

# Drs Kessler, McRobert, Weil, Blythe, Goodger and Platt

## Quality Report

Gaywood House Surgery  
Gaywood House,  
North Street,  
Bedminster,  
Bristol BS3 3AZ

Tel: 0117 966 1412

Website: [www.gaywoodhousesurgery.nhs.uk](http://www.gaywoodhousesurgery.nhs.uk)

Date of inspection visit: 17 November 2015

Date of publication: 24/12/2015

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

### Summary of this inspection

	Page
Overall summary	2
The five questions we ask and what we found	4
The six population groups and what we found	7
What people who use the service say	10
Areas for improvement	11

### Detailed findings from this inspection

Our inspection team	12
Background to Drs Kessler, McRobert, Weil, Blythe, Goodger and Platt	12
Why we carried out this inspection	12
How we carried out this inspection	12
Detailed findings	15

## Overall summary

### Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection of Drs Kessler, McRobert, Weil, Blythe, Goodger and Platt at Gaywood House Surgery on 17 November 2015. 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 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.

- Patients said they were able to make an appointment with a named GP which provided continuity of care; urgent appointments were available the same day.
- The practice had purpose built 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 actively sought feedback from 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:

- Produce a written vision for the practice which encompasses the planned changes to service provision.
- Develop wider use of formal consultation and surveys for staff so they are able to contribute to the vision and values of the practice.
- Review risk assessments for the service to ensure they cover all the areas of the building and functions which the practice has responsibility for such as risk assessment of the individual rooms to ensure they are fit for purpose.

# Summary of findings

- Further develop the internal audit processes so as to be able to demonstrate the quality of the service such as timely response to telephone calls.
- Relocate the emergency equipment and medicines to a more accessible place.
- Review the infection control audit to ensure it reflects the latest best practice guidance.

**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?

The practice is rated as good for providing safe services.

Good



- 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 there were unintended or unexpected safety incidents, patients receive reasonable support, truthful information, a verbal and written apology and 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.
- We found environmental risk assessments could be further developed in order to reduce potential hazards to staff and patients using the building.

### Are services effective?

The practice is rated as good for providing effective services.

Good



- Data showed patient outcomes were at or above average for the locality.
- 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 multidisciplinary teams to understand and meet the range and complexity of patient's needs.

### Are services caring?

The practice is rated as good for providing caring services.

Good



- Data showed that patients rated the practice higher than others for several aspects of care.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.

# Summary of findings

- We also saw that staff treated patients with kindness and respect, and maintained confidentiality.
- Patient feedback was positive and identified the practice as always putting patients first.

## Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

Good



- The practice 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 such as securing funding for a new building.
- Patients said they were able to make an appointment with a named GP which provided continuity of care; urgent appointments were available the same day. We found pre-bookable appointments were available within three days of a request.
- The practice had purpose built facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders. Complaints were shared anonymously with the Patient Participation Group which allowed for suggestions about improvements.

## Are services well-led?

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

Good



- The practice had outlined its' aims within the statement of purpose which focussed on the delivery of high quality care and good outcomes for patients. However, the vision for the practice was not a written document and staff were not clear about 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 reporting and sharing information about notifiable safety incidents.
- The practice proactively sought feedback from patients, which it acted on. The patient participation group was active.
- There was a strong focus on continuous learning and improvement at all levels.

# Summary of findings

## The six population groups and what we found

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

### Older people

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

- The practice offered proactive, personalised care to meet the needs of the older patients in its population such as holding weekly clinics at care homes for older people.
- It was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. For example, patients who may have additional communication needs.
- The practice could access a community based nurse specifically overseeing the care of older patients.
- The practice accessed the Rapid Assessment Clinic for Older people based at the local community hospital and assigned a GP to attend sessions in which to observe the consultant and then take the learning to the practice to share with colleagues.
- The practice hosted the Age UK foot care clinic.

Good



### People with long term conditions

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

- Nursing staff had specialist training for management of chronic disease, such as diabetes, asthma and chronic obstructive pulmonary disease (COPD).
- The practice offered winter rescue packs to patients with COPD and encouraged patients to self-manage.
- The percentage of patients with diabetes, on the register, who have had influenza immunisation in the preceding 1 September to 31 March (01/04/2013 to 31/03/2014) which was comparable to other Clinical Commissioning Group practices at 95.46% but higher than the national average of 93.46%.
- Longer appointments and home visits were available when needed.
- All these patients had a named GP and a structured annual review to check that their health and 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.

Good



### Families, children and young people

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

Good



# Summary of findings

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations in comparison to other practices in the clinical commissioning group area.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- The percentage of women aged 25-64 whose notes record that a cervical screening test had been performed in the preceding 5 years (01/04/2013 to 31/03/2014) was comparable to other practices.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice had introduced a child friendly health advice leaflet.
- We saw good examples of joint working with midwives, health visitors and school nurses.

## Working age people (including those recently retired and students)

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 reflected the needs for this age group.
- The practice hosted a councillor for patients with substance misuse one day a week.

Good



## People whose circumstances may make them vulnerable

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 patients and those with a learning disability.
- The practice offered longer appointments for patients with a learning disability.

Good





# Summary of findings

- The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patients. They maintained lists of the vulnerable patients which were regularly reviewed.
- The practice had told vulnerable patients about how to access various support groups and voluntary organisations.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

## People experiencing poor mental health (including people with dementia)

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

- 87.69% of patients diagnosed with dementia had had their care reviewed in a face to face meeting in the last 12 months.
- The percentage of patients with a diagnosis of schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2013 to 31/03/2014) was 91.63% higher than the national average of 86.04%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including patients living with dementia.
- The practice carried out advance care planning with patients living with dementia and involved their families.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- They 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 those living with dementia.

Good



# Summary of findings

## What people who use the service say

We spoke with three patients visiting the practice and we received 24 comment cards from patients who visited the practice. We also looked at the practice's NHS Choices website to look at comments made by patients, which showed a mixed experience of the practice. (NHS Choices is a website which provides information about NHS services and allows patients to make comments about the services they received). We also looked at data provided in the most recent NHS GP patient survey.

The NHS England- GP Patient Survey data was published on 4 July 2015. There were 305 survey forms distributed for Drs Kessler, McRobert, Weil, Blythe, Goodger and Platt and 101 forms were returned, this was a response rate of 33.1% and represented 1.3% of the number of patients registered at the practice.

The data indicated:

- 74.8% of respondents found it easy to get through to the practice by phone compared to the to the Clinical Commissioning Group average of 72.7% and national average of 73.3%.
- 94.1% of respondents found the receptionists at this practice helpful compared to the to the Clinical Commissioning Group average of 88.5% and national average of 86.8%.
- 62.8% of respondents with a preferred GP usually get to see or speak to that GP compared to the to the Clinical Commissioning Group average of 60.7% and national average of 60%.
- 88.2% of respondents were able to get an appointment to see or speak to someone the last time they tried compared to the to the Clinical Commissioning Group average of 88% and national average of 85.2%.
- 92% of respondents said the last appointment they got was convenient compared to the to the Clinical Commissioning Group average of 91.2% and national average of 91.8%.

- 63% usually wait 15 minutes or less after their appointment time to be seen compared to the to the Clinical Commissioning Group average of 62.1% and national average of 64.8%.
- 70.1% described their experience of making an appointment as good compared to the to the Clinical Commissioning Group average of 72.5% and national average of 73.3%.

The information showed all but one of these results were better than the average for the Bristol Clinical Commissioning Group.

We read the commentary responses from patients on the comment cards and noted they included observations such as;

- The service as experienced by some patients was excellent.
- The appointment access was good; patients confirmed they were seen if they needed an appointment.
- Staff were helpful, friendly, respectful and interested in the patients.
- Patients felt treated with dignity and respect
- Patients expressed their satisfaction overall with the treatment received.

We also spoke with patients; the comments made by patients were very positive and praised the care and treatment they received. Patients had commented positively about being involved in the decisions about their treatment and expressed confidence in the clinicians.

The practice had a patient participation group (PPG). The gender and ethnicity of the group was not representative of the total practice patient population, however, the group was widely advertised and information about the group was available on the practice's website and in the practice. We were told that a recent event involving the PPG was where they coordinated patients at a combined practice flu clinic held at a local community venue.

The practice had also commenced their 'friends and family test' which was available in a paper format placed in the reception area and online.

# Summary of findings

## Areas for improvement

### Action the service **SHOULD** take to improve

The areas where the provider should make improvement are:

- Produce a written vision for the practice which encompasses the planned changes to service provision.
- Develop wider use of formal consultation and surveys for staff so they are able to contribute to the vision and values of the practice.
- Review risk assessments for the service to ensure they cover all the areas of the building and functions which the practice has responsibility for such as risk assessment of the individual rooms to ensure they are fit for purpose.
- Further develop the internal audit processes so as to be able to demonstrate the quality of the service such as timely response to telephone calls.
- Relocate the emergency equipment and medicines to a more accessible place.
- Review the infection control audit to ensure it reflects the latest best practice guidance.

# Drs Kessler, McRobert, Weil, Blythe, Goodger and Platt

## 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 special advisor and a nurse special advisor.

## Background to Drs Kessler, McRobert, Weil, Blythe, Goodger and Platt

Gaywood House Surgery is located in an urban area of Bristol. They have approximately 7700 patients registered.

The practice operates from one location:

Gaywood House,  
North Street,  
Bedminster,  
Bristol BS3 3AZ

It is sited on the ground floor of a residential block of flats owned by Bristol City Council. The practice has five consulting rooms, one for each GP partner and one allocated for any trainee GPs on placement. There are two treatment rooms (for use by nurses, health care assistants and phlebotomists); reception and records room; and a waiting room area. There is limited patient parking immediately outside the practice with spaces reserved for those with disabilities.

The practice is made up of six GP partners, one salaried GP and the practice manager, working alongside three qualified nurses and one health care assistant and two phlebotomists. The practice is supported by an administrative team made of medical secretaries, receptionists and administrators. The practice is open from Monday to Friday for urgent and routine appointments between 9am-6pm and extended hours are available on Monday evenings. The reception is open Monday to Friday 8.30am-6.30pm for appointment booking and enquiries. The practice has a Saturday surgery each month, on the second Saturday of the month in the morning for pre-booked appointments. The practice provides 36 GP sessions each week. It is a training practice and regularly has a registrar (who will be in their final year of GP training) who works under the supervision of another GP.

The practice has a General Medical Services contract with NHS England (a locally agreed contract negotiated between NHS England and the practice). The practice is contracted for a number of enhanced services including extended hours access, facilitating timely diagnosis and support for patients with dementia, patient participation, immunisations and unplanned admission avoidance.

The practice also manages the GP Tackling Violence Service. Patients are enrolled in the GP Tackling Violence Service, following immediate removal from their own regular GP practice for violent or verbally abusive behaviour; they can be seen in a weekly clinic. The aim is to provide the same standard of GP care available to all patients, working with patients to have a productive relationship with the GP and support staff. The clinic is held in a safe facility located within Bristol Royal Infirmary. The practice staff provide the GP cover and undertake all the

# Detailed findings

administrative tasks such as appointment booking and making referrals. Patients accessing the service outside of the clinic times do so by phone, normally being booked in for a phone consultation with the practice duty GP.

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

## Patient Age Distribution

0-4 years old: 6.2%

5-14 years old: 8.24% (lower than the national average)

15-44 years old: 46.39%

45-64 years old: 22.49%

65-74 years old: 7.83% (higher than the national average)

75-84 years old: 5.97%

85+ years old: 2.87% (higher than the national average)

## Patient Gender Distribution

Male patients: 51.17 %

Female patients: 48.83 %

## Other Population Demographics

% of Patients in a Residential Home: 0.79 % (higher than the national average)

% of Patients on Disability Living Allowance: 4.58 %

% of Patients from BME populations: 7.15 %

The area has a higher than average unemployment rate and has a higher than average crime deprivation index.

All GP practices across Bristol CCG are engaged in contract reviews with NHS England. There is a wide disparity across practices in funding terms of income per patient, and this exercise will put in place a process over the next five years to equalise the per patient rate across the 55 Practices.

Gaywood House offers a consultation rate of 6.3 per weighted patient per year against a national average of 5.5, delivering 6,435 appointments above the national average. The data from Health and Social Care Information Centre (HSCIC) indicates this demand is due to higher than predicted disease prevalence rates.

## Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2015, 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 that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 17 November 2015. During our visit we:

- Spoke with a range of staff including administrative staff, GPs and nurses, and spoke with patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members
- Reviewed 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 are provided for specific groups of patients and what good care looks like for them. The population groups are:

- Older people
- People with long-term conditions
- Families, children and young people

## Detailed findings

- 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.

# 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 also a recording form available on the practice's computer system.
- The practice carried out a thorough analysis of the significant events.

We reviewed safety records, incident reports national patient safety alerts and minutes of meetings where these were discussed. Lessons were shared to make sure action was taken to improve safety in the practice. For example, we read a significant event which resulted in shared learning within the practice about the availability of urgent referral for investigations.

When there were unintended or unexpected safety incidents, patients received reasonable support, truthful information, a verbal and written apology and were told about any actions to improve processes to prevent the same thing happening again.

### 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 that reflected relevant legislation and local requirements and 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 relevant to their role. GPs were trained to Safeguarding level 3 for children.
- The practice staff were trained and participated in the MARAC (Multi Agency Risk Assessment Conference, a local multi-agency victim-focussed meeting. A forum where information was shared on the highest risk cases of domestic violence and abuse between different

statutory and voluntary sector agencies) and the IRIS (a general practice-based domestic violence and abuse (DVA) training support and referral programme) schemes.

- A notice in the waiting room advised patients that nurses would act as chaperones, if required. All staff who acted as chaperones were trained for the role and had received a disclosure and barring check (DBS check). (DBS checks identify whether a person has a criminal record or is on an official list of patients 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. A GP partner was the infection control clinical lead. There was an infection control protocol in place and staff had received training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result. We found some areas where infection prevention precautions did not always follow best practice such as for clear work surfaces and equipment like sharps bins to be wall mounted. This was raised with the practice to review.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). The practice carried out regular medicines audits, with the support of the local Clinical Commissioning Group pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Prescription 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 vaccines in line with legislation. The practice had a system for production of Patient Specific Directions to enable Health Care Assistants to administer vaccines.
- We reviewed two personnel files and found that 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.

# Are services safe?

## 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. The practice had up to date fire risk assessments and 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 also had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health, infection control and legionella. However, we found the scope of the environmental risk assessments was limited and did not cover all the areas of the building which the practice had responsibility for, such as risk assessments of the individual rooms and equipment to ensure they were fit for purpose.
- 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 that enough staff were on duty. The practice used planned locum cover for all staff groups and we found that they had undergone the same level of pre-employment checks as permanent staff. There was also an induction process and specific information for locum to staff to refer to such as the GP locum file.

## Arrangements to deal with emergencies and major incidents

- The practice had 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. There was also a first aid kit and accident book available.
- Emergency medicines were in a secure area of the practice and available to staff. All the medicines we checked were in date and fit for use. We observed the location of the equipment and medicines did not have any signage, and were not well sited for ease of access. This was raised with the practice to review.

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.



# Are services effective?

## (for example, treatment is effective)

## Our findings

### Effective needs assessment

The practice assessed needs and delivered care in line 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 audits and random sample checks of patient records. For example, they audited the number of patients with a learning disability who were invited to attend a yearly comprehensive health review to ensure the system they used was effective, and found they had achieved 91% uptake rate. The practice had a 'two week wait' (2WW) book which recorded when referrals were sent and had received a response. This was used as an instant reference tool when patients contacted the practice to follow up referrals and content was monitored so the practice could chase the referral if no information had been received by them.

### Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 94.9% of the total number of points available, with 4.1% exception reporting for all domains. Data from NHS England showed the practice consistently performed above the national average:

- Performance for diabetes related indicators was better than the national average. For example, the percentage of patients with diabetes, on the practice register, in whom the last IFCC-HbA1c was 64 mmol/mol or less in the preceding 12 months (01/04/2013 to 31/03/2014), was 82.93% and the national average was 77.72%.
- The percentage of patients with atrial fibrillation with a CHADS2 score (a clinical prediction tool for estimating the risk of stroke in patients with non-rheumatic atrial

fibrillation) of 1, measured within the last 12 months, who were currently treated with anticoagulation drug therapy or an antiplatelet therapy (01/04/2013 to 31/03/2014) was 100% and the national average was 98.32%.

- Performance for mental health related indicators was comparable to the Clinical Commissioning Group and national average, for example, the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption had been recorded in the preceding 12 months (01/04/2013 to 31/03/2014) was 88.89% and the national average was 88.61%.
- The percentage of patients diagnosed with dementia whose care had been reviewed in a face-to-face review in the preceding 12 months (01/04/2013 to 31/03/2014) was 87.69% and the national average was 83.82%.

Clinical audits demonstrated quality improvement.

- There had been ten clinical audits completed in the last two years, three of these were completed audits where the improvements made were implemented and monitored.
- Findings were used by the practice to improve services. For example, a clinical audit undertaken in 2011 – 2012 of antibiotic prescribing for tonsillitis and sore throat to monitor practice adherence to the National Institute for Health and Care Excellence standards. This had been reflected on in the practice though a learning event. The practice reaudit in 2014 found the number of antibiotics issued inappropriately had fallen from the initial 14.3% to 0%.
- The practice participated in applicable local audits, national benchmarking, accreditation, peer review and research. For example, one GP was involved with a Bristol wide project to monitor patients with mental illness (specifically psychoses) following discharge from secondary care.

### Effective staffing

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

- The practice had an induction programme for newly appointed non-clinical members of staff that covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.

# Are services effective?

## (for example, treatment is effective)

- The practice could demonstrate how they ensured role-specific training and updating for relevant staff for example, for those staff reviewing patients with long-term conditions, administering vaccines and taking samples for the cervical screening programme.
- 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 these learning needs and to cover the scope of their work. This included observation of practice sessions, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and facilitation and support for the revalidation of doctors. We found the recording of the observational practice and ongoing supervision of the nurse team had not been recorded and appraisal had exceeded one year interval due to staff sickness. The practice had a remedial plan in place to address these issues. We found all other staff had had an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire procedures, basic life support and information governance awareness. 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. Information such as NHS patient information leaflets were also available.
- The practice shared relevant information with other services in a timely way, for example, when referring patients to other services.

Staff worked together and with other health and social care services to understand and meet the range and complexity of patient's 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. We saw evidence that multi-disciplinary team meetings took place on a bi-monthly basis and that care plans were routinely reviewed and updated.

### 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 patient's capacity to make an informed decision about their treatment, and if appropriate, recorded the outcome of the assessment.
- The process for seeking consent was demonstrated through records and showed the practices met its responsibilities within legislation and followed relevant national guidance.

### Health promotion and prevention

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

- These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice about their diet, smoking and alcohol cessation. Patients were then signposted to the relevant service.

The practice had a failsafe system for ensuring results were received for every sample sent as part of the cervical screening programme. The practice's uptake for the cervical screening programme was 79.11% which was comparable to the Clinical Commissioning Group average. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

Childhood immunisation rates for the vaccines given were comparable to Clinical Commissioning Group and national averages. For example, childhood immunisation rates for the vaccines given to under two year olds ranged from 90%

# Are services effective?

(for example, treatment is effective)

to 99% and five year olds from 96.4% to 100%. Flu vaccination rates for the over 65s were 74.59%, and at risk groups 48.95%. These were also comparable to the Clinical Commissioning Group and national averages.

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 on the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

# Are services caring?

## Our findings

### Respect, dignity, compassion and empathy

We observed that 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 and that 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.
- The waiting room was separated from the reception area to improve confidentiality.

Of the 24 patient Care Quality Commission comment cards we received, 22 were positive about the service experienced. Patients had written they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. There were no common themes from the two less positive comments received.

We also spoke with three members of the patient participation group. They also 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. We also observed patients had access to a 'white board' in the entrance lobby on which they wrote comments and the practice responded to them. This was a form of indirect communication for the practice and alerted them to minor issues which patient may not have wished to raise an issue but also allowed patients to be complimentary about the service. We saw the comments recorded on this board formed part of the practice patient feedback.

Results from the national GP patient survey published in July 2015 showed patients felt they were treated with compassion, dignity and respect. The practice had a variable response for its satisfaction scores on consultations with doctors and nurses. For example:

- 86.8% said the GP was good at listening to them compared to the Clinical Commissioning Group average of 89.5% and national average of 88.6%.
- 80.9% said the GP gave them enough time compared to the Clinical Commissioning Group average of 86.5% and national average of 86.6%.
- 96% said they had confidence and trust in the last GP they saw compared to the Clinical Commissioning Group average of 96% and national average of 95.2%.
- 83.2% said the last GP they spoke to was good at treating them with care and concern compared to the Clinical Commissioning Group average of 85.3% and national average of 85.1%.
- 96.6% said the last nurse they spoke to was good at treating them with care and concern compared to the Clinical Commissioning Group average of 91.7% and national average of 90.4%.
- 94.1% said they found the receptionists at the practice helpful compared to the Clinical Commissioning Group average of 88.5% and national average of 86.8%.

### Care planning and involvement in decisions about care and treatment

Patients told us that 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 on the comment cards we received was also positive and aligned with these views.

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

- 84.4% said the last GP they saw was good at explaining tests and treatments compared to the Clinical Commissioning Group average of 86.4% and national average of 86.0%.
- 87.3% said the last GP they saw was good at involving them in decisions about their care compared to the Clinical Commissioning Group average of 81.8% and national average of 81.4%.

## 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. The practice routinely used the RNIB to convert written communications to Braille for patients with sight loss.

### **Patient and carer support to cope emotionally with care and treatment**

Notices in the patient waiting room told patients how to access a number of support groups and organisations. The practice had introduced a child friendly health advice leaflet.

We saw the practice had commissioned wall art to entertain and distract young patients whilst attending the

practice. This had been produced in partnership with a local community group. Patients we spoke with commented on the positive affect this had on the younger patients.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 113 patients on the practice list as carers and they were contacted by the practice carer's champion. Written information was available to direct carers to the various avenues of support available to them.

All patient deaths were reviewed at the weekly practice meeting to share any concerns or learning. Staff told us that if families had suffered bereavement, the practice 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.

# 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 to secure improvements to services where these were identified. The practice manager was a locally elected representative to Bristol Clinical Commissioning Group.

The practice was part of the Bristol Primary Care Agreement which aimed to simplify the contracting process to support practices to deliver the primary care element of the Clinical Commissioning Group's five year plan and move towards outcomes based commissioning. The practice was working with four other practices in the immediate area in order to develop internal referral between the practices for specialist treatment such as dermatology, and to further develop areas of expertise to become centres of excellence for treatment of long term conditions. The practice had made a successful bid for inclusion on to the "Integrated Model of Care for Diabetes Pilot" (HG Wells Project - a new one year pilot aimed at delivering significant and sustainable improvements in the management and treatment of diabetes) being commissioned by the South West Commissioning Support unit.

- Services were planned and delivered to take into account the needs of different patient groups and to help provide ensure flexibility, choice and continuity of care. For example, urgent access appointments were available for children and those with more acute medical conditions.
- There were longer appointments available for patients with long term chronic diseases.
- Extended hours appointments were available for working patients
- The practice responded to requests from patients unable to go to the surgery, for home visits. Additional nurse time had been freed up to enable visits to chronically ill patients.
- Two GPs held regular clinics in two local care homes for older people which promoted continuity of care for the patients.

- Patients with a learning disability were invited to attend a yearly comprehensive health review which followed the Cardiff protocols. Patients were sent accessible information in order to be prepared for their appointment.
- There were accessible facilities, hearing loop and translation services available.
- All vulnerable families had a named GP which provided continuity of care to the whole family.
- The practice hosted a specialist diabetes nurse who supported the practice nurses with complex patients.
- The practice offered winter rescue packs to patients with chronic obstructive pulmonary disease and encouraged patient to self-manage.
- An administrator had a lead role to contact mothers individually, by telephone and letter, to ensure the maximum attendance at the 8 week post-natal checks and immunisation clinics. All patients who 'did not attend' were notified to the health visitor.
- In partnership with the other 'cluster' practices they had worked with the retired and senior volunteer programme (RSVP) to appoint volunteers to combat the social isolation of older patients.

### Access to the service

The practice was open from Monday to Friday for urgent and routine appointments 9am-6pm and extended hours were available on Monday evenings, Tuesday mornings and Thursday mornings and evenings. The reception was open Monday to Friday 8.30am-6.30pm for appointment booking and enquiries. The practice had a Saturday surgery each month, on the second Saturday of the month in the morning for prebooked appointments. In addition to this there were pre-bookable appointments that could be booked up to six weeks in advance.

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. Patients told us on the day that they were able to get appointments when they needed them. We observed that the patient wait for prebookable appointments was three days.

- 77.8% of patients were satisfied with the practice's opening hours compared to the Clinical Commissioning Group average of 74.6% and national average of 73.8%.

# Are services responsive to people's needs?

(for example, to feedback?)

- 74.8% of patients said they could get through easily to the surgery by phone compared to the Clinical Commissioning Group average of 72.7% and national average of 73.3%.
- 70.1% of patients described their experience of making an appointment as good compared to the Clinical Commissioning Group average of 72.5% and national average of 73.3%.
- 63% of patients said they usually waited 15 minutes or less after their appointment time compared to the Clinical Commissioning Group average of 62.1% and national average of 64.8%.

## Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system on the practice website and posters displayed within the practice. Patients we spoke with were aware of the process to follow if they wished to make a complaint.

We looked at a selection of complaints received in the last 12 months and found these were satisfactorily handled and 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 all the complaints received had been resolved without reference to other outside agencies.

Lessons were learnt from concerns and complaints and action was taken to as a result to improve the quality of care. We found the learning points from each complaint had been recorded and communicated through the team such as ensuring that when a patient needed an interpreter for a consultation this was actioned.



# 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 written statement of purpose which outlined the ways in which the practice worked to deliver high quality care and promote good outcomes for patients. We heard from all the staff we spoke with that there was a 'patient first' ethos within the practice. This was corroborated by the patients with whom we spoke. We found that there was strong leadership and strategic vision within the practice which encompassed the planned changes to service provision.

However, this was only verbalised by the practice manager and partners and was not a written document and so was not a shared vision for the whole practice.

The practice had a strategic approach to future planning and had put in place succession arrangements to identify and address future risks to personnel leaving or retiring. The practice also participated and engaged with colleagues as part of the Bristol Clinical Commissioning Group (CCG) locality and specifically with four other practices to form the Bedminster Medical Group which will collaborate to share resources and expertise in areas such as dermatology and mental health.

### Governance arrangements

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

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities
- Practice specific policies were implemented and were available to staff on internal computer shared drives. The practice also issued a handbook to all staff.
- A comprehensive understanding of the performance of the practice and the impact for patients was maintained.
- A programme of continuous clinical internal audit which 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, the GPs peer reviewed all referrals and used the South Bristol Referral Screening Service which ensured referrals were appropriate and complete.

### Leadership, openness and transparency

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

The provider was aware of and complied with the requirements of the Duty of Candour. The partners encouraged a culture of openness and honesty. Complaints were also reviewed by topic by the Patient Participation Group as a way of being open and transparent and also stimulating discussion about any change which could be made to prevent reoccurrence.

The practice had systems in place for reporting and sharing information about notifiable safety incidents.

When there were unexpected or unintended safety incidents:

- The practice gave affected patients reasonable support, truthful information and a verbal and written apology
- They 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.

- We saw that the practice held regular team meetings.
- We were told there was an open culture within the practice and staff had the opportunity to raise any issues at team meetings, felt confident in doing so and supported if they did.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. The management team encouraged all members of staff to identify opportunities to improve the service delivered by the practice. An example of this was a suggestion by a staff member to reduce telephone call waiting at peak times by introducing additional telephone lines.

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



# Are services well-led?

Good 

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

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.

- It had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. There was an active PPG which met on at least bimonthly and who carried out patient surveys and were consulted on proposals for improvements by the practice management team.
- The practice had also gathered feedback from staff 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.

## Continuous improvement

There was a strong focus on continuous learning and improvement at all levels within the practice. The practice

held a quarterly education meeting for staff; at the meeting held in May 2015 the team revisited an updated themselves on various topics as well as cascading information from learning events attended by staff externally. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. They participated in the Bedminster Town team community programme (a scheme to improve local facilities and infrastructures for businesses and the community) so that the developments within the practice reflected the developments in the local community. 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.