Eastville Medical Practice

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

On Wednesday 3 December 2014 we carried out an announced comprehensive inspection at Eastville Medical Practice. During the inspection we gathered information from a variety of sources. For example, we spoke with patients, members of the patient participation group, interviewed staff of all levels and checked the systems and processes in place.

Overall the practice is rated as good. Specifically, we found the practice to be good for providing well-led, effective, caring, safe and responsive services. They were also good for providing services for patients who circumstances may make them vulnerable, families, children and young patients, older patients, working age and retired patients, patients with long term conditions and patients experiencing poor mental health.

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients found it difficult to contact the practice either by phone or visiting the practice. It was often found patients would be queuing outside the practice for appointments or were on hold waiting for a significant time on the phone to make an appointment. The practice had tried to improve this for patients but had a number of challenges making this difficult to achieve.

Summary of findings

- 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 practice had good communication with other services to ensure patients received the best care possible.

We saw several areas of outstanding practice including:

- The practice supports a local drug project and a support worker attended the practice once a week to provide support to patients who need help and advice. One of the GPs led on drug and alcohol misuse. We were told the service had been very beneficial to patients. The agencies work closely together and were able to share information about patient's welfare regularly with each other.
- The practice had a high number of patients who were from Somalia. The practice had a health link worker who spoke Somali visiting the practice once a week to support these patients who may need assistance, such as with interpreting English when visiting the GP.

However, there were also areas of practice where the provider needs to make improvements.

The provider should:

- Ensure all fire safety recommendations were addressed promptly and clearly recorded to ensure risks to patient safety were reduced if there was a fire.
- Ensure nurse practitioners receive regular formal clinical supervision from a GP for their independent prescribing role
- Ensure the recruitment policy reflects current legislation, such as detailing whether health and social care relation references were required depending on the employee's previous experience and proof of identification for new employees.
- Continually review staffing levels and ensure patients were seen and spoken with promptly when visiting and phoning the practice.
- Ensure staff monitoring refrigerator temperatures where vaccines were kept are aware of current practice protocols in line with this.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Safety concerns, such as fire safety, were not consistently identified or addressed quickly enough. The practice was in process of taking action to address this. Staffing levels will be reviewed when they are in new purpose built premises and this may increase reception and administration staff levels for the practice.

Are services effective?

Good

The practice is rated as good for providing effective services. Our findings showed systems were in place to ensure all GPs, clinical pharmacist and nursing staff were up to date with both national guidelines and other locally agreed guidelines. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health.

The practice was using innovative and proactive methods to improve patient outcomes and it linked with other local providers to share best practice. The practice had good links and communication with the community teams and provided services for young patients in the area for sexual health and for patients who had drug and alcohol addictions through a local drug project which benefitted its patients.

Regular appraisals took place and personal development plans were agreed with staff. However, nurse practitioners did not receive formal clinical supervision for their independent prescribing role.

Are services caring?

Good

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

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice had initiated positive service improvements for its patients that were over and above its contractual obligations. They acted on suggestions for improvements and changed the way it delivered services in response to feedback from the patient participation group (PPG). The practice reviewed the needs of its local population and engaged with the NHS England local area team and Bristol Clinical Commissioning Group (CCG) to secure service improvements and additional services where these had been identified.

Generally patients told us they could be seen the same day by a GP. Patients struggled with the appointments system and often queued at the practice to try and get an appointment. If patients needed to be seen urgently then they would be seen by the GPs the same day. The practice had taken a number of actions to address this, such as building a new purpose built premises due to be complete end of 2015 which will include a new appointment telephone system and a review of staffing arrangements, surveying patients and an open surgery was provided Monday to Friday each week.

The practice had adequate facilities and was equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff and discussed at monthly team meetings.

Are services well-led?

Good

The practice is rated as good for being well-led. They had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. 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 were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

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

People with long term conditions

Good

The practice is rated as good for the care of patients with long-term conditions. There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. Longer appointments and home visits were available when needed. All these patients had a structured annual review to check their health and medication needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young patients. Information from the Health and Social Care information centre identified that immunisation rates were slightly lower than average for standard childhood immunisations for the local CCG area. The practice were continuing to inform parents of the benefits of the immunisations and ensuring patients were regularly contacted to attend for their child's immunisations. Patients told us children and young patients were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We heard good examples of joint working with health visitors.

There were a number of children on the child protection register and the child protection lead worked closely with the community teams in the area to ensure information was shared appropriately. The practice held weekly clinical meetings where patients of concern were discussed.

The practice run a scheme set up by Bristol Clinical Commissioning Group called 4YP (for young people) this service provided advice and support for young patients under the age of 25 years old on sexual

Summary of findings

health matters. This service was available to all young patients in the community not just patients at the practice. Patients using this service were able to drop in during specific times in the practice opening hours without an appointment or could make an appointment to be seen.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age patients (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of patients whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless patients, travellers and those with a learning disability. They had carried out annual health checks for all 43 patients registered at the practice with a learning disability in the last year. They offered home visits and longer appointments for patients with a learning disability. They also worked closely with the community learning disabilities team who were based in the practice.

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

The practice had a high number of patients who were from Somalia. The practice had a health link worker who spoke Somali visiting the practice once a week to support these patients who may need assistance.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of patients experiencing poor mental health (including patients with dementia). There were 101 patients registered who had a mental health condition and all were offered an annual physical health check. The practice regularly

worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with a diagnosis of dementia. They had carried out advance care planning for the 15 patients registered at the practice with a diagnosis of dementia.

The practice had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for patients with mental health needs and dementia.

The practice supports a local drug project and a support worker attends the practice once a week to provide support to patients who need help and advice. One of the GPs led on drug and alcohol misuse and told us the service had been very beneficial to patients. Because the agencies work closely they were able to share information about patient concerns easily and the practice had an open door policy for discussions.

Summary of findings

What people who use the service say

During our inspection we met with the practice patient participation group (PPG) which was formed in 2011. We met six of the 20 PPG members. They told us the practice was committed to improving patient care and included the PPG in the decision making when improvements were planned.

We received 13 comment cards, all patients who had commented were highly satisfied with the service received. There were two negative comments; one patient had made a comment about their repeat prescription medicines being changed to a different brand and another patient told us about the difficulty to get an appointment.

During our inspection our expert by experience spoke with seven patients who were very complimentary about the practice. Five out of seven patients told us the most frustrating aspect about the service provided was the appointment system. We saw and were told by patients and staff that there were often queues of patients which extended outside the front door. These patients were mainly queuing to book appointments at the practice.

The practice responded to patient comments on their website. This provided an opportunity to inform patients of changes in the practice systems and reasons behind the difficulties faced by the practice. We read that some comments raised in the last four months had reflected dissatisfaction with the appointment systems. The practice had recognised the appointment system was in need of improvement and had decided to conduct a patient survey to gain views from patients that had experienced difficulty with the appointment system. They were hoping this would enable them to make some minor changes to the system to improve it so they could increase patient satisfaction before they moved into their new premises. However, they were restricted by space and their technology which hampered any improvements but had a plan for improving the whole system when they moved to their new site in autumn/winter 2015.

The practice had completed its own survey in 2013. They contacted 200 patients either by phone, post or email. They received 91 completed patient surveys. We saw 85% of patients thought GPs provided a good service, 90% nurses provided a good service and 83% reception staff provided a good service. We saw 27% of 91 patients said they wanted Saturday morning appointments and so did three out of the seven patients we spoke with. Currently the practice provided a service to patients one Saturday every month. However, patients told us they either did not know about this service or would like appointments to be available every Saturday.

Prior to our inspection we reviewed other information sources about patients' experience of the service provided. This included NHS Choices (a forum for patients to publicly provide their views about the practice and where the practice can respond to these views). We saw there had been eight comments made about the practice in the last year. Three out of the eight were positive about the service provided. They said the staff would go above and beyond to accommodate needs and staff were professional and friendly. The other five patients had raised concerns about the appointments either GPs running late or not being able to get an appointment.

We reviewed the national GP patient survey taken from patients for the periods of January to March and July to September 2013. This is a national survey sent to patients by an independent company on behalf of NHS England. We saw 118 patients had completed the surveys from the 413 sent. We saw 95% of patients surveyed said their overall experience of the practice was good with 94% of patients saying they trusted and had the confidence in the last GP with whom they spoke. We saw 45% of patients felt the areas to improve were about waiting too long to be seen for their appointment and that they did not find it easy to get through on the phone.

Areas for improvement

Summary of findings

Action the service SHOULD take to improve

- Ensure all fire safety recommendations were addressed promptly and clearly recorded to ensure risks to patient safety were reduced if there was a fire.
- Ensure nurse practitioners receive regular formal clinical supervision from a GP for their independent prescribing role
- Ensure the recruitment policy reflects current legislation, such as detailing whether health and social care relation references were required depending on the employee's previous experience and proof of identification for new employees.
- Continually review staffing levels and ensure patients were seen and spoken with promptly when visiting and phoning the practice.
- Ensure staff monitoring refrigerator temperatures where vaccines were kept are aware of current practice protocols in line with this.

Outstanding practice

- The practice supports a local drug project and a support worker attended the practice once a week to provide support to patients who need help and advice. One of the GPs led on drug and alcohol misuse. We were told the service had been very beneficial to patients. The agencies work closely together and were able to share information about patient's welfare regularly with each other.
- The practice had a high number of patients who were from Somalia. The practice had a health link worker who spoke Somali visiting the practice once a week to support these patients who may need assistance, such as with interpreting English when visiting the GP and advising them of benefits they may be entitled to and how to apply for this.

Eastville Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP, a practice manager and an Expert by Experience.

You should also be aware that experts who take part in the inspections, for example, Experts by Experience, are not independent individuals who accompany an inspection team – they are a part of the inspection team and should be described in that way. They are granted the same authority to enter registered persons' premises as the CQC inspectors.

Background to Eastville Medical Practice

We inspected the location of Eastville Medical Practice, Eastville health centre, East Park, Eastville, Bristol, BS5 6YA, where all registered regulated activities were carried out.

The practice serves approximately 8500 patients and sees patients who live in Easton, Eastville, Stapleton, St Werburghs and Fishponds in the inner city east area of Bristol. The practice is based in a diverse area of Bristol and practice approximate figures say there are approximately 60% of patients registered are from a non-white British ethnicity covering approximately 40 different ethnicities. The highest ethnicity population being Somalian and South East Asian. A high number of patients had a language barrier which was one of the biggest challenges for the practice.

Additional services are provided from the practice premises including a child audiology clinic and a local drug project counsellor visited the practice on a regular basis to provide services to practice patients and others in the community. The practice provides specialist services such as circumcision for boys aged between 1 and 6 months. They also provide 4YP (for young people) a scheme set up by Bristol Clinical Commissioning Group for young patients under the age of 25 years old to provide advice on sexual health matters.

The national general practice profile shows the practice has 23% of patients under the age of 18 years old which is over the England and Bristol Clinical Commissioning Group (CCG) average, particularly between the ages of 0 to 9 years old. They also have above the national and local average numbers of patients in the 25 to 39 year olds category. The practice is significantly under the national and CCG average for patients over 50 years old. The practice is in an area of Bristol which has a higher than average level of deprivation.

Each week the GPs work the full time equivalent to four and half full time GPs. There were three GP partners and three salaried GPS; three male and three female. The practice was a registered GP training practice. They had one GP registrar and a GP retainer. A registrar is a qualified doctor who requires additional experience in a GP practice to qualify as a GP. A retainer is a GP who is working a reduced contract whilst they had child care responsibilities.

The practice employed a clinical pharmacist who leads on auditing and reviewing patient's medicines. They work an equivalent to 0.75 of a full time worker.

There were seven members of the nursing team, all female. This consisted of two practice nurses who can also independently prescribe medicines, two practice nurses, two health care assistants and a phlebotomist. Each week the nursing team work the equivalent of just over four full time workers.

Detailed findings

The practice had a Personal Medical Service (locally agreed) contract with NHS England. The practice referred their patients to Brisdoc for out-of-hours services when the practice was closed.

The practice had previously been inspected under our old methodology in December 2013. We did not have any concerns about this practice prior to our inspection following this inspection. We followed up on some areas which were highlighted on the last report, such as the practice now has a whistle-blowing policy.

Why we carried out this inspection

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

How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to patient'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 patients
- Patients with long-term conditions
- Families, children and young patients
- Working age patients (including those recently retired and students)
- Patients whose circumstances may make them vulnerable
- Patients experiencing poor mental health (including patients with a form of dementia)

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We spoke with the Bristol Clinical Commissioning Group, NHS England local area team, Avon Local Medical Council and local area Healthwatch. We carried out an announced visit on the 3 December 2014. During our visit we spoke with 16 staff including the five GP's, the practice manager, two practice nurses, two administration staff, two team leaders for reception and administration and two receptionists.

We spoke with 13 patients including six members from the patient participation group and reviewed 13 comment cards where patients shared their views and experiences of the service prior to our inspection.

We also spoke with members of the community team that were based the practice. Two health visitors and two members from the learning disabilities community team.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents, updates from the National Institute of Health and Clinical Excellence (NICE) and National Patient Safety Alerts (NPSA). The practice manager received the NPSA alerts and then forwarded them onto the clinical pharmacist who took action to follow up on any changes and inform relevant members of staff. We were told NICE guidelines were disseminated by the lead GP to other relevant staff.

The staff we spoke with were aware of their responsibilities regarding how to raise concerns, and knew how to report incidents and near misses. For example, a nurse was concerned about a patient who was displaying signs of abuse. They had reported this to the GP who then acted in response to the situation sensitively and appropriately.

We reviewed the significant events and complaints over the last year. We saw practice meeting minutes discussed these incidents and how the practice could improve service provision to prevent recurrence. This showed the practice had managed these consistently over time and so demonstrated evidence of a safe track record over the longer term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We saw 10 significant events had occurred during the last year. Significant events were a standing item on the practice meeting agenda and a dedicated meeting was held monthly to review actions from past significant events and complaints. Additional meetings were held to discuss significant events between the GPs on a more informal basis at weekly clinical meetings and during coffee breaks. We saw evidence of action taken as a result of a significant event. The hospital informed the practice of a patient condition and the GP had asked the patient to come in for an appointment. It was established that the hospital had informed the wrong patient of a diagnosis. This was highlighted to the hospital immediately who then contacted the correct patient. Another significant event involved a patient receiving a delayed positive test result. The practice had changed their processes to ensure checks were made for patient personal details when tests were taken to ensure they could contact the patient promptly. There was evidence the practice had learned from these and the findings were shared with relevant staff.

Staff, including receptionists, administrators and nursing staff felt comfortable to raise an issue for consideration at the meetings and they felt encouraged to do so by the partners.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children and adults. We read training records which showed all staff had received relevant training about safeguarding vulnerable adults. This was completed through an e-learning module many of staff had completed this in November 2014. Training was run on a three year cycle. All GPs and nurse practitioners had completed level 3 child protection training with the majority of training completed in November 2012. Other members of staff had completed online safeguarding modules for child protection.

Staff we spoke with knew how to recognise signs of abuse in vulnerable adults and children. We heard of an example of when a nurse had recently become concerned about a patient and had escalated it to the lead GP partner for safeguarding. They were also aware of their responsibilities in raising a concern and how to contact the relevant agencies in working hours and out of normal hours. We saw policies were easily accessed by staff on the shared computer system. All staff we spoke with were aware who the lead GP was in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to raise staff awareness of any relevant issues when patients attended appointments. For example, children who were subject to a child protection plan. GPs ensured risks to children and vulnerable adults were flagged on the patient record system. This enabled practice staff to be aware these patients may need additional support and monitoring. The practice had a high number of children who were deemed to be 'at risk'. GPs told us that awareness and action taken when a child deemed 'at risk' moved practices was important to ensure continuity of care and treatment. GPs had close links with the health visitors to ensure information was shared appropriately others.

Good

Are services safe?

The practice had a number of patients who had experienced female genital mutilation (FGM) or were at risk of this. Patients were confidentially identified on the practice IT system if they were considered at risk or who had experienced FGM. Nursing staff were aware of the issues around this and routine questions were asked at travel clinics when patients visiting countries where FGM was most commonly found.

We saw the practice had posters in the waiting area advertising the availability of a chaperone to patients. We were informed receptionists who acted as chaperones for patients had received training and criminal background checks had been completed.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. The practice had a system for checking the refrigerator temperatures daily. However, the process for ensuring refrigerators that were outside the recommended temperature was not clear to staff. For example, on two occasions we saw the temperature had exceeded the recommended temperature. There had been no further records of checks made. The practice manager was informed of this and the protocol was amended shortly after the inspection to ensure additional checks were completed and the action to take if the temperature was not within the acceptable range. We saw two of the refrigerators did not warn staff not to turn off or unplug the refrigerators. This was particularly relevant for this equipment because the plugs were not clearly identified as refrigerator plugs and were easily accessed, so the risk was higher.

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

We saw records of practice meetings that noted the actions taken in response to a review of antibiotic prescribing data. For example, audits had been completed by the clinical pharmacist, which found correct antibiotics were prescribed and required improvements were made to ensure national guidance was followed. All GPs and nurse prescribers had been reminded of this in a practice meeting.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance.

The clinical pharmacist mainly monitors repeat prescriptions to ensure patients were ordering at the correct time and dose and had checked tests and reviews with GP/nurse to ensure they were up to date. They also checked that all routine health checks were completed for long-term conditions such as diabetes and the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP or nurse prescribers were prescribing medicines. Administration staff deal with requests for repeat prescriptions and had received training from the clinical pharmacist. They told us of the systems in place to ensure repeat prescriptions were dealt with by the most appropriate person. The prescriptions were signed by a GP before they were given to the patient. Prescription pads were kept securely at all times.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse). We saw controlled drugs were stored in a controlled drugs cupboard, access to them was restricted and the keys were held securely. We saw an audit trail of the controlled drugs in stock. We found the practice had a limited amount of controlled drugs in stock.

Cleanliness and infection control

We observed the premises to be clean and tidy. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. We saw evidence an infection control audit had been carried out in June 2014. There was one treatment room in the practice and this was mainly used for higher risk infection procedures, such as dressings for wounds. Where possible the treatment room would be used for patient treatments. However, consulting rooms were often used because of the lack of space and facilities in the practice.

Consulting rooms were carpeted and used to complete treatments such as cervical smears, specialist surgical procedures and family planning. The practice had

recognised that carpeted rooms were an infection control risk and provided us with a risk assessment which mitigated any risks to patients. For example, the assessment identified action to take for spillages. They had a spillage kit for staff to use and a cleaning company who could attend the practice within 30 minutes of any spillage. A new practice was being built which will have additional treatment rooms and we were informed there would be an operating theatre style room for high risk procedures to be undertaken.

We observed in the consulting and treatment rooms we visited that personal protection equipment was available for staff to use, such as gloves, aprons, visors and gowns. Disposable curtains were used and changed every six months or if soiled, as required. There were hand washing facilities including soap and hand towel dispensers.

Notices about hand hygiene techniques were displayed in staff and patient toilets. We saw toilets had hand washing sinks with soap and hand towel dispensers and foot pedal bins.

We were informed by the practice manger the recent previous building owner had carried out a legionella risk assessment and carried out weekly flushing in the building. Legionella is a germ found in the environment which can contaminate water systems in buildings. The practice manager told us they were checking with the previous owner to determine what checks had been carried out and if any further assurances were required.

Equipment

Staff told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. We saw the electrocardiogram machine and nebuliser had been last serviced in September 2014. Records showed that other equipment for use at the practice had been tested and serviced in June 2014. The practice manager was unable to confirm all portable appliance testing had been completed but did confirm this had been scheduled for completion in January 2015.

Staffing and recruitment

We read three staff files which contained evidence criminal background checks were carried out through the Disclosure and Barring Service (DBS). The practice had a recruitment policy, which was last reviewed in May 2014. This described the standards it followed when recruiting clinical and non-clinical staff. The policy did not include checks that should be taken place as part of the legislation, such as proof of identification and specific information about references for new employees who come from a health and social care background.

Staff told us about the arrangements for planning and monitoring the number and mix of staff to meet patients' needs. The practice had carried out an audit in April 2014 to determine whether GP appointments were being used effectively. It was found the practice could increase the nurse practitioner appointments for patients to use. However the nurse practitioners were already working to full capacity. The practice had plans in place to provide additional training to another nurse at the practice to take on more responsibility, this would then allow for the release the nurse practitioner for additional appointments.

We were told about patients queuing up outside the front of the practice to book appointments, and waiting on the phone to speak to someone for up to 45 minutes. We were informed by the practice manager that part of the problem was the telephone system, (which the practice planned to upgrade in the new build) and that they were restricted on improvements with the current system. The practice had considered increasing their staffing on reception and answering calls. However, they were restricted by the space within the practice to accommodate them. They told us they were planning on reviewing the staffing arrangements for the new premises.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy and there was an identified health and safety representative. We saw staff were up to date for health and safety and manual handling training.

Identified risks were incorporated into risk assessments. Risk assessments were available on the shared drive for all staff to review when necessary.

We saw reception staff had received various training in communication, assertiveness and interpersonal skills and dealing with challenging patients. Reception staff told us they would often see or speak to patients who were

frustrated with the appointment system or who required more time for patients with complex needs such as language barriers. Reception and administration staff felt supported by management.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment. We heard that when a medical emergency had occurred the learning from the event was discussed at the next team meeting and decided some additional equipment would be useful to assist in the event of another emergency.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. The practice did not routinely hold stocks of medicines for the treatment for reversing the side effects of an opiate overdose. The reason for this was the potential for use was minimal. However, after discussion the practice informed us they were arranging for this medicine to be in stock. Processes were also in place to check whether emergency medicines were within their expiry dates and suitable for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed. Paper copies of the business continuity plan were held offsite by the practice manager & senior partner.

The practice had carried out a fire risk assessment which included actions required to maintain fire safety. We saw some of the actions raised from the risk assessment had not been completed. The practice told us they would contact the fire safety company to carry out the outstanding actions. We noted there was a query in relation to whether all the fire extinguishers had been serviced and the practice manager was looking into this. Records showed that staff were up to date with fire training and they practised regular fire drills, the last one was carried out in November 2014. Fire alarms were tested on a weekly basis but there was no record of this and no fire log book was available for inspection.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

GPs, the clinical pharmacist and nursing staff we spoke with were very open about asking for and providing colleagues with advice and support. For example, GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of antibiotic prescribing. Our review of the clinical meeting minutes confirmed this happened.

Through our intelligence reporting data we found there were some areas that were flagged as a concern. The practice had reviewed these areas prior to our visit and provided reasonable explanations for why they were shown as a risk. For example, dementia diagnosis rate was low and showing as a risk, the practice had a lower than average over 65 year old population and the residential/ supported living homes where their patients were living were for patients with learning disabilities. Another area was the level of prescribing of anti-inflammatory medicines was low in comparison to other practices. The clinical pharmacist had completed an audit and found there were a very low number of patients on repeat anti-inflammatory. This was because the pharmacist regularly reviewed patient's medicines and there was a low proportion of older patients registered at the practice.

We spoke with one of the administration staff where part of their role was to process referrals. The computerised system highlighted urgent referrals initiated by the GP and these were always completed as a matter of priority and always by the end of the working day. Routine referrals were usually completed within the day or next working day. There was three staff trained to enable a continuation of service if the usual member of staff was absence from work.

We saw no evidence of discrimination when staff made care and treatment decisions.

Management, monitoring and improving outcomes for people

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

We saw the practice had completed 16 clinical audits in the last year. Four of these were completed audits where the practice was able to demonstrate the changes resulting from the initial audit. For example, an audit was completed for Disease Modifying Anti-Rheumatic Drugs (DMARDS) both audits indicated that prescribing and checks for these medicines had been correct. Another audit was completed for the use of anti-inflammatory medicine completed in October 2013 and reviewed in November 2014. This showed there had been an improvement in results from the previous audit. For example, the level of patients who were taking the anti-inflammatory medicine over a long period had decreased. Other examples included audits, a chronic obstructive pulmonary disease audit to review their treatment and medicines, to help prevent admissions to hospital. Another audit had been completed to review patients receiving opiate therapy to see if they had been encouraged to have a hepatitis B check. Improvements were made to the system of asking by having on the spot tests for patients when they initially saw the patient and updating the system to remind GPs to ask the patient when they visited.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). QOF is a national performance measurement tool. In the year April 2013 to March 2014 the practice had met with 89% of the target for QOF. Some areas of the QOF were a challenge for the practice due to

Good

Are services effective?

(for example, treatment is effective)

the patient demographics. Some patients were resistant to attending the practice for reviews and tests. The practice had systems in place to encourage these patients to attend when they missed their reviews. An administrator sent patients reminders for their reviews and then either they would or a GP or nurse would phone the patient. The practice also had a health link worker attend the practice once a week to help support Somalian patients who would also try and encourage patients to attend. Another area of challenge was child immunisations; other countries had different age brackets for their immunisations so some parents were reluctant to bring their child in for these immunisations if they felt it was too soon.

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

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw the majority of staff were up to date with all mandatory courses such as safeguarding children and vulnerable adults, health and safety and information governance. We noted a good skill mix among the GPs with one GP with a diploma in children's health and three GPs with diplomas in obstetrics and gynaecology. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England.

All staff undertook annual appraisals which identified learning needs from which action plans were documented. Our interviews with staff confirmed the practice was proactive in providing training and funding for relevant courses, for example additional training had been provided to advise staff on issues in respect of human trafficking as this had been recognised a problem in the local area.

As the practice was a training practice, doctors who were training to be qualified as GPs had access to a senior GP throughout the day for support. We heard from one of the GP trainees and they told us they were very impressed with how the practice was run and had supported them during their training.

Two members of the nursing staff were qualified as independent prescribers and they told us they had not received any formal clinical supervision on a one to one basis with a GP. Nurse independent prescribers should have regular formal clinical supervision for this part of their role with a GP. However, the nurse practitioners told us they supported each other on a daily basis and a GP was always at hand for support. They also attended weekly clinical meetings with GPs and members of the nursing team where they discussed patients of concern.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage complex cases. They received blood test results, X ray results, and letters from the local hospital including discharge summaries, and information from the out-of-hours Brisdoc service, both electronically and by post.

The practice held multidisciplinary team meetings bi-monthly. Community team members were welcomed to join the practice weekly clinical meeting to discuss the needs of complex patients. Health visitors were based in the practice. This was beneficial for both the practice and the community teams because concerns about patients could be discussed promptly if needed. Also the practice had a system to enable the community teams to update GPs on particular cases.

The community teams felt there was good communication between the practice and them. The health visitors provided us with examples of when GPs had acted quickly to their concerns to ensure patient safety and the practice's ability to continue learning when events happen. For example, improving how locums received child protection information so they can make the right decisions about the child's care. Also, the practice and health visitors changed the way child immunisations clinics were run. For example, they held health visitor checks the same day to encourage patients to use both services at their convenience.

GPs, nurses and the practice manager attend meetings with their peers (in the same Bristol Clinical Commissioning Group area) every month to discuss areas to improve upon and also to provide any relevant training. For example, the

Good

Are services effective?

(for example, treatment is effective)

practice nurse meeting provided learning on raising awareness on female genital mutilation and new enhanced services, such as the 40-74 year old health checks. Also, this was an opportunity to discuss what support services were available in the local area.

The practice had held discussions with other practices in the area and had recently decided to support another practice because they were an all female GP practice and patients sometimes requested a male GP. The practice was planning on providing a male GP from their practice to work a session a week in their practice.

The practice supports the local drug project and a support worker attends the practice once a week to provide support to patients who need help and advice. One of the GPs led on drug and alcohol misuse and we were told the use of the service had been very beneficial to patients. They worked closely and shared information about patient concerns easily with each other.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made referrals through the Choose and Book system. The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital.

The practice had not yet signed up to the electronic Summary Care Record due to system problems but planned to do this in the near future. Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the GPs and nursing staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice. We heard some specific examples of where the capacity of patient was in question for them to make an informed decision about their care or treatment. For example, a patient with a learning disabilities required hospital treatment and the practice was involved in best interest decision making on whether to inform the patient beforehand. We heard relevant parties were involved in the decision making process to enable a best interest decision.

We spoke with nursing staff who demonstrated a clear understanding of Gillick competencies. These help clinicians to identify children aged under 16 years who had the legal capacity to consent to medical examination and treatment. Gillick competence had a significantly higher use here because the practice provided a service for young patients providing advice and treatment for sexual health issues called 4YP. This service was provided to young patients in the local CCG area and had proved to be successful.

Health promotion and prevention

It was practice policy to offer a health check with the health care assistant to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering chlamydia screening to patients aged 18-25 and offering smoking cessation advice to smokers.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and practice records showed 100% had received a check up in the last 12 months. The practice had also identified the smoking status for patients over the age of 15 and 90% were actively offered nurse-led smoking cessation clinics.

The practice's performance for cervical smear uptake was 81%, which was 1.5% better than others in the local CCG area. The practice had systems in place to encourage these patients to attend when they missed their cervical smear

Good

Are services effective?

(for example, treatment is effective)

tests. An administrator sent patients reminders for their reviews and then either they would or a nurse would phone the patient. The practice also had a health link worker attend the practice once a week to help support Somalian patients. They would also try and encourage patients to attend for screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all child immunisations was just below average for the CCG area, and again there was a clear policy for following up non-attenders by the named practice nurse. The practice had achieved good figures in consideration of their patient demographic and the challenges faced with patients attending for these immunisations.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice regarding patient satisfaction. This included information from the national GP patient survey which consisted of 97 patient views surveyed out of 404 surveys sent out in 2014. The evidence showed patients were satisfied with the way they were treated and this was with compassion, dignity and respect. For example, data from the national patient survey showed 85% of patients rated their overall experience of the practice as "Good". The practice was above average for its satisfaction with 98% of patients saying their GP listened to them and showed them care and concern during consultations. The practice used its website to feedback to patients about comments/ suggestions received by patients. The practice also hoped this would improve patient understanding about the changes being made to improve the service.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 13 completed cards and all were positive about the service experienced. Out of the 13 comments we received two comments about appointment availability and prescription medicine changes. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We spoke with 13 patients on the day of our inspection including six patients from the patient participation group (PPG). All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. However, five out of seven patients commented on the difficulties with the appointment system and queues at reception. In addition the PPG mentioned the problems surrounding the appointment system.

Staff and patients told us all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so patients' privacy and dignity was maintained during examinations, investigations and treatments. We observed consultation and treatment room doors were closed during consultations and conversations that took place in these rooms could not be overheard.

The receptionists either answered patient calls at the desk or in the office behind the desk. Receptionists understood confidentiality and the need to keep patient information private. The reception desk was within the patient waiting area and noted that often there were queues of patients in the practice.

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

We observed there was no notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us it was very rare for a situation to happen of physical aggression. However, often they did have to deal with patients' frustration and verbal aggression on occasions often in relation to the appointments system. They advised they had received training on how to deal with these situations and there was always a manager available for support.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey from 2014 showed 73% of practice respondents said the GP involved them in care decisions and 87% felt the GP was good at explaining treatment and results. Both these results were above average compared to Bristol CCG area.

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

Staff told us translation services were available for patients who did not have English as a first language. We did not see any notices in the reception areas informing patents this service was available, even though this service was often used for patients. The practice website was available in other languages for patients to access and information on interpretation services. Every week a health support worker visited the practice to support Somali patients with advice

or translation services. The website also provided information for patient on how to access information in other formats, such as British Sign Language and easy read formats.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. The patients we spoke with on the day of our inspection and the comment cards we received informed us staff were good at providing emotional support was needed.

We heard from patients about their experience when they thought the GP had gone above and beyond their call of duty. One patient told us the GP had called them in their coffee break to provide them with additional details about a relevant support service they could use. The patient really appreciated their time and thought to help improve their care. Another patient told us their partner had been diagnosed with a condition and the GP had organised for another patient who was willing to share their experience with them about the condition and how they managed it. Another patient told us when they had been diagnosed with depression they had received a call from the nurse practitioner every other day to see how they were and to ask if they needed any additional support.

Notices in the patient waiting room and patient website informed patients' how to access a number of support groups and organisations. For example, for carers and young patients local support groups and advice. The practice had a carers champion. Although not all staff knew who this was. Their role was to meet with the local carers support centre twice a year, which enabled them to provide up to date information in the practice carer's pack about local services available. The practice's computer system alerted GPs if a patient was a carer.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The practice told us they regularly engaged with NHS England local area team and Bristol Clinical Commissioning Group (CCG) and the other 14 practices in their local area 'Bristol inner city east'. They discussed local needs and service improvements that needed to be prioritised. CCG meetings were held for practice managers and practice nurses and they often used this opportunity to discuss local needs and provide area specific training from external sources, such as on female genital mutilation as this was a challenge in the area.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG) and patient surveys conducted for 2013/2014. The practice and PPG had recognised the appointments system was not meeting patient's needs effectively. One of the actions to enable the service to improve the appointment system was to gain patient views who had experienced problems, using an agreed survey template. The survey was in progress when we inspected.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The practice was situated in a diverse area of Bristol city. We were told homeless patients, asylum seekers and people who had been trafficked in the UK, were never turned away from the practice and were signposted to specific services locally to meet their needs as appropriate. The practice had 43 registered patients with a learning disability. All patients with a learning disability had received an annual health review, often completed in their own homes and were offered longer appointments when necessary.

The practice had a high number of patients who were from Somalia. The practice had a health link worker who spoke Somali visiting the practice once a week to support these patients who may need assistance, such as with interpreting English when visiting the GP and advising them of benefits they may be entitled to and how to apply for this. The practice had access to online and telephone translation services for any patient who required assistance with English.

The practice ran a scheme set up by Bristol Clinical Commissioning Group called 4YP (for young patients) this service provided advice and support for young patients under the age of 25 years old on sexual health matters. This service was available to all young people in the community not just patients at the practice. Patients using this service were able to drop in during specific times in the practice opening hours without an appointment or could make an appointment to be seen. The practice had been awarded the 'Young People Friendly' award, which means they had worked hard to ensure they were a welcoming, friendly practice for patients to visit in confidence and without prejudice.

The practice provided an additional specialised service to provide circumcision for boys between one to six months old. This service was provided because the practice recognised that children were at risk of receiving this operation by an unqualified person and admissions to accident and emergency had been high. Specialised staff had been trained by a consultant urologist and a local paediatric urological consultant who then provided on-going support the practice. Completed audits showed a low number of complications and infections arising from procedures and reduced admissions to accident and emergency. We were told this service was highly valued by the Muslim community.

The practice provided equality and diversity training to all staff. Staff we spoke with confirmed they had completed the equality and diversity training and we saw from the practice training record that training was provided every three years.

The premises and services had been adapted to meet the needs of patients with disabilities. All patient areas in the practice were on the ground floor. Accessible toilet facilities were available for all patients. We saw that the waiting area was large enough to accommodate patients with wheelchairs and pushchairs and allowed for easy access to the treatment and consultation rooms.

Access to the service

Appointments were available from 8:30am to 6.30pm on weekdays. The practice had extended hours on a Monday

Good

Are services responsive to people's needs?

(for example, to feedback?)

evening from 6.30pm to 7.30pm and one Saturday a month from 8.30am to 12pm. The practice had an open surgery for an hour each weekday from 12.30pm for quick five minute consultations. Urgent appointment slots were available each weekday and a GP or nurse would triage these appointments to ensure patients were seen by the most appropriate person and could be prioritised. Longer appointments were available for patients who needed them and those with long-term conditions. This included appointments with a named GP or nurse.

Comprehensive information was available to patients about appointments in the practice leaflet and some information was available on the practice website about appointments. This included how to arrange urgent appointments and home visits and how to book appointments through the website. The practice waiting room also had information about appointment types, such as open surgery times, nurse practitioner appointments and telephone consultations. There were arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Patients spoken with were frustrated with the telephone appointment system and would attend the practice in person to book an appointment. Patients confirmed they could be same the day for an urgent appointment. The practice had changed the appointment system three times to try and improve the service. We observed and were told there was often a queue of patients going outside the front door waiting to book an appointment. The practice had tried a number of things to improve the service provided to patients, including changing the appointment systems three times, trying to reduce phone calls into practice by changing the repeat prescription process (patients can order online or bring their repeat prescription into the practice). The practice had considered additional receptionists and administration staff to answer calls and see patients. However, they were unable to employ additional staff due to the size of the premises.

The practice had a large number of patients that did not attend appointments. For example, the week before we inspected 65 patients had missed their booked appointment. One of the GP partners told us missed appointments could often be by patients who had booked an appointment the same day who did not attend. The practice tried to increase patient education in the effect of missed appointments had on other patients and the practice to try and decrease missed appointments. They did this by displaying missed appointment information in the waiting area and on the practice website.

The practice had other challenges including approximately 100 patients registering and leaving the practice each month. This created additional workload for the practice staff to ensure patients were safely registered and information about patients was forwarded on to the next practice.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. The complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The policy also included details for the patient to contact if they required advocacy services. There was a designated responsible person who handled all complaints in the practice.

We saw information was available to help patients understand the complaints system in the practice leaflet and the complaints policy was available on the practice website and at reception. Patients we spoke with were generally aware of the process to follow if they wished to make a complaint.

We saw records of nine complaints received in the last eight months and found these were mainly around appointments or consultations. All complaints, where appropriate, were discussed in a monthly team meeting with reception and administration team leaders, the practice manager, GPs and nurses. We saw complaints had been discussed and learning identified. Following patient feedback the practice was currently in the process of completing a patient survey to establish how they could improve the appointment system and improve the system for use in the new premises. They were gaining feedback from patients who had been frustrated with the system to enable them to drill down on the issues patients were experiencing. The practice had acknowledged the premises was no longer fit for purpose due to increasing patient numbers and had partly funded a new premises that was due to be completed late 2015.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's strategy and business plan. The practice vision and values included to offer a friendly, caring good quality service that was accessible to all patients. Part of the practice main objectives was to complete the rebuild in a smooth transition ensuring the new premises meet the needs of the current population.

We read minutes of the annual whole team practice meeting held in December 2013 and saw staff were involved in decision making and discussions about improvements in the practice and future developments, such as the telephone appointment system and reducing do not attends for patient appointments.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. Policies reviewed included child protection, recruitment, business continuity plan, complaints, consent and whistle blowing. We read nine of these policies and procedures and saw they had been reviewed annually and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and one of the GP partners was the lead for safeguarding. We spoke with 16 members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing at 89%, 4.5% below national standards. However, we were told this may have been because of the challenges the practice face with their patient base and the patient did not attend rate for appointments. We saw the QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, reviewing and prescribing of medicines.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us the risk assessments which addressed a range of potential issues, such as health and safety, infection control and maintaining business continuity. We saw that risks were regularly discussed at business team meetings and updated in a timely way.

The practice held monthly governance meetings with management, GPs and nursing staff. We read minutes from two of these meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

Staff told us there was an open culture within the practice and they had the opportunity and were happy to raise issues at either whole practice team meeting or individual team meetings, such as nurse or reception meetings. There was an open door policy and staff told us management staff were approachable and professional when raising issues.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example, recruitment, staff induction and whistle blowing, which were in place to support staff.

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

The practice had gathered feedback from patients through patient surveys, suggestion and comment cards and complaints received. The main cause for patient feedback was, as previously mentioned, the appointment system. Actions were and had been taken to improve this service to patients.

The practice had an active patient participation group (PPG) of 20 members and 53 members in the practice email group. The PPG included representatives from the majority of age groups, however did not match percentage of population registered. The PPG did not represent the ethnicities of the patients registered with the practice as the group members were mainly of white British ethnicity. The practice had tried to gain additional members either for the PPG or through emails by advertising within the practice, through surveys and newsletters produced for

Are services well-led?

Good

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

patients. The PPG had met every four months with the practice to discuss the action plan and consider further improvements for the practice. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys were available on the practice website.

The practice had gathered feedback from staff through staff meetings, appraisals and informal discussions. 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 in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Staff told us the practice was very supportive of training. We saw regular staff appraisals took place which included a personal development plan. However, nurse practitioners did not have the opportunity to receive formal clinical supervision for their independent prescribing role from a GP.

The practice was a GP training practice and one of the GP partners was a qualified GP trainer. They currently had one GP registrar and a GP retainer. We heard from the GP registrar, who informed us how they considered the practice to be a very good support and very forward thinking to ensure they continued to improve patient satisfaction and staffing support. For example, they had recently introduced texting test results to patients (if the patient agreed and contact details were checked), this was to help improve patient experience and to reduce telephones calls into the practice.