The Wellspring Surgery

Quality Report

Wellspring Healthy Living 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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Wellspring Surgery on 2 December 2014. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services. It was also good for providing services for the care of older patients, patients with long term conditions, the working aged patients including the recently retired and students, mothers, babies and young patients, patients whose circumstances make them vulnerable and patients experiencing poor mental health including patients with a diagnosis of dementia.

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

- There were systems in place to monitor safety including safeguarding children and the protection of vulnerable adults.
- The practice was effective in meeting the needs of the practice population ensuring staff were skilled to undertake the duties required of them.
- Patients were treated with kindness and respect. The identified cultural needs of the practice population were met.
- The practice offered extended appointments to meet the needs of patients.
- There were good governance arrangements and the practice sought the views of patients about the service.

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

The provider should:

- Ensure all actions taken in response to significant events are recorded so there is a clear audit trail that includes learning, following the event.

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. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Are services effective?

Good

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

Are services caring?

Good

The practice is rated as good for providing caring services. 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 and available in different languages We also saw that staff treated patients with kindness and respect, and maintained confidentiality. The practice maintained a register of patients who had caring responsibilities and this was taken into account when planning their care.

Are services responsive to people's needs?

Good

Patients said they found it easy to make an appointment, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. There was learning from complaints with staff and other stakeholders.

Summary of findings

Are services well-led?

Good

The practice is rated as good for being well-led. It 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 induction, face to face meetings with their manager, regular performance reviews and attended staff meetings and events.

Summary of findings

What people who use the service say

We spoke with 11 patients. They included three mothers of young children, older people, people with long term conditions and three patients of working age.

Patients told us they thought the practice was clean and hygienic and that staff had the required skills and expertise to provide a good service. Patients said they were referred to specialist services as necessary and were involved in decisions about their care. One patient told how the GP was careful to ensure they understood treatment by explaining information until they were clear.

Two of the patients we spoke with told us they had been asked to complete a satisfaction survey in the past. Three patients said they knew how to complain whilst others said they would telephone the practice.

Most patients we spoke with said they felt the practice was well managed and spoke of the improvements in the telephone system but were critical about the appointment arrangements including the long queues sometimes at the reception desk.

We received eight completed comments cards including one that had negative comments about the telephone system and appointments. The other seven cards recorded patient satisfaction complimenting reception staff GPs and nurses. Patients referred to an 'excellent' service, being satisfied with the services provided and being treated with respect and dignity.

The National Patient Survey results (2013/14) showed the proportion of patients who responded described the overall experience of their GP practice as good or very good, this was in line with the national average. Similar results were achieved in relation to confidentiality at the reception desk, the GP or nurse involving patients in decisions about care and treatment and being treated with care and concern. However, the proportion of patients who stated that they always or almost always saw or spoke with the GP they preferred was lower than average. Similarly, the number of patients who gave a positive answer to ease of access by telephone was lower than average. Additionally the number of patients who got an appointment when they wanted and were satisfied or very satisfied with the surgery opening hours were in line with the national average.

Areas for improvement

Action the service SHOULD take to improve

- Ensure all actions taken in response to significant events are recorded so there is a clear audit trail that includes learning, following the event.

The Wellspring Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP, CQC inspectors and a Somali interpreter.

Background to The Wellspring Surgery

The Wellspring Surgery is a modern purpose built GP practice located in part of a healthy living centre built in 2004. It replaced the service provided at Corbett House Surgery.

All patient services are situated on the ground floor of the building and provide full access.

There are six GP partners, four of whom work on a full time basis. There are two male GPs and four female. The Wellspring Surgery is a teaching practice and at the time of our visit there was one male GP trainee.

One of the GPs is identified as the 'clinical lead' and supervises the senior lead nurse, specialist nurse, treatment room nurses and healthcare assistant. The executive partner, who is the registered manager supervises the strategic business manager and operations manager. The practice is supported by a team of administrators and reception staff.

The practice has over 8,000 patients and is situated in an area of significant deprivation. Its patients have a variety of cultural backgrounds speaking up to 40 languages. There are a high number of patients from Somalia and Poland. Most consultations are carried out in English however, there is an employed interpreter who can translate Somali. The practice also uses a telephone interpreting service.

The practice has twice the national average of patients under five years old and only half of the national average of patients over the age of 65 years. The life expectancy of patients is 75 years for men and 81 years for women.

All services are provided from The Wellspring Surgery. The practice has opted out of providing Out of Hours emergencies and contracts with another provider, Brisdoc Healthcare Ltd.

Our last inspection of the service was carried out on 5 September 2013 when it was found to be compliant with the outcomes we inspected.

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.

Detailed findings

How we carried out this inspection

We visited The Wellspring Surgery on 2 December 2014. In advance of our visit we contacted the Clinical Commissioning Group, the NHS England Local Area Team and Healthwatch – Bristol. They had no concerns about the practice.

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

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

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. During our visit we spoke with a range of staff including GPs, the practice management team, nurses and administrative staff and spoke with 11 patients who used the service. We observed how people were being cared for and talked with carers and/or family members. We reviewed the eight comments cards patients completed in advance of the inspection.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, we saw a significant event report was discussed at a meeting on 17 November relating to an occasion when a child was given a medicine they were allergic to. It resulted in the child going to the local accident and emergency (A&E) department for remedial action. In response to the event action taken was in the form of an email to all medicines prescribers in the practice reminding them to ensure they ask whether the patient had any allergies when prescribing antibiotics.

The senior partner was identified as the practice lead person for health and safety. Patient safety alerts received from the Medicines and Healthcare Products Regulatory Agency (MHRA) were received in the practice and cascaded to the staff team. They were also displayed on the staff notice board for all staff to be aware of. If the medicines or healthcare products identified within a MHRA affected any of the patients in the practice their use was treated as a significant event.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last two years. Records showed there was a description of the event along with learning points and actions to be taken. These records showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. Significant events were audited approximately every six months. We looked at the significant events audits and analysis for December 2013, June 2014 and November 2014. They showed evidence of peer discussion, reflection, conclusions and proposed actions. The audits showed the practice identified significant events to review at the next staff meeting to ensure that actions were carried out.

We saw examples of how the practice responded to significant events ensuring the patient involved was appropriately communicated with. In addition, when a patient was prescribed medicine for a long period of time the practice response was to search for other patients on the medicine to ensure they were not prescribed it for longer periods than necessary. The findings were reviewed and decisions made about whether to stop the medicine. Another event regarding contra-indication of medicine in pregnancy led to the practice liaising with secondary care services and changed the appointment booking protocol for women in respect of contraception, pregnancy and thyroid disorder. We also saw an example where the public address system was once used inappropriately, by accident, so that patient consultations could be heard in the waiting room. All staff were made aware of this and the system has since been used appropriately to maintain patient confidentiality.

Whilst the practice was able to evidence actions on most occasions there were significant events where follow up was not clear. For example, there was a significant event recorded regarding the interpretation of an electrocardiogram reading. The practice identified the GPs needed to learn how to interpret the readings and it was not evident training had been completed since the incident.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. The practice identified a GP with lead responsibility for child protection and safeguarding vulnerable patients. All of the GPs were trained to level three in child protection and this was updated in 2014. Other staff completed on-line training provided by the Avon Local Medical Committee.

We saw the policies for child protection and safeguarding vulnerable patients were available for staff on the practice computer system. Staff had also completed training about domestic violence provided by 'Identification and Referral to Improve Safety' (IRIS) to enable them to support vulnerable families.

We spoke with the lead GP about child protection and the differing types of abuse. They explained they looked out for unexplained injuries, patterns of attendance at the accident and emergency department and any concerns about the child's parents, especially in relation to the use of

drugs and alcohol. They also looked at failed attendance at the practice and late presentation of illness. Where concerns were identified these were discussed in the practice and shared with relevant organisations such as the local authority safeguarding team.

The safeguarding lead met with health visitors each month to discuss children at risk and vulnerable families. Discussions were recorded by updating patient records to reflect the concerns of vulnerability. Information and learning was disseminated to other staff in the practice.

The practice lead attended six monthly meeting for practice safeguarding leads with a consultant and named GP and nurse from Bristol Clinical Commissioning Group (CCG). The meetings considered any new serious case reviews and changes to legislation and aimed to keep practice up to date.

The GP told us how the practice had recently been contacted by a paediatrician who had reported concerns to the safeguarding team about a child and information received was communicated with all of the GPs and nurses. Information from the child's records was appropriately shared with the paediatrician.. This showed the practice worked well with colleagues for the benefit of patients.

We discussed child protection in relation to the high number of children under the age of five and the deprived conditions some grew up in. Staff we spoke with demonstrated a good understanding of child and vulnerable adult safeguarding issues. They knew who took the lead within the practice and were aware of their responsibilities. One of the staff told us how they had reported concerns about vulnerable children and how this led to a health visitor becoming involved with the family.

The practice lead told us how they considered health and social problems for patients with learning disabilities. They described how they advocated on behalf of one patient who they thought was having money/property stolen from them. This led them to being provided support from a different support provider. They also told us how they recognised a patient needed an improved care package and had written to the local authority and the patient's local Member of Parliament to advocate this.

One of the GPs met regularly with a drugs project team as the practice's prescribing lead to keep up to date with developments in the area.

Any concerns staff had about children or vulnerable adults were reported to the practice lead or one of the other GPs. Contact details for reporting concerns were included within the practice policy along with how the safeguarding and child protect arrangements worked locally.

The practice whistleblowing policy and procedure was displayed in the staff room and we saw they were reviewed and updated in 2014. The accessible management structure within the practice meant there were many ways staff could raise concerns if needed. The GPs we spoke with told us they would report concerns to the executive partner, senior partners or practice manager. Partners meetings would also be used to raise concerns.

There were notices in each of the consulting and treatment rooms advising patients they could ask for a chaperone. A chaperone is a person who acts as witness during a consultation or examination to offer protection to the staff and patients. Some staff were trained to act as chaperone and a further two staff were to receive the training. The policy outlined the roles of a chaperone, what they should do and what should be recorded.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

Some controlled medicines were held in the practice for emergency use. These required special storage and recording and we found this to be satisfactory. Any out of date medicines were destroyed and this was witnessed by the NHS England Local Area Team Accountable Officer.

There were two fridges, one for the storage of routine immunisation vaccines and the other for foreign travel immunisation vaccines. The temperatures of the fridges were checked twice each day and recorded in a temperature log book. We saw the fridges were operating within the correct range for the vaccine storage. The stock of vaccines was checked monthly.

The practice employed a pharmacist on one day each week, funded by the Bristol Clinical Commissioning Group (CCG) to audit prescribing within the practice. The audit was set by the CCG medicines management team.

Good

Are services safe?

In addition, the practice was undertaking a project with a community pharmacist looking at anti-coagulant therapy in the treatment of atrial fibrillation in line with National Institute for Health and Care Excellence (NICE) guidance.

There was a dedicated member of staff to deal with repeat prescription requests.

Cleanliness and infection control

The practice maintained good hygiene standards and minimised the risk of the spread of infection. All areas of the practice looked clean and we saw there was a schedule of cleaning for each day of the week. The practice nurse was identified as having the lead responsibility for infection control.

There was a good supply of soap and paper hand towels in each of the consulting and treatment rooms and personal protective equipment and clothing was available for staff. We noted there was a supply of sanitising hand gel at the reception desk and electronic arrival station to encourage patients to participate in the practice commitment to good hand hygiene.

We saw separate schedules for the cleaning of medical equipment such as spirometers, nebulisers and ear irrigation kits. Disposable mouthpieces and ear irrigation tips were used to maintain hygiene. The practice did not sterilise reusable equipment on site but sent it to the local NHS Trust central sterile supply department (CSSD) for sterilising.

There was a clear policy on dealing with spillage of bodily fluids and the practice had various cleaning kits available for use.

We saw evidence of infection control audits completed by the practice lead and countersigned by the practice manager for operations.

The sharps injury policy was displayed in each of the treatment rooms and staff were offered hepatitis vaccinations for their protection. The company that collected the bins identified the practice by labelling its bins with a blue band.

The practice completed a healthcare waste pre-acceptance audit for the contractor that collected waste from the practice in 2012 when the contract was re-assigned from the previous contractor. We saw there were different bins for different types of waste and bins were labelled accordingly.

Equipment

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

All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. We saw that portable appliance testing was carried out in December 2013 and was due for testing again. A schedule of testing was in place. We saw evidence of calibration of relevant equipment. Equipment calibration had been carried out in December 2014.

Staffing and recruitment

The recruitment policy outlined the aim of the practice as being able to select the most suitable person to fill any job vacancy in line with equal opportunities legislation.

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. We looked at five staff records which contained a copy of the curriculum vitae (CV) submitted to the practice along with personal details of the staff member. They also contained authority to obtain references, references, record of interview and statement of terms and conditions. We saw that for some staff only one reference had been received. There was evidence of the member of staff's identity and proof of right to work along with an occupational health questionnaire.

All staff had enhanced criminal records checks through the Disclosure and Barring Service. GPs and nurses had evidence of their registration with the General Medical Council or Nursing and Midwifery Council and up to date indemnity arrangements.

In order to recruit the most recently appointed GP the practice used a process that involved candidates being interviewed by 14 panel members. They were required to give a presentation relating to the challenges facing general practice and respond to case scenarios played by actors which were observed by two of the GPs. The final stage in the process was to participate in group exercises to test their team building and leadership ability

One of the GPs we spoke with was previously a registrar in the practice.

Good

Are services safe?

In order to maintain adequate staffing levels within the practice to meet the needs of patients locum GPs and locum specialist nurses were employed . The practice aimed to engage a locum when there was a shortage of GP or specialist nurse for more than five sessions.

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. It accommodated staff with specific needs.

From the evidence we saw we were satisfied the practice had a proactive approach to maintaining a safe environment and practice. The practice worked in collaboration with the Healthy Living Centre to ensure the premises were safe for patients to visit and for staff to work in. It used evidence based information to ensure medicines were appropriately prescribed.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Staff completed annual training in dealing with medical emergencies and resuscitation and we were told this was due to take place later in December 2014.

Emergency medicines were checked monthly to ensure they were within their 'use by' date. The automatic external defibrillator was checked weekly to ensure it functioned properly and we saw the oxygen was in date.

The practice continuity and recovery plan had been reviewed annually. It identified immediate responses to be taken in the event of a significant event affecting the practices building such as fire or flood. In addition there were actions described in response to the loss of the computer system, access to paper medical records and loss of essential services such as gas, electricity and the telephone system. The plan also outlined the 'communication cascade' identifying which staff were responsible for communicating information to others.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners.

The GPs told us they had sufficient facilities and equipment to be able to deliver safe and effective care. The practice used a multi-disciplinary approach to managing the needs of those with complex medical needs and long term conditions.

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

Patients over the age of 75 years had a named GP and personalised care plans were in place. The practice also had care plans in place for patients with learning disabilities.

Management, monitoring and improving outcomes for people

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

We looked at audits conducted in 2013 and 2014 related to Coeliac Disease, the use of non-steroidal anti-inflammatory medicines and the management of diabetes. As a result of the audits the clinical team reflected on its practice and made changes to the review of patient's health needs and prescribing arrangements.

The practice achieved high results in the Quality and Outcomes Framework (QOF) targets having scored 95% compared to the national average of 96% for total QOF points. The practice was lower than the national average for the percentage of patients with long term conditions at 46% compared to the national average of 53% however this reflected the large number of children registered with the practice and the smaller than average number of older people.

The two practice managers and the executive GP partner considered performance at their weekly meetings and measurement against targets was discussed at the partners meetings and at practice meetings as appropriate.

There was a combination of new patient checks, NHS health checks, chronic disease management, consultation appointments and opportunistic checking. The practice population uptake on NHS health checks is the second highest for the Bristol Clinical Commissioning Group area.

There were regular health checks for patients with learning disabilities. There were some patients who lived in sheltered accommodation for the homeless and some who misused substances. The practice actively engaged with these groups to encourage them to attend appointments by visiting the services.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw the staff induction checklist ensured newly appointed staff were given all of the information they needed including details of future training opportunities and practice rules.

The staff training 'passport' identified mandatory training including its frequency, the staff member's personal objectives, the practice objectives and how they were being met and a 'time plan' for meeting outstanding objectives. The passport recorded the date the training was completed and identified gaps where training was required. All staff were up to date with attending mandatory courses such as annual basic life support.

There was a strong ethos of learning, reflecting and supporting continued professional development (CPD) within the practice. Three of the GP partners had additional roles in the training of new GPs at the University of Bristol. One of the GPs was responsible for the integrative medicine course and others were teaching 'fellows' there. One of the GPs was the ear, nose and throat (ENT) lead GP for Bristol and offered email advice and guidance to other GPs.

The Wellspring Surgery was a training practice and took a number of students each year. One of the GPs told us this

Good

Are services effective?

(for example, treatment is effective)

led to positive feedback from the students. Two of the GPs were trainers however the practice could only offer one placement at a time because of the availability of consulting rooms.

We saw the GPs had completed adequate continuing professional development (CPD) for their professional and revalidation requirements. The specialist minor illness nurse had completed training in prescribing, minor illness and long acting reversible contraception. They told us they felt they had been well supported by the practice in attaining evidence of their CPD. We saw the practice had an appropriate clinical skill mix and the addition of the specialist minor illness nurse had made a big difference to the services available.

The GPs told us they valued the training sessions provided by the Bristol Clinical Commissioning Group (CCG). The GPs told us about the 'peer learning' groups they belonged to which provided support and self-directed learning opportunities.

The GPs, nurses and healthcare assistant attended training about learning disabilities, mental health and dementia. They also received training about domestic violence. Nursing staff had completed training about 'spotting the sick child', wound and leg ulcer management and cervical cytology.

The practice used the weekly clinical meetings to update the knowledge base of GPs and nurses such as reflecting on good practice in relation to end of life care.

The practice used a number of performance indicators to assess the competence of staff. This included punctuality, completion of workload within set timescales, participation in meetings, significant events and audits. Feedback and constructive criticism from patients was also taken into account.

The whistle-blowing policy was displayed in the staff room. Staff we spoke with understood their responsibilities in raising concerns of colleagues.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. When patient discharge letters and results were received they were given to the patient's GP in the first instance. They recorded what action should be taken and patients were sent letters if they needed to see a GP. The originals were scanned into the patient records retained for six months before being destroyed. All staff we spoke with understood their roles and felt the system in place worked well.

There were regular multi-disciplinary meetings on Mondays with the community matron, district nurses, health visitors GPS and nurses. The meetings were used to discuss patient's healthcare in their homes and the end of life care and support for those patients on the palliative care register. There were discussions about child protection issues and consideration of contagious disease management in the community and liaison with other agencies. We saw an example of where the practice liaised with a paediatrician, acting in the best interests of a child.

The practice had adopted evidence-based clinical pathways along with those initiated by the Bristol Clinical Commissioning Group. The weekly clinical meeting were used to update the knowledge base of staff in respect of these.

The practice used the South Bristol referral service for making referrals to secondary care. With the exception of the two week wait for suspected cancer referrals all others were made within three hours. Feedback from the referral service was used by the staff team to reflect on maximising referral processes and pathways.

The practice participated in the Bristol Primary Care Agreement in relation to a number of streams to reduce winter pressure, aid hospital discharge planning and support community nursing services. In addition the streams included reviewing and ensuring the management of palliative care patients met the gold standard framework, developing links with mental health services, promoting self care in patients with long term conditions and widening the use and knowledge of community services and groups.

Information sharing

The practice used the 'Summary Care Record' in order to share essential information about a patient's health to

Good

Are services effective?

(for example, treatment is effective)

secondary health services. This included the patients details, immunisation history, medicines the patient was prescribed and any allergies they had. For patients with on-line access they could see the information being shared.

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.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record (EMIS) to coordinate, document and manage patients' care.

Consent to care and treatment

The three GPs we spoke with demonstrated a good understanding of The Mental Capacity Act 2005 and its implications. They had attended training.so they had a good understanding of The Act. In order to ensure they were effective they refreshed their learning to familiarise themselves with deprivation of liberty safeguards (DOLS) and the independent mental capacity advocacy service.

Consent was mostly verbal or implied through patient attendance for treatment. For some contraceptive services consent was obtained in writing otherwise consent was recorded by the GP providing the procedure.

The GPs described patient centred consultations where decisions about whether to proceed with treatment lies with the patient. They acknowledged there were exceptions to this such as when the patient is a child or if the patient lacks capacity to make such decisions. Where a patient's first language was not English, an interpreter was used to ensure their full understanding of the treatment.

We discussed examples of confidentiality and Gillick competence where children under the age of 16 were deemed to fully understand and give consent. The GPs we spoke with were aware of the legal requirement to report any cases of children under the age of 13 years, requesting contraception, to the relevant safeguarding authority.

Where a patient lacked capacity this was recorded within their medical record. If there were discussions about consent to treatment these were recorded including how questions were asked and how explanations were given to enable the patient to make their own decision. If a third party was involved in decision making we were told this would be recorded.

The practice had templates for recording the healthcare needs of patients with learning disabilities or those with a diagnosis of dementia. The templates recorded the next of kin or carer's name to indicate who the patient had been consulted about with and whom the practice should share information. A GP gave an example related to a patient who was consulted about their wishes in respect of a life threatening event. The patient did not want to make a decision unless their family member was involved and this was documented in the patient's medical notes.

The practice responded to a complaint regarding patient consent. The practice had supplied information to a third party and obtained consent from the patient to provide the information. However, when the third party requested further information the practice did not check whether the patient was happy for the information to be given. The practice policy now included that in all requests for information the patient should give consent.

When information was requested from hospitals the practice would only release the information when they received signed consent from the patient concerned.

If a patient expressed a wish not to be resuscitated (DNAR) in the event of an emergency this was recorded in their care plan. A form was completed by the GP and sent to the patient to record their consent to share information with the Out of Hours service and ambulance service. This was scanned into the patient's record. A GP told us the DNAR order could be changed at any time if a patient's circumstances changed. If third parties were involved in discussions about DNAR this was recorded.

Health promotion and prevention

The practice newsletter enabled patients to be kept informed of updates in relation to the practice, healthy living centre and the local community. The December newsletter referred to the many resources available in the practice to promote good health or aid recovery from illness.

Good

Are services effective?

(for example, treatment is effective)

There were a wide range of leaflets in the waiting area for patients to take away with them relating to health conditions and lifestyle. The patient participation group (PPG) complimented the practice on the information it made available to patients.

The practice had launched a new web site and involved the PPG when its usefulness was reviewed. They were happy that the web site met patient's needs.

In addition there was an internal 'intranet' that enabled staff to access policies and procedures.

Feedback from patients included a request to be kept informed if their appointment was behind schedule. The practice responded and patients were told how long to expect to wait if their appointment was delayed by 20 minutes.

All new patients were offered a consultation. There was information on the practice website regarding registration. Prospective patients could download the patient registration form to complete before taking it to the practice.

For mothers to be there were ante-natal packs that provided relevant information to support them during their pregnancy. These included leaflets about pregnancy and a clinic booking form. Leaflets related to screening choices and ante-natal information and a copy of the leaflet 'Having a baby at North Bristol Trust'. There was good liaison with community services for the mother and baby clinics.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice about patient satisfaction. This included information from the national patient survey (2013/14), a survey of patients who attended influenza immunisation clinics in October 2014 and a survey of 265 patients carried out by the University of Exeter Medical School conducted between August and November 2014. The evidence from all these sources showed most patients were satisfied with how they were treated and that this was carried out with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated as average for patients who rated the practice as good or very good. Respondents to the University of Exeter Medical School survey invited patients to add comments and these were mixed with some patients complimenting the practice whilst others were critical about availability of appointments

Patients completed eight CQC comment cards to tell us what they thought about the practice. We received eight completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. One comment was less positive. We also spoke with nine patients on the day of our inspection. Patients told us they were satisfied with the care provided by the staff at the practice and said their dignity and privacy was respected. Some patients commented on the length of time they had to wait for their appointment however patients spoke about improvements in the telephone system and appointment bookings.

There was a polite sign at the reception desk asking patients to respect the privacy of others whilst in the queue for reception. In the consulting and treatment rooms we saw disposable curtains around examination couches to maintain patient's dignity.

We sat beside one of the administrative staff who was taking calls from patients wanting to make appointments or order repeat prescriptions. They were polite and friendly. They did ask the patient for a brief explanation as to why they needed an appointment, but explained they did not have to answer the question if they wanted the reason to remain private.

An interpreter worked each day for half of the day and offered face to face interpretation and telephone triage. They were employed by Bristol Community Health and reception staff aimed to make appointments for those who would benefit from this service when the interpreter was available. The practice also had access to the telephone interpreting service.

The practice participated in the 'Million Women Study' where, with patient's consent, consultations were filmed and GPs were given feedback afterwards. The Million Women Study is a national study of women's health, involving more than one million UK women aged 50 and over. It is a collaborative project between Cancer Research UK and the National Health Service. The main focus of the study relates to the effects of hormone replacement therapy use.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 71% of practice respondents said the GP involved them in care decisions. These results were in line with the national average.

A wide range of services were available at the practice. These included a minor mental ill health service which was designed to sign post patients to the most appropriate resource for their condition.

We saw patient's records system included alerts to the GP about a patient's particular needs. These included an alert that a patient was in denial of their terminal condition. One of the GPs told us this patient would be given a same day appointment regardless of whether one was available. We were told of other examples where alerts would prompt reception staff to ensure patients were given a same day appointment.

Patient/carer support to cope emotionally with care and treatment

The practice had an identified 'carers champion' who maintained a register of patients who had caring

Good

Are services caring?

responsibilities and how they were supported. Carer assessments were carried out and the practice sign-posted patients who were carers to resources available locally to support them.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

The practice had repeatedly sought ways to map the demands for appointments throughout the week. The biggest demand for appointments was Mondays with Tuesdays being the second most popular day. To respond to this the practice operated extended opening on those days.

There was a combination of telephone triage, minor illness appointments, with the dedicated nurse, advance booking appointments and same day appointments for emergencies.

One of the GPs told us the minor illness appointments met with scepticism from patients initially but had proved to be hugely successful. There was a dedicated nurse who specialised in minor illnesses and the senior nurse assisted with chronic disease management. There were three other nurses and a health care assistant who carried out blood tests and adult health checks. The practice had the second highest uptake of adult health checks in the Bristol Clinical Commissioning Group area.

There were a large number of children under the age of five years and the practice arranged for their parents to be contacted to remind them of the need for immunisations.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services such as patients with long term conditions, patients with learning disabilities, those for whom English was not their first language, the homeless and substance misusers. For example, the practice had interpreter services available and made contact with the homeless and substance misusers by visiting the services they used.

The practice was situated on the ground and first floors of the building with most services for patients on the ground floor. There was lift access to the second floor. The practice had wide corridors to enable patients with mobility aids to maintain their independence.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities and a designated breast feeding room.

Equality and diversity was central to the work of the practice. The practice was situated in one of the most ethnically diverse areas of Bristol with patients whose first language could be one of 40 different languages. The practice responded to the needs of its patients by having interpreter services available, including a Somali/Arabic interpreter. One of the GPs told us they had the telephone number for an interpreter service on direct dial as they used it so frequently. The practice offered extended appointments when the telephone interpreter serviced was used.

The practice provided leaflets in a range of languages to assist patients understanding of a variety of health conditions.

The practice aimed to ensure staff with cultural awareness were recruited and provided on going training. The practice made an e-learning package about diversity available to staff provided by the Local Medical Committee to ensure staff maintained their awareness.

The Wellspring Health Centre provided a range of services the practice were able to access. These included the 'kitchen prescription' GPs could refer patients to in order to support them in managing their nutrition and exercise to optimise their health.

Access to the service

Appointments were available from 8.00 am to 6.30 pm on weekdays with extended evening appointments on Monday and Tuesday. Comprehensive information was available to patients about appointments on the practice website including reference to contacting reception about the times of extended opening hours. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Appointments were bookable in advance and patients could do this by telephone, in person or on-line. In addition same day appointments were available for emergencies with the nurse prescriber for minor illness. The GPs offered a telephone triage service for patients who wanted a same day appointment. The on-line appointments booking system had been upgraded to make it easier to use.

Appointments were limited for on-line booking as some were reserved for same day requests.

Same day appointments were available with the nurse practitioner who was trained to prescribe certain medicines. In addition there was a telephone 'triage' service available on the 'same day' which enabled patients to speak with a GP and for the GP identify the best course of treatment for the patient.

The practice installed a new telephone system in 2014 to enable easier access for patients.

All telephones in the practice could access incoming calls to enable a speedy response during peak times. The receptionist had a bell to summon assistance if required.

There were 39 GP sessions available each week for appointments and home visits and the nurse worked each week day.

The practice provided a service to a local nursing home and home visits to patients if they were housebound or too ill to attend the practice for an appointment.

A range of clinics were provided for patients with coronary heart disease, asthma, chronic obstructive pulmonary disease, diabetes, hypertension and family planning. There was a designated child health and immunisation clinic held. A range of specialist clinics were offered including the BCG immunisation clinic (related to the prevention of tuberculosis) and nasal influenza immunisation clinic for young children. When there was an outbreak of measles earlier in the year the practice held additional measles, mumps and rubella (MMR) clinics.

Listening and learning from concerns and complaints

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

The complaints policy was outlined on the practice website. It stated the practice made every effort to give the best possible service to every patient. However, it stated the practice was aware things can go wrong resulting in a patient feeling they have a genuine cause for complaint. It continued by adding if that was the case the practice would wish for the matter to be settled as quickly and amicably as possible. The website advised patients who wished to pursue a complaint to contact the operations manager who would deal with concerns and complaints. It also pointed out that further information about the complaints process could be obtained from reception.

Complaints were reviewed in the practice every three months. Complaints were treated as significant events and analysed and any actions arising followed up at the next three monthly meeting when complaints and significant events were reviewed. During the meeting consideration was given to whether lessons learned were being applied throughout the practice.

We looked at the complaints log for the last two reviews and saw that complaints were responded to promptly. In all the practice received 18 complaints in the last 12 months and these were listed along with the date received, who dealt with the compliant and the actions taken. In addition, where appropriate, the learning from the complaint was recorded.

A recurring theme recorded in the log of complaints related to waiting times for appointments when GP consultations were running late. The practice responded to this in June 2014 by adding an additional screen to the waiting room messaging screen to advise patients to speak with a receptionist if they had not been called in to see a GP within 20 minutes of their appointment time. The practice also built in 'catch up time' into each GP's timetable. Other complaints related to delayed referral to secondary care and the obtaining of consent prior to issuing information to a third party.

We saw one complaint had been elevated to the Health Service Ombudsman as the complainant was not happy with the initial response from the practice. The ombudsman felt there was no case to answer and the practice sent a further letter to the complainant.

There was evidence of how complaints were linked to the staff appraisal system to demonstrate how the practice responded to complaints about staff. We saw an example

Good

Are services responsive to people's needs?

(for example, to feedback?)

related to a missed home visit. The practice reiterated the need for GPs to review the home visit list on the computer system. In addition the system was modified so that the GPs received reminders to do so four times each day to avoid missed visits.

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. There were six areas within the practice vision, values and objectives plan. These included patient access, appointments, creating a learning environment for staff, finance and developing extended appointments with nurses.

The practice used local and national clinical guidelines and the staff 'intranet' provided links to the National Institute for Health and Care Excellence (NICE) website, the Bristol GP service and the South Bristol referral service. We saw from some of the audits the practice aimed to align its medicines prescribing in line with the best clinical evidence available.

We were told the GP partners had an away day to discuss the development of the practice and formulate a longer term strategy.

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.

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 the executive partner was the lead for safeguarding. We spoke with eight members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards and in some cases had higher than average results. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice was contracted to provide 26 'enhanced' services. Enhanced services related to services above that expected from a general medical services contract. There was an identified person within the practice who monitored QOF achievement. They told us they felt the practice was doing as well if not better than last year and how there had been an increase in the take up of recall appointments for patients with long term conditions.

The practice participated in the Bristol Clinical Commissioning Group prescribing quality and productivity scheme. The scheme required GP practices to check they were following guidelines provided by the National Institute for Health and Care Excellence (NICE) and those provided locally. Audits were used as a means of measuring quality and identifying learning needs. We saw audits that checked prescribing against the guidelines for type two diabetes and the prescribing of non-steroidal anti-inflammatory medicines for patients with heart conditions. The audits showed the practice was responding to the guidelines. We also saw audits relating to coeliac disease, psoriasis, anti-biotic prescribing and the use of medicines for thyroid disorder.

A study to gauge patient satisfaction was carried out between August and November 2014, in conjunction with the University of Exeter Medical School. It obtained 'real time' feedback by asking questions after patients attended for an appointment. Results showed 60% of patients felt they were "likely" or "extremely likely" to recommend the practice to others. The percentage of patients who were satisfied with the care they received at the practiced was 68% and 78% found reception staff to be helpful. Most patients (88%) said they were listened to and 81% felt their problems were taken seriously.

The GPs and practice manager attended a range of meetings organised by the Bristol Clinical Commissioning Group (CCG). These included monthly 'clinical meetings' and 'membership events'. The strategic practice manager attended meetings for practice managers organised by the CCG and the nurses attended meetings organised by the CCG for them.

The practice held quarterly meeting to review complaints and significant events.

Leadership, openness and transparency

The practice was entering a period of change with the imminent retirement and replacement of the strategic manager. Recruitment to the post had taken place and the new manager was due to start after Christmas.

Staff meetings were held every four weeks. We saw that meetings covered guidelines issued by the National

Are services well-led?

Good

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

Institute for Health and Care Excellence (NICE) and the practice response. In addition, there were sessions that covered 'insights into cultural background and the health expectations of local Somali patients' and 'HIV and primary care'. Updates were provided and we saw these had related to cardio-vascular risk, heart attack medicines and eczema treatments.

In addition there was a weekly meeting between the executive GP, operations manager and strategic manager. They explained how these meetings were used to review staff performance and how an external human resources service was used for support in the past where poor performance or staffing issues had been identified.

We saw a clear diagram to show staff responsibilities and roles were covered when staff were away.

The practice valued its staff. There was annual appraisal and a monthly staff reward system. All staff were sent an email and asked to nominate one or their colleagues. Winners were given vouchers to enable them to purchase what they wished as a reward. There were emails sent to staff to disseminate information about practice achievements.

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

The practice had gathered feedback from patients through face to face consultation at the influenza immunisation clinics in October 2014 and during the period August to November when a survey was conducted by the University of Exeter School of Medicine. We looked at the results of the survey and saw It obtained 'real time' feedback by asking questions after patients attended for an appointment. Results showed 60% of patients felt they were "likely" or "extremely likely" to recommend the practice to others. The percentage of patients who were satisfied with the care they received at the practiced was 68% and 78% found reception staff to be helpful. Most patients (88%) said they were listened to and 81% felt their problems were taken seriously.

The practice Patient Participation Group (PPG) met regularly. Meetings of the members of the PPG were held regularly and minutes of the meetings were available for patients and staff to see. We saw evidence the practice valued feedback and how it responded. An example of this was recorded in the notes of the meeting held in October 2014 when there was reference to the improved telephony in the practice following complaints from patients. It had similarly responded to requests for information to be included in the waiting room television monitor programme.

Patients were able give feedback to the practice through email, letter and verbally. In addition the PPG would represent patients on request. As part of their re-validation, a General Medical Council process to confirm they are eligible to work as a GP, some of the GPs devised a new survey questionnaire. The last survey was conducted at the beginning of 2014.

There was a recent staff survey in November 2014. It asked staff to comment on things about the practice that worked well and things that did not work well. Staff indicated their responsiveness to patients and their flexibility in aiming to fit them in for an appointment, helping each other and the supportive and approachable management team worked well.

The practice had a whistleblowing policy which was available to all staff in the staff handbook, displayed on the staff noticeboard and accessible electronically on any computer within the practice.

Management lead through learning and improvement

Staff had regular face to face meetings with the operations manager to review their work and monitor their development.

The annual staff appraisal system provided the means for learning and staff development to be identified and agreed..

Formal, clinical meetings were held twice each month. We saw there were learning sessions organised monthly and sometimes external speakers were brought in. We saw that the sessions for 2014 included insights into the culture and health expectations of the local Somali community. In addition there were updates on dermatology and HIV in primary care.

There were multi-disciplinary meetings held monthly with the community matron and district nurses to discuss those patients on the palliative care register and monthly meetings with health visitors that centred on children at risk and child protection.