Wells Road Surgery

Quality Report

233 Wells Road,
Bristol
BS4 2DF
Tel: 0117 977 0018
Website: www.wellsroadsurgery.co.uk

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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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Wells Road Surgery 4 October 2016.

Overall the practice is rated as good.

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

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- Risks to patients were assessed and well managed.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of and complied with the requirements of the duty of candour.

The areas where the provider should make improvement are:

- The provider should monitor and ensure that there is an annual infection control audit of 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, however we found some areas for where action was needed, for example, completion of a full infection control audit and retention of proof of identity for all staff.

Are services effective?

Good

The practice is rated as good for providing effective services.

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

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice comparable to 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.

Summary of findings

- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and clinical commissioning group to secure improvements to services where these were identified. For example, they were an active member of the One Care Consortium and accessed pilot programmes in order for patients to have greater access to treatment such as physiotherapy.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions, including people with a condition other than cancer and people with dementia, ensuring these patients had a care plan in place.
- 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.

- 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.

Summary of findings

- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken
- The practice proactively sought feedback from staff and patients, which it acted on.
- There was a strong focus on continuous learning and improvement at all levels with a 'Hot Topic' board in the staff room and regular educational meetings and sessions.
- Staff had received inductions, annual performance reviews and attended staff meetings and training opportunities. Staff training was a priority and 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.
- The practice identified at an early stage older people who may be approaching the end of life and involved them in planning and making decisions about their care.
- The practice followed up on older patients who had been discharged from hospital and ensured that their named GP had updated care plans to reflect any extra needs. Care plan meetings were held every three months involving the clinical team and the community nursing services. Recent admissions to hospital were discussed and any learning regarding admission avoidance shared.
- Where older patients had complex needs, the practice shared summary care records with local care services such as the out of hours service.
- Older patients were provided with health promotional advice and support to help them to maintain their health and independence for as long as possible such as referral to the carers centre.
- The practice participated in pilot schemes such as the Bristol Rapid Assessment Clinic for older people based at the local community hospital (A rapid medical assessment and management plan are for a deteriorating patient who may otherwise end up in hospital). They allocated a practice GP to attend four sessions in which to observe the consultant and then take the learning to the practice to share with colleagues.
- The whole team were aware of the difficulties that older patients found in attending the practice so often the nursing team would fit in a patient for blood tests if they have just seen the doctor rather than asking them to come back at another time.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions.

Summary of findings

- Nursing and clinical staff had lead roles and specialist knowledge in long-term disease management and patients at risk of hospital admission were identified as a priority. Nurse and GP, patient diabetic leads are both trained in insulin and GLP-1 agonist conversion (medicines used and this is undertaken at the practice for suitable patients.
- The practice were involved in the H.G. Wells project, this is an "Integrated Model of Care for Diabetes Pilot" - a new project aimed at delivering significant and sustainable improvements in the management and treatment of patients with a diagnosis of diabetes commissioned by the South West Commissioning Support unit.
- The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12months (01/04/2014 to 31/03/2015) was 80% higher than the clinical commissioning group (CCG) average of 76% and the national average of 78%.
- 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 we saw the care plans given to patients with asthma to help them recognise, self manage and control their illness.
- The practice GPs followed up on patients with long-term conditions discharged from hospital and ensured that their care plans were updated to reflect any additional needs.
- There were emergency processes for patients with long-term conditions who experienced a sudden deterioration in health.
- Longer appointments and home visits were available when needed.
- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. There was a designated reception lead for all major chronic disease to manage chronic disease clinics to ensure all patients are invited for review and have appropriate tests prior to appointment; patients with more than one long term condition were reviewed in a multi-morbidity appointment.

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.
- Appointments were available outside of school hours and the premises were suitable for children and babies. We found that the practice offered after school clinics for flu vaccines.
- We saw positive examples of joint working with midwives, health visitors and school nurses. They held weekly baby and postnatal clinics and undertook six week reviews of new mothers and their babies to coincide with their first vaccination visit. The practice had developed information pack for new mothers at the post-natal visit. The practice was a breast feeding friendly building and had designated areas.
- The practice had emergency processes for acutely ill children and young people and for acute pregnancy complications by offering rapid access to appointments and using the secondary care 'hot clinics' for advice. (This is a clinic is staffed by a consultant, available to GPs to refer patients they feel meet the referral criteria. It is intended to prevent the admission of patients to hospital.
- There was an extended family planning service offered by the practice for intrauterine contraceptive devices and implants and regular clinics were held for this.

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, for example, there was an extended hours with two GPs and one practice nurse every Wednesday until 8pm.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.
- Students who were previous patients were seen as temporary residents during university holidays.

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 those with a learning disability.
- The practice offered longer appointments for patients with a learning disability. The practice made home visits to a care home to complete the patient's annual health check. The practice nurse arranged home to vaccinate patients who were unable to attend the surgery
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. All staff had in house training on the Mental Capacity Act and Safeguarding Adults; safeguarding was an agenda item on the monthly practice meeting.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.

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).

- Patients at risk of dementia were identified and offered an assessment.
- The practice carried out advance care planning for patients with dementia
- The practice specifically considered the physical health needs of people with poor mental health, with a clinical lead to ensure their needs were met. The reception lead for mental health was responsible for booking all patients on the mental health register for review, including blood tests for medicines monitoring where needed, as per the practice protocol. Annual mental health reviews achieved 25.6 out of 26 points of the quality and outcomes framework in 15/16.
- The practice had a system for monitoring repeat prescribing for patients receiving medicines for mental health needs.
- 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 (01/04/2014 to 31/03/2015)

Summary of findings

- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia. They had access to email consultations with an allocated consultant psychiatrist.
- 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.
- Staff had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2016, and contained aggregated data collected from July-September 2015 and January-March 2016.

257 survey forms were distributed and 105 were returned. This represented 1.5% of the practice's patient list. The results showed the practice performance was comparable to local and national averages.

- 84% of patients found it easy to get through to this practice by phone compared to the national average of 73%.
- 88% 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%.
- 70% of patients described the overall experience of this GP practice as good compared to the national average of 73%.
- 81% of patients said they would recommend this GP practice to someone who had 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 eight comment cards which were all positive about the standard of care received.

We spoke with one patient during the inspection and undertook an observation of the reception area. We observed patients' needs were met by the reception team and they were satisfied with the care they received.

The recent responses from the NHS friends and families test (September 2016) was that from 11 respondents 10 would recommend the practice. We saw the practice also collated the compliments received in the practice, we read comments such as the staff being identified as being bright, happy and attentive.

Wells Road Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Wells Road Surgery

Wells Road Surgery is a suburban practice providing primary care services to patients resident in the Knowle area of Bristol.

233 Wells Road,

Bristol

BS4 2DF

The practice is sited in a converted bungalow which has undergone extensive re-modelling to provide four consultation rooms and two treatment rooms. All patient services are located on the ground floor of the building. The practice has a patient population of approximately 7300.

Wells Road Surgery has four GPs, two of whom are partners. Between them they provide 28 GP sessions each week. Three GPs are female and one is male. There are two practice nurses, whose working hours are equivalent to a whole time employee and a newly engaged health care assistant due to start in December 2016. The GPs and nurses are supported by management and administrative staff including a practice manager.

The practice patient population has slightly more patients between the age of 0 and 4 years and between the ages of 25 – 49 years than the national average. Approximately 18% of the patients are over the age of 65 years compared to a national average of 27%. Approximately 45% of patients have a long standing health condition compared to a national average of 54%. Patient satisfaction scores are good with 83% of patients describing their overall experience at the practice as good compared to a national average of 85%.

The general Index of Multiple Deprivation (IMD) population profile for the geographic area of the practice is in the fifth least deprivation decile. (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). Average male and female life expectancy for the area is the same as the national average of 79 and 84 years respectively and one year higher than the clinical commissioning group average.

The practice is open between 8am and 6.30pm Monday to Friday. Appointments are available from 8am 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. Extended hours appointments are offered on Wednesdays 8pm and the practice also offers telephone consultations. 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 a Personal Medical Services (PMS) contract to deliver health care services; the contract includes enhanced services such as childhood vaccination and immunisation scheme, facilitating timely diagnosis and support for patients with dementia and a minor surgery services. An influenza and pneumococcal

immunisations enhanced service is also provided. These contracts act 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. Patients can access NHS 111 or BrisDoc provide the out of hours GP service. Information on how to access these services is on the provider website.

Patient Gender Distribution

Male patients: 51 %

Female patients: 49 %

Other Population Demographics

% of Patients from BME populations: 4.5 %

Why we carried out this inspection

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

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 4 October 2016. During our visit we:

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

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

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

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

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

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

Good

Are services safe?

Our findings

Safe track record and learning

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

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again. The practice had a 'Being Open' policy which related to openness and transparency when dealing with patient incidents.
- 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 were told about requested home visit which had been missed. On investigation the visit had been put on the wrong date so the patients had not been allocated a GP to visit. The practice reviewed the home visiting policy and sent a reminder to all reception staff regarding importance of putting home visits on the correct day. They also commenced a care plan for the patient which would alert practice staff when the patient contacted the practice on subsequent occasions. We saw this had been put into place and the event reviewed at the practice clinical meeting.

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 were trained to child protection or child safeguarding level three and nurses to level two. Staff had attended domestic abuse awareness training.
- A notice in the waiting 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. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. One practice nurse had recently taken on the role of infection control clinical lead. There was an infection control protocol in place and we saw all staff had received up to date training. Infection control audits had been undertaken for hand washing and of the aseptic technique practiced by staff who provided treatments such as contraceptive coil fittings or wound dressings. There had not been an overall assessment of infection control measures since the building work had been completed, however, we saw evidence of control measures in place such as correct sharps bins; personal protective equipment and cleaning protocols for clinical instruments. We were also told that the whole practice had been subject to a deep clean following the completion of building work. We raised the need for a complete audit and the practice confirmed post inspection they had actioned this.
- 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). We saw that the medicines were checked to ensure they

were in date and that sufficient stock was available. The practice were advised that best practice would be to maintain a record of when stock items were used as this would provide a complete audit record. 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 teams, to ensure prescribing was in line with best practice guidelines for safe prescribing.

- Blank prescription forms and pads were securely stored and there were systems in place to monitor their use.
- Patient Group Directions had been adopted by the practice to allow nurses to administer medicines according to relevant legislation.
- We reviewed three personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service. We saw that the practice had not retained any documentation relating to proof of identity or recent photograph of the employee. This was raised with the practice for action, they confirmed post inspection that this had been completed and the information was available on all files.
- There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office which identified local health and safety representatives. The practice had a fire safety risk assessment which was due to be updated when the building work was signed off as completed. The practice provided a copy of this post inspection. The practice carried out regular fire drills. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health 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 for whom they undertook appropriate checks to ensure they were suitable to be employed, for example, checking the GMC 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 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, for example, we saw the practice used the asthma care plan from Asthma UK which reflected current best practice guidance.
- The practice monitored that these guidelines were implemented through the root cause analysis of significant events and complaints.

Management, monitoring and improving outcomes for people

The practice had a whole staff team approach to monitoring and reviewing patients with long term conditions. They had produced protocols for each long term condition outlining the responsibilities and actions for each member of staff to ensure the review was completed. This resulted in a high level of achievement for the Quality and Outcomes Framework (QOF). Performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 99.2% of the total number of points available. The combined clinical domain QOF exception rate was 11% lower than the clinical commissioning group (CCG) rate of 12% and slightly higher than the national average of 9%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014/15 showed:

- 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 (01/04/2014 to 31/03/2015)
- The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12months (01/04/2014 to 31/03/2015) was 80% higher than the CCG average of 76% and the national average of 78%.

There was evidence of quality improvement including clinical audit.

- There had been sixclinical audits started over the last two years, twoof these were completed audits where the improvements made were implemented and monitored.
- The practice participated in local audits, national benchmarking, accreditation, peer review and research.

Findings were used by the practice to improve services. For example, recent action taken as a result included Vitamin B12 audit reviewing patients receiving vitamin B12 injections and re-assessing clinical diagnosis and need. The evidence and guidance was presented at practice meeting with a reduction in the number of patients who needed to continue the treatment.

Information about patients' outcomes was used to make improvements such as improvement in the contraceptive advice and pre-pregnancy counselling in women of child bearing age who were prescribed sodium valproate for epilepsy.

Effective staffing

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

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- 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 completed disease specific diplomas such as diabetes.
- 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.

- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. All staff had received an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

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

- This included care and risk assessments, care plans, medical records and investigation and test results.
- 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. All of the results were reviewed on the day they were sent to the practice to minimise any risks to patients so that any necessary actions was taken.

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

Consent to care and treatment

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

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

National Cancer Intelligence Network data (2014/15) showed that female patients aged, 25-64, attending cervical screening within target period (3.5 or 5.5 year coverage) was 70.5% whilst the clinical commissioning group (CCG) average was 71.0% and the national average was 73.5%.

Childhood immunisation rates for the vaccinations given were higher than CCG averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 73% to 99% compared to the CCG average from 68% to 97% and five year olds from 71% to 97% compared to the CCG average from 67% to 98%.

Good

Are services effective?

(for example, treatment is effective)

Patients had access to appropriate health assessments and checks. These included health questionnaires for new patients with appropriate follow-ups 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 sex clinicians were offered where appropriate.

All of the eight patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

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

- 84% of patients said the GP was good at listening to them compared to the clinical commissioning group CCG average of 91% and the national average of 89%.
- 83% of patients said the GP gave them enough time compared to the CCG average of 87% and the national average of 87%.
- 94% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and the national average of 95%.
- 82% of patients said the last GP they spoke to was good at treating them with care and concern compared to the national average of 85%.
- 94% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 91%.
- 86% of patients said they found the receptionists at the practice helpful compared to the CCG average of 88% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. 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 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:

- 78% of patients said the last GP they saw was good at explaining tests and treatments compared to the clinical commissioning group (CCG) average of 88% and the national average of 86%.
- 78% of patients said the last GP they saw was good at involving them in decisions about their care compared to the national average of 82%.
- 95% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 90% national average of 85%.

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

- 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.

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

Good

Are services caring?

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 whole team was aware of the difficulties that older patients attending the practice so often the nursing team would fit in a patient as an extra for blood tests if they have just seen the doctor rather than asking them to come back at another time.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 105 patients as carers. Written information was available to direct carers to the various avenues of support available to them. Elderly carers were offered timely and appropriate support such as influenza vaccines and home visits where there were issues with transport. A member of staff acted as a carers' champion to help ensure that the various services supporting carers were coordinated and effective. The practice offered for all carers the opportunity to have influenza vaccines, flexibility with appointments and health checks.

Staff told us that if families had suffered bereavement, their usual GP contacted them and sent them a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and by giving them advice on how to find a support service.

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, they were an active member of the One Care Consortium and accessed pilot programmes in order for patients to have greater access to treatment such as physiotherapy.

- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- The practice had developed information pack for new mothers at the post-natal visit. The practice was a breast feeding friendly building and had designated areas to provide privacy for mothers.
- The practice were involved in the H.G. Wells project an "Integrated Model of Care for Diabetes Pilot" - a new project aimed at delivering significant and sustainable improvements in the management and treatment of diabetes commissioned by the South West Commissioning Support unit.
- Nursing and clinical staff had lead roles and specialist knowledge in long-term disease management and patients at risk of hospital admission were identified as a priority. Nurse and GP, patient diabetic leads were both trained in insulin and GLP-1 agonist conversion (medicines used for the treatment of type 2 diabetes) and this was done at the practice for suitable patients.
- The practice participated in pilot schemes such as the Bristol Rapid Assessment Clinic for older people based at the local community hospital (A rapid medical assessment and management plan for a deteriorating patient who may otherwise end up in hospital). They allocated GP to attend four sessions at this clinic in which to observe the consultant and then took their learning to the practice to share with colleagues.
- Patients were able to receive travel vaccinations available through the NHS.
- There were accessible facilities and designated parking bays for blue badge holders.

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday. Appointments were available from 8am 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.

Extended hours appointments were offered at the following times on 6.30pm- 8pm on Wednesday evening.

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

- 84% of patients were satisfied with the practice's opening hours compared to the national average of 78%.
- 75% of patients said they could get through easily to the practice by phone compared to the national average of 73%.

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

The practice had a system in place to assess:

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

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

Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns.

- Its complaint policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- 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 looked at a selection of the five 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, they reviewed the duty doctor arrangements in times of high demand. This resulted in an action plan to deal with winter pressures when the reception team or duty doctor felt demand exceeded the resource available to deal with it.

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 called '2016 Vision'. This was the devised following a recent away day session for all staff, and involved service development and sustainability such as the introduction of minor illness clinics. There was a strategy for the implementation of the vision and a supporting business plan which was regularly monitored for effectiveness.

We saw that all staff took an active role in ensuring high quality care on a daily basis and behaved in a kind, considerate and professional way.

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. All of the partners undertook responsibility in different areas of practice such as vaccines or mental health and reported back at meetings.
- Practice specific policies were implemented and were available to all staff.
- A comprehensive understanding of the performance of the practice was maintained.
- There was a formal schedule of meetings to plan and review the running of the practice, for example, the GPs and practice manager met weekly for business planning.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. For example, they monitored data on unplanned admissions to hospital as part of their involvement with the local clinical commissioning group (CCG). The practice was aware of the need to have future sustainability and had worked closely with their landlord to develop the premises to offer a wider range and increased volume of services.

Leadership and culture

On the day of inspection the partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable and always took the time to listen to all members of staff.

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

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

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

- 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. We noted team away days were held every six months. Minutes were comprehensive and were available for practice staff to view.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were

Are services well-led?

Good

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

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

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

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

- The practice had gathered feedback from patients through surveys and complaints received. The patient participation group (PPG) was a virtual group who although received regular information did not always engage and respond. This was an area for development.
- The practice had gathered feedback from staff through staff away days 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.
- Staff told us they felt involved and engaged to improve how the practice was run. The practice used social media to inform those patients who may not use GP services frequently about upcoming events.
- The practice had a suggestion box and ran the family and friends test.
- The practice updated patients with a regular newsletter and a news section on the website.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area participating in the One Care Consortium. For example, the practice participated in pilot schemes such as the Rapid Assessment Clinic for older people based at the local community hospital (A rapid medical assessment and management plan for a deteriorating patient who may otherwise end up in hospital). They assigned a GP to attend four sessions in which to observe the consultant and then took the learning to the practice to share with colleagues.

The practice was also involved in the H.G. Wells project an "Integrated Model of Care for Diabetes Pilot" - a new project aimed at delivering significant and sustainable improvements in the management and treatment of diabetes commissioned by the South West Commissioning Support unit.

There was a strong focus on continuous learning and improvement at all levels with a 'Hot Topic' board in the staff room and regular educational meetings and sessions to reflect and learn.

Medical students were sometimes attached to the practice as part of their course.