding level 3.
- The practice had a system in place for sharing child protection information and responded to MARAC) requests were shared. We noted that the practice was not confident that their current patient record coding had ensured all vulnerable patients are identified. Staff had recently attended further training and the practice planned to undertake a patient record exercise to ensure it complied with the South Gloucestershire Clinical Commissioning Group (CCG) recommendations. However, the practice also sent a list monthly to the Bristol and South Gloucestershire team of health visitors who covered the practice advising them of any newly registered patients to alert them of any potential risks.
- A notice in the waiting room and each consultation room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check.
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy and patients told us there had been a big improvement in cleanliness. The practice nurse was the infection control clinical lead who liaised with the local infection prevention teams and the BrisDoc infection control lead to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training including hand washing with a UV light box. Annual infection control audits were undertaken along with

weekly in-depth checks. We saw evidence that action was taken to address any improvements identified as a result. For example, appropriate hand washing taps and alcohol gel had been installed.

- 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 CCG pharmacy team to ensure prescribing was in line with best practice guidelines for safe prescribing. We spoke with the pharmacist who related the issues with medicines reviews and prescribing that the current provider inherited with their contract. They were positive about the progress the provider had made in establishing clear protocols with a GP medicines lead who implemented good practice guidance.
- We noted there had been several reported incidents involving prescription security. However we found that the system had been overhauled to ensure that blank prescription forms and pads were securely stored and the systems in place allowed for monitoring of their usage. We spot checked the system and found the records to be accurate.
- Two of the practice nurses had qualified as an Independent Prescriber and could therefore prescribe medicines for specific clinical conditions. They received regular feedback from the CCG pharmacist around high risk medicine prescribing; prescribing was overseen by the GP medicines lead.
- 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.
- We reviewed four personnel files 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.
- There was a policy to offer three written reminders for patients who did not attend for their cervical screening test. We looked at performance rates for cervical smears and noted an episode of increased volume of inadequate samples. We spoke to the lead practice nurse who agreed to undertake a local audit to investigate reasons why. They completed an audit immediately following the inspection and shared the results. The changes the practice had made was to ensure competency of testers and that there were failsafe systems in place to ensure results were received for all samples sent and the practice followed up women who were referred as a result of abnormal results.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- Since taking over the practice in January 2016, they had been proactive with identifying risks to patients. Following four separate incidents of unexpected deaths of male patients, an extraordinary general meeting was held in the practice to review the cases.Following this meeting the practice started a register of patients felt to be at risk of self-neglect or harm from others. This was on the shared drive so all members of the practice could add patients they felt should be included. The lead GP had also reviewed the notes of all female patients aged over 65 who had not had contact with the surgery in the last year and planned to do the same for the comparable males. The register was reviewed quarterly at multidisciplinary practice meetings and patients who had no contact with the practice in the previous quarter were telephoned and services offered.
- 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 the reception office which identified local health and safety representatives. The practice had up to date fire risk assessments and had plans to carry out a fire drill before the end of March 2017. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. We found the provider did not have a current electrical installation certificate. 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 and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).

- 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.
- The practice used regular locum GPs from the BrisDoc organisation for whom they undertook appropriate checks to ensure they were suitable to be employed, for example, checking the General Medical Council register and the NHS England Performer's List.

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 and comprehensive equipment 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.
- The practice monitored that these guidelines were implemented through peer sampling of patient records and through the root cause analysis of significant events and complaints.

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 from 2015/16 showed 83% of the total number of points available was achieved. This period covered the changeover of provider which impacted on performance. However, the overall exception rate for the practice was 4.9% lower than the clinical commissioning group average. (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). The practice confirmed that to date for this reporting year 2016/17, there had been no exception reporting.

Data from 2015/16 showed:

Performance for diabetes related indicators was worse than the local average. For example, the percentage of patients with diabetes, on the register, whose last measured total cholesterol was 5 mmol/l or less was 66% and the clinical commissioning group average was 82%.

We asked the practice what action they had taken to address these issues they told us:

- A comprehensive recall system for diabetes had been put in place along with a change to the patient review process. The practice nurse had a post graduate diploma in diabetic management and had commenced telephone follow-ups for patients who had difficulty attending the practice. A visit had been planned for the following month for a diabetic consultant to attend and update all clinical staff with particular focus being given to the practice demographics.
- Patients with diabetes had undergone a review of their medicines and blood test results. This had resulted in patients having medicine changes in line with NICE guidance. And the practice had started to offer appointments to patients who were at risk of diabetes.
- Known and newly highlighted patients with diabetes and pre-diabetes had been invited in for an appointment with the newly appointed diabetic lead nurse. There was telephone follow up by the lead nurse in order to assist patients to monitor and manage their disease.It had been both popular with patients and effective in reducing their HbA1c as well as subsequent increase in the QOF scores for diabetes.

The most up to date data obtained on the day of the inspection indicated , the percentage of patients with diabetes, on the register, whose last measured total cholesterol was 5 mmol/l or less was 78% a significant increase as the QOF year was not yet completed.

- Performance for mental health related indicators was worse than the local average. For example, the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months was 73% and the clinical commissioning group average was 92%.

The practice were taking positive steps to address this by ensuring patients with severe mental illness were invited to attend the practice for a review, and maintaining contact with the mental health community services.

We noted that the practice has a lower prevalence of dementia amongst its older patients compared to the

national average. The clinical team was aware of this and carried out initial memory assessments regularly, progressing to investigations and diagnosis when appropriate.

There was evidence of quality improvement including clinical audit.

- There had been several clinical audits completed since the provider took over the contract. For example, we found they had audited the number of patients who had been prescribed multiple medicines, with a significant number of patients on over thirty medicines, but who had not had them reviewed. Medication reviews had not been kept up to date prior to BrisDoc taking over. The practice had employed additional locum resource to facilitate the clinical team to address the backlog. Many patients had benefitted as a result.
- The practice participated in local audits, national benchmarking, accreditation, peer review and research. For example, the South Gloucestershire Clinical Commissioning Group pharmacist highlighted that the practice was the highest prescriber of benzodiazepines in South Gloucestershire. This was highlighted as a key area for development within the practice; the practice implemented their repeat medicines policy and had made progress in addressing these issues.
- Findings were used by the practice to improve services. For example, it was also noted that many elderly patients or those with long term conditions were under medicated or had undiagnosed conditions. 21 new patients had been identified as having diabetes in the last three months and 67 patients had been identified as taking an inhaler without a respiratory diagnosis. The practice had started working with the South Gloucestershire Clinical Commissioning Group respiratory specialist nurse to review patients diagnosed with chronic obstructive pulmonary disease (COPD) and prescribed triple therapy medicines to assess their suitability for newer medications and devices which may give improved outcomes with fewer side effects. This project followed the Global Initiative for Chronic Obstructive Lung Disease (GOLD) guidelines which provide evidence-based advice on the prevention, diagnosis, and management of COPD in primary care.

Effective staffing

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

- 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 on-going support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. All staff except two had received an appraisal within the last 12 months; the two remaining staff had a date booked for their appraisal.
- The practice had a corporate induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. Staff also undertook a specific induction according to role. We saw there was a locum information file for GPs on the premises.
- 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 and minor injuries. The two nurses with a prescribing qualification were about to commence a Physical Assessment and Clinical Reasoning course which offered further training in clinical examination skills for advanced practitioners. One nurse had an advanced nurse practitioner qualification and ran minor illness surgeries on two mornings per week.
- 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 access to on line resources and discussion at practice meetings.
- Staff received training that included: safeguarding, domestic violence and abuse, fire safety awareness, 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

Good

Are services effective?

(for example, treatment is effective)

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, discharge records, medical records and investigation and test results. We found the practice should further develop processes and systems and embed them with the staff team, for example, medicine monitoring processes, and a protocol for hospital discharge medicine changes.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services. We were told patient correspondence from other health and social care providers was scanned into patient records once the GPs had seen the results. This ensured the patient records were current and held electronically to be accessible should they be needed, for example, for a summary care record to take to the hospital.
- Community nurses teams could access a restricted area of the patient records remotely for any test results and to add details of their visits.
- Patients' blood and other test results were requested and reported electronically to prevent delays. We found that the buddy system in place could allow for a test result to not be viewed for up to four days after it had been received. We raised this with the practice who confirmed after the inspection that the system had been reviewed to ensure a more timely reading of test results.

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 on-going 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 fortnightly 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.
- 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.

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, smoking and alcohol cessation. Patients were signposted to the relevant service.
- The practice nurses were undertaking training in the Bradford's Healthy Hearts initiative to allow the practice to implement a programme of education and events to reduce heart disease and strokes within the population.

Childhood immunisation rates for the vaccines given were higher than clinical commissioning group averages. For example, childhood immunisation rates for the vaccines given to under two year olds ranged from 90% to 95% compared to the national average of 90% and five year olds from 96% to 98% compared to the national average from 88% to 94%.

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 treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Same gender clinicians were offered where appropriate.

We received 17 comment cards, all but one were positive about the standard of care received. Some comments highlighted specific members of staff where patients felt they had received and exceptional service. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with four patients who told us they were 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 and provided support when required.

Results from the national GP patient survey (July 2016) 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%.
- 88% of patients said the GP gave them enough time compared to the CCG average of 88% and the national average of 87%.
- 92% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 93% and the national average of 95%.
- 94% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 87% and compared to the national average of 85%.
- 98% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 93% and compared to the national average of 91%.
- 92% of patients said they found the receptionists at the practice helpful compared to the CCG average of 86% 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. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

Results from the national GP patient survey (July 2016) 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:

- 82% of patients said the last GP they saw was good at explaining tests and treatments compared to the clinical commissioning group (CCG) average of 86% and the national average of 86%.
- 84% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 81% and the national average of 82%.
- 91% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 86% and the national average of 85%.

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

Good

Are services caring?

- Staff told us that 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.
- There was a hearing loop system in the practice.
- We found the practice had changed website providers but that the information accessible by the public on the website was not yet up to date.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website. Support for isolated or house-bound patients included signposting to relevant support and volunteer services.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 186 patients as carers (3.6% of the practice list). Written information was available to direct carers to the various avenues of support available to them. A member of staff acted as a carers' champion to help ensure that the various services supporting carers were coordinated and effective. The practice had a carer's action plan in place to validate all carers on the register in order to identify any particularly vulnerable groups such as child carers, and to target support and advice. For example, the administration team had identified the caring arrangements for patients with dementia, especially those that live alone. The reception team knew these patients and offered assistance such as double appointments when appropriate. The practice referred patients and carers to the community dementia advisor for support.

Staff told us that if families had suffered 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 or by giving them advice on how to find a support service.

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. For example, the practice recently became part of the Substance Misuse Shared Care scheme commissioned by South Gloucestershire Clinical Commissioning Group. Patients misusing drugs can now see a Substance Misuse support worker in the practice with substitute prescribing from a GP.

- All appointments were for 15 minutes however, longer appointments and home visits were available when needed.
- The practice had a system for monitoring repeat prescribing for patients receiving medication for mental health needs. For example, there was a system to identify patients who requested prescriptions early, and they planned to monitor patients so that those who fail to renew their prescription for medicines are identified.
- We saw positive examples of joint working with midwives, health visitors and school nurses. The practice had a list of all patients who were pregnant with their expected delivery date and monitored patients to ensure the babies are registered with the practice and attend for their immunisations. The practice followed up non-attendance and highlighted to the GP any patients who failed to attend.
- Minor illness clinics were offered twice weekly.
- There was a minor injury drop in service.
- The practice undertook monthly record searches for patients needing a repeat blood test and contacted those who had not attended. They intended to introduce a system to check patients taking cytotoxic medicines were attending for regular monitoring.
- The respiratory nurse was part of a pilot scheme with a specialist nurse to look at step down care in patients with milder disease and infrequent or no exacerbations. For patients this meant a reduction in use of triple inhalation therapy and maximal achievable bronchodilation supported by exercise and pulmonary rehabilitation, as this improved dynamic lung function, aiding daily activity and enhancing quality of life.
- Patients identified with high blood glucose levels were phoned by the GP and advised that they were pre-diabetic. Patients were then asked to make an appointment with the nurse to discuss their lifestyle factors. 31 patients with pre-diabetes were seen this year and given advice.
- Two staff members were booked to attend 'Frailty Friday' training which would provide training and guidance for identifying and addressing frailty in older patients
- There were longer appointments available for patients with a learning disability.
- Patients were able to receive travel vaccines available through the NHS.
- There were accessible facilities and a designated parking bay for blue badge holders.
- Other reasonable adjustments were made and action was taken to remove barriers when patients find it hard to use or access services.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday. Appointments are available from 8.30am and emergency telephone access was available from 8am. The practice operated a mixed appointments system with some appointments available to pre-book and others available to book on the day. The practice also offered telephone consultations. GP appointments are 15 minutes each in length and appointment sessions are typically 8.30am until 11.30am and 3pm until 6pm. The practice offered online booking facilities for non-urgent appointments and an online repeat prescription service. There were limited early morning appointments on a Thursday from 7.30am.

Results from the national GP patient survey (July 2016) showed that patient's satisfaction with how they could access care and treatment was comparable to local and national averages.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- 77% of patients were satisfied with the practice's opening hours compared to the clinical commissioning group (CCG) average of 75% and the national average of 78%.
- 82% of patients said they could get through easily to the practice by phone compared to the CCG average of 70% and the national average of 73%.

Patients told us and we saw 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 referred to 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 complaint 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 complaint system on the website and a practice leaflet.

We reviewed a selection of the 26 complaints received in the last 12 months and found these were dealt with in a timely way to achieve a satisfactory outcome for the complainant. For example, complaints were responded to by the most appropriate person in the practice and wherever possible by face to face or telephone contact. The information from the practice indicated at what stage the complaint was in its resolution.

Lessons were learnt from concerns and complaints and action was taken as a result to improve the quality of care. We found the learning points from each complaint had been recorded and communicated to the team or appropriate action taken. For example, there were several complaints about the attitude of some of the locum GPs working at the practice. The action taken included reviewing the consultation notes and outcomes, and using their clinical governance processes directly with the individuals involved to make improvement.

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. The practice was part of BrisDoc Healthcare Services Limited. The service had a clear vision to deliver high quality care and promote good outcomes for patients.

The provider vision was to be advocates of the 6c's (commitment, care, compassion, courage, communication and competence) and enable all staff to contribute and commit to a caring healthcare culture.

Their mission statement was :

'Patient care by people who care'.

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. Four GPs on the BrisDoc board were non-executive directors and helped provide clinical oversight.
- Provider specific policies were implemented and were available to all staff.
- A comprehensive understanding of the performance of the service was maintained.
- There was a formal schedule of meetings to plan and review the running of the service.
- Representatives from all areas of the business participated in the leadership boards meetings which were held bi-monthly.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements. We found the practice used audit to establish which areas of patient care required remedial action such as diabetes treatment and prescribing, and had an on-going programme of monitoring.
- The provider had developed its governance systems to ensure that quality was systematically embedded.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. For example, they monitored at risk groups such as older patients with little or no engagement with the practice, to offer services.
- BrisDoc operated Quality Management and Environmental Management systems which meet the requirements of the ISO 9001 quality management system and ISO 14001 environmental management system respectively, which were subject to annual review and reaccreditation.

Leadership and culture

BrisDoc is a limited company whose shareholders were the current employees. The leadership for the organisation was from an executive board whose membership was made up from representatives from all areas of operation. On the day of inspection the provider demonstrated they had the experience, capacity and capability to run the service and ensure quality care. They told us they prioritised safe, high quality and compassionate care. Staff told us the management were approachable and always took the time to listen to all members of staff. The provider had a staff handbook. The staff team members who spoke with us had a good understanding of the values and culture of the service; we saw there was a regular staff news bulletin and there were staff benefits and social events which promoted the inclusive culture of the organisation.

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 management 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.

Are services well-led?

Good

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

- The practice held and minuted a range of multi-disciplinary meetings including meetings with district nurses and social workers to monitor vulnerable patients. GPs, where required, met with health visitors to monitor vulnerable families and safeguarding concerns.
- 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. Minutes were comprehensive and were available for practice staff to view.
- Staff said they felt respected, valued and supported, particularly by the management in the practice. All staff were involved in discussions about how to run and develop the practice, and the management 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 staff through an annual staff survey, and generally through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. There was a corporate and practice staff newsletter.
- Staff told us they felt involved and engaged to improve how the practice was run.
- The practice had a suggestion box and ran the family and friends test.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. We found the complete clinical team had only been in post since October 2016 and had worked to address the immediate areas of improvement needed for patients registered with the practice, such as improvements in diabetes care and prescribing.

- We were told that they intended to introduce a system to check patients taking cytotoxic medicines (a medicine that has a toxic effect on certain cells) were attending for regular monitoring.
- The practice was part of trial email 'add ons' for the Integrated Clinical Environment (ICE) which allowed clinicians to be more specific about the test required.