Bradgate Surgery

Inspection report

Ardenton Walk
Brentry
Bristol
Avon
BS10 6SP
Tel: 01179591920
www.bradgatesurgery.nhs.uk

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

Ratings

Overall rating for this location	Outstanding ☆
Are services safe?	**Outstanding** ☆
Are services effective?	**Outstanding** ☆
Are services caring?	**Outstanding** ☆
Are services responsive?	**Outstanding** ☆
Are services well-led?	**Outstanding** ☆

Overall summary

This practice is rated as outstanding overall. (Previous inspection 3 March 2015 – Outstanding)

The key questions are rated as:

Are services safe? – Outstanding

Are services effective? – Outstanding

Are services caring? – Outstanding

Are services responsive? – Outstanding

Are services well-led? - Outstanding

We carried out an announced inspection at Bradgate Surgery on 25 April 2018 as part of our inspection programme.

At this inspection we found:

- The provider's strategy and supporting objectives for the practice were challenging and innovative, working with partners to develop integrated care services and a seven day primary care service.
- The practice had a clear and strong management structure. GP partners at the practice had a history of initiating and developing new ways of working.
- There was clear documentation which showed that new developments had been fully researched and discussed by the practice before implementation, with targets sets, which were later reviewed to ensure the new development was delivering the anticipated benefits.
- The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence- based guidelines.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Patients found the appointment system easy to use and reported that they were able to access care when they needed it.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.
- By taking part in research, the practice had identified new ways to use technology to improve the quality of care.

Professor Steve Field CBE FRCP FFPH FRCGPChief Inspector of General Practice

Population group ratings

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

Our inspection team

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

Background to Bradgate Surgery

Bradgate Surgery is part of the Pioneer Medical Group and is situated in the North of Bristol looking after approximately 20,000 residents in Brentry, Henbury, Southmead, Westbury on Trym; Coombe Dingle, Hallen, Lawrence Weston, Easter Compton, Henleaze, Avonmouth, Severn Beach, Shirehampton and Sea Mills.

Bradgate Surgery has a shared list, which means that patients do not have to see the doctor they are registered with. However, patients are encouraged to keep with the same doctor for any one episode of illness. All patients have a named GP. Patients can visit any of the Pioneer sites for care as they have one clinical database which can be accessed from all sites. The duty doctor runs the urgent care from the Bradgate site, the Urgent Care team comprises of two duty GPs, a nurse practitioner, a paramedic, a care coordinator, consulting GPs and administrative support.

The Bradgate practice operates the registered location from:

Ardenton Walk,

Brentry,

Bristol BS10 6SP

www.pioneermedicalgroup.co.uk

Pioneer Medical Group has a 9 GP and one business partner partnership and employs eight salaried GPs. GP's of both genders are working alongside nurse practitioners, qualified nurses, a paramedic and health care assistants. These staff work across the three sites.

Patient Gender Distribution

Male 50 %

Female 50 %

% of patients from BME populations 11.9 %

The practice catchment area has pockets of high deprivation assessed at Decile 3 (with decile 1 the lowest and decile 10 the highest) with a higher than average crime rate and low income, alongside areas of high income. People living in more deprived areas tend to have greater need for health services.

The services are registered to provide the following regulated activities:

Maternity and midwifery services

Treatment of disease, disorder or injury

Diagnostic and screening procedures

Family planning

Surgical Procedures

The practice does not provide out of hour's services to its patients, This is provided via NHS111 by BrisDoc. Contact information for this service is available in the practice and on the website.

Outstanding ☆

Are services safe?

We rated the practice as outstanding for providing safe services.

The practice was rated as outstanding for providing safe services because:

- They demonstrated an open culture in which all safety concerns raised by staff and people who use services were valued as integral to learning and improvement. They were innovative and developed systems and processes which were implemented to support them to minimise risks to patients. The provider was responsive to any concerns or risks and took action to prevent reoccurrence.

Safety systems and processes

The practice had clear systems to keep people safe and safeguarded from abuse.

- The practice had appropriate systems to safeguard children and vulnerable adults from abuse. All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Reports and learning from safeguarding incidents were available to staff. Staff who acted as chaperones were trained for their role and had received a DBS check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.)
- Clinicians had an application on their IT equipment/ telephones which linked directly to the local safeguarding reporting processes.
- A comprehensive library of safeguarding information had been developed which was available to all staff on the practice's intranet, including information on local safeguarding protocols, guidance on female genital mutilation, domestic violence and the Prevent programme.
- Staff took steps, including working with other agencies, to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect. They were participants in the local Identification and Referral to Improve Safety (IRIS) domestic violence scheme. All staff had undertaken training for the scheme.
- The practice carried out appropriate staff checks at the time of recruitment and on an ongoing basis.
- There was an effective system to manage infection prevention and control.
- The practice had arrangements to ensure that facilities and equipment were safe and in good working order.
- Arrangements for managing waste and clinical specimens kept people safe.

Risks to patients

There were adequate systems to assess, monitor and manage risks to patient safety.

- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness, busy periods and epidemics. The practice kept resource planning under review; we found that following a recent bank holiday there had been an unexpected peak in patient demand. The practice agreed a minimum staffing level to be in place for the day following any closure so that patients' needs could be met safely. This level was above what they had used routinely in the past to accommodate the bank holidays and reflected the increased demand on health care services.
- The practice had worked with the local care homes they visited to ensure the clinicians could access the practice electronic patient records system so that informed treatment decisions could be made and recorded contemporaneously.
- There was an effective induction system for temporary staff tailored to their role.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures. We found a proactive approach to anticipating and managing risks to people who use services was embedded and was recognised as the responsibility of all staff. The provider had undertaken a critical event drill in March 2018 following which 17 points for improvement had been considered. We found that these had been actioned and staff were aware of the new processes.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in

need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections including sepsis. We saw that all staff had information to hand about sepsis; the practice had updated their electronic patient record template to reflect the additional assessment steps in the National Early Warning Score Two issued in December 2017.

- The practice had undertaken an audit of disease registers to ensure the expected prevalence of patients was identified appropriately and were linked to the correct treatment/review regime. They found there had been under identification in some areas and invited patients to attend the practice for a full assessment.
- When there were changes to services or staff the practice assessed and monitored the impact on safety. We found that any changes were subject to risk and impact analysis; for example, this was undertaken in respect of a plan to extend the car park.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- The care records we saw showed that information needed to deliver safe care and treatment was available to staff. Innovation was encouraged to achieve sustained improvements in safety and continual reductions in harm. The practice had developed their IT system and introduced an 'F12' process which was compatible with the electronic patient system. The F12 process allowed the practice to link additional information including National Institute for Health and Care Excellence (NICE) guidance, and alerts to the system to facilitate safety and best practice.
- There was a programme of joint multidisciplinary meetings, in addition the service held a daily meeting which reviewed any home visit requests and patients of concern. The meeting encouraged discussion about the most effective way in which to provide a service to these patients, and who would be the most appropriate clinician. Clinical staff led this meeting and invited other health care professionals who were involved with the patient.
- There was a documented approach to managing test results. We saw the service was in the process of developing an IT programme which would allow a weekly reconciliation of tests sent to the laboratory against the results received, so that any discrepancies could be quickly identified. This was an action which followed an adverse event to promote patient safety. This was expected to be in place by the end of August 2018.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. The practice used a common clinical IT platform, which allowed for other providers such as Out of Hours services and community services to access patient records via Connecting Care enabling seamless transfer of information. This meant that the systems to manage and share the information was coordinated, provided real-time information across services and supported integrated care for patients.
- Clinicians made timely referrals in line with protocols; they used an electronic referral service which meant that there was less potential for errors in referring to secondary care as all of the proformas were available on the patients record system; the process ensured referrals were complete and met specified criteria before being sent to secondary care services.

Appropriate and safe use of medicines

The practice had reliable systems for appropriate and safe handling of medicines.

- The systems for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment minimised risks.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with current national guidance. The practice had reviewed its antibiotic prescribing and taken action to support good antimicrobial stewardship in line with local and national guidance. The service had agreed on use of the 'No Antibiotic' support leaflet to give to all patients who requested antibiotics where they were not indicated. They had developed a strategy in line with the Royal College of General Practitioners Target Toolkit, and were in the process of focusing on reducing prescribing for urinary tract infections through their nursing home project and prophylactic antibiotic audit.
- Compliance with the practices medicines policy and procedures were routinely monitored and we saw action plans were always implemented promptly. For example, the practice had implemented a process of recording advice for sodium valproate prescribing prior to national guidance being issued.

Outstanding ☆

Are services safe?

- Patients' health was monitored in relation to the use of medicines and followed up on appropriately. Patients were involved in regular reviews of their medicines. We saw there was a clinical audit specifically for prescribing in the elderly.

Track record on safety

The practice had a good track record on safety.

- There were comprehensive risk assessments in relation to safety issues.
- The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture of safety that led to safety improvements. We found the whole team was engaged in reviewing and improving safety. The service held a monthly safety meeting at which all incidents were discussed and actions agreed.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice. For example, following an event in a care home the procedure for monitoring care home patients was improved with use of a triage process to support classification of patient need, use of the national early warning score (NEWS) for patients requiring urgent attention and access to patient electronic records whilst at the care home.
- The practice acted on and learned from external safety events as well as patient and medicine safety alerts.

Please refer to the Evidence Tables for further information.

Outstanding ☆

Are services effective?

We rated the practice overall as well as all the population group as outstanding for providing effective services.

The practice was rated as outstanding for providing effective services because:

- Outcomes for people who use services were consistently better than expected when compared with other similar services. Staff were actively engaged in activities to monitor and improve quality and outcomes. Opportunities to participate in benchmarking and peer review were proactively pursued, including participation in approved accreditation schemes.

(Please note: Any Quality Outcomes (QOF) data relates to 2016/17. QOF is a system intended to improve the quality of general practice and reward good practice.)

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols. The service had a library system on their intranet. This application held 'top tips' for managing diseases with the links to the latest guidance. All clinical staff were able to top tips and these were reviewed by one GP to ensure they followed national guidance.

- Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions. We found routine letters such as review invitations, had been translated into Polish to accommodate the largest group of patients for whom English was a second language.
- The provider had won two Innovation Awards from NHS England South for best use of technology and had used the money to purchase a health pod. The pod had been installed in the practice in October 2017. Since then it had been used by 389 patients to monitor their blood pressure/weight/Body Mass Index the results from the measurement were entered directly onto the patient record and an alert sent to their GP if measurements were outside of expected parameters. We saw evidence that the availability of this equipment to all patients had resulted in 68 patients being identified as having a reading outside of accepted guidelines from which 38 patients received a new hypertension diagnosis.
- All new patients used the pod as part of the registration process and recorded their data on their new patient health questionnaire.
- Staff used appropriate tools to assess the level of pain in patients.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. The practice used an appropriate tool to identify patients aged 65 and over who were living with moderate or severe frailty. Those identified as being frail had a clinical review including a review of medication. The provider had installed an additional alert on their patient record system for when frailty may impact on a treatment plan such as in diabetes.
- The service contacted all older patients discharged from hospital. They had a care co-ordinator who ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- There was a daily check of any patients who were in hospital to facilitate a timely discharge and any follow up visit which may be needed. A discharge audit undertaken in April 2018 showed that 100% of actions for the primary care team had been implemented. This meant that follow up actions could be pre-empted and patients had an integrated care pathway.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs. Patients were referred to the social prescribing service to support them and prevent social isolation.
- The service operated a usual clinician booking policy which offered continuity of care.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.

Outstanding ☆

Are services effective?

- Staff who were responsible for reviews of patients with long term conditions had received specific training. We found that each disease group was led by a GP partner and nurse with specialist interest and additional training. This meant that the patients had access to specialist knowledge for their treatment.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice had arrangements for adults with newly diagnosed cardiovascular disease including the offer of high-intensity statins for secondary prevention, people with suspected hypertension were offered ambulatory blood pressure monitoring and patients with atrial fibrillation (AF) were assessed for stroke risk and treated as appropriate. We saw a review of patients with AF diagnosis where 30 out of 321 were identified as not on any anticoagulation. These patients were contacted for review and where appropriate medication commenced which reduced the risk of stroke.
- The service had a new AF review template with pictorial decision aids which could be used to assist patients to be better informed when taking decisions about treatment.
- The practice was able to demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension. For example, their Healthy Homes project involved patients with learning disability and those caring for them learning about wellbeing, healthy diet, diabetes and the benefits of exercise and screening for diabetes. Eight of the patients involved were tested for pre-diabetes, with the results that three (37.5%) were shown to be at risk of developing diabetes and received appropriate treatment.
- The service had used money awarded for innovative achievements to purchase a health pod which meant patients could access this independently to monitor their health.
- The service demonstrated how they applied learning from involvement in innovation such as the HG Wells pilot aimed at delivering significant and sustainable improvements in the management and treatment of diabetes. Identification of patients not on optimal therapy had a positive impact on the HBA1c (average blood glucose level) and cholesterol level for patients. The learning from this had been developed into a service wide strategy.
- They had an alert on the patient record system to remind clinicians to refer patients who meet the criteria to the National Diabetes Prevention Programme education course and had referred 305 patients since July 2017.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were in line with the target percentage of 90% or above.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- The practice had a policy for following up all failed attendance of children's appointments.

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

- The practices' uptake for breast and bowel cancer screening was in line the national average.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- The service had a Facebook page with regular health updates which targeted the patient population and linked to You Tube health education videos and health campaigns. The success of this was monitored and site had recorded 3500 posts for some campaigns.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- The improved access programme had facilitated more primary care access outside of normal working hours for working patients. In three months (February to April 2018) patients were offered under improved access, 192 fifteen minute GP appointments and 205 ten minute nurse appointments.
- The website had comprehensive self-care information and recorded approximately 800 visits each week.

Are services effective?

- The practice's uptake for cervical screening was 68% (NHS Digital), which was in line with the 72% England average. The service maintained a record of contact with patients who had not attended and offered opportunistic screening to facilitate compliance.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- There was a designated lead GP and lead nurse who supported each local care home for people with complex learning disabilities.
- The service enabled patients to access the food bank by issuing vouchers.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.

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

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services. There was a system for following up patients who failed to attend for administration of long term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- 90% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This is comparable to the national average the national average.
- 87% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This is comparable to the national average.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example, 85% of patients experiencing poor mental health had received discussion and advice about alcohol consumption. This is comparable to the national average.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- The service supported three specialist dementia care homes and had developed an in-house team to support patients and carers. This meant there was continuity of care for patients and their families.

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. We found staff were actively engaged in activities to monitor and improve quality and outcomes. We were shown an audit summary which demonstrated that clinical audit was an integral part of the clinical work. We found that over the past two years 17 clinical audits had been undertaken in addition to quality improvement work. We saw examples of where this had an impact on clinical care for example, for patients with diabetes the incidence of congenital malformations in babies is higher, therefore the organisation agreed to include contraception and pre-conceptual counselling in their diabetes review template and review its impact in 12 months. In addition, we saw audits of clinical practice, such as coil fitting and non-clinical audits which supported the function of the service such as telephony and appointment availability. Where appropriate, clinicians took part in local and national improvement initiatives such as the 'Don't wait to anticoagulate' guidance.

- We found the overall exception rate for the QoF indicators was above the national average. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.)
- The practice used information about care and treatment to make improvements. It was standard practice to review roles and competencies each time

they recruited or changed service delivery. This had assisted in the system re-design of the nursing workload so that work was appropriate to skill level and appointment time was sufficient for the task.

- The practice was actively involved in quality improvement activity. We found that a care co-ordinator had been allocated responsibility to ensure those patients diagnosed with cancer were reviewed within six months. This had resulted in an improvement in the number of reviews achieved from 76% (2016-2017) to 92% (2017-18). Opportunities to participate in benchmarking and peer review were proactively pursued, including participation in approved accreditation schemes. For example, the practice had been selected to become an innovator practice to form part of the West of England Primary Care Collaborative. This process included learning and sharing events as well as quality improvement training to deliver quality improvement projects.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

- Staff had appropriate knowledge for their role, for example, to carry out reviews for people with long term conditions, older people and people requiring contraceptive reviews.
- Staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.
- Staff were proactively supported and encouraged to acquire new skills, use their transferable skills, and share best practice. The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop with individual development plans and funding available for professional development and higher education courses such as supporting staff to complete Master's degree courses.
- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. The induction process for healthcare assistants included the requirements of the Care Certificate. The practice ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.
- Staff, teams and services were committed to working collaboratively and had found innovative and efficient ways to deliver more joined-up care. For example, the care coordinator had the task to review discharge summaries for patients so that any identified actions needed were taken.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for people with long term conditions and when coordinating healthcare for care home residents. They shared information with and liaised with community services, social services and carers for housebound patients and with health visitors and community services for children who had relocated into the local area.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- They had effectively used innovative and pioneering approaches to care such as use of teledermatology which meant there was a quicker diagnosis and reduction for the need to refer to secondary care.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

Outstanding ☆

Are services effective?

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- GPs from the service attended the local children's centre for health promotion sessions for identifying and managing childhood illness.
- Staff were consistent in supporting people to live healthier lives, including identifying those who need extra support, through a targeted and proactive approach to health promotion and prevention of ill-health. Staff encouraged and supported patients to be involved in monitoring and managing their own health, for example through social prescribing schemes. The service had a high level of referral for social prescribing and saw positive results for patients such as an increase in well-being and ability to self-care.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately. They undertook peer audits of patient records as part of their professional feedback process.

Please refer to the Evidence Tables for further information.

Outstanding ☆

Are services caring?

We rated the practice outstanding for caring.

The practice was rated as outstanding for caring because:

There was a strong, visible person-centred service where staff were motivated and inspired to offer care that was kind and promotes people's dignity, and respected the totality of people's needs. They worked in partnership with patients to develop services. Feedback from patients was consistently positive with the National GP Survey.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from patients was positive about the way staff treat people. There was a care coordinator whose role principally involved coordinating the handover and interface between primary (GPs) and secondary care (accident and emergency and local hospitals). This meant that patients being discharged from hospital were contacted to ensure support services had been arranged and if not then they would be arranged. The care coordinator also arranged any follow up appointments or tests.
- The practice had a volunteer driver scheme to support patients to attend appointments.
- The practice understood the challenges of social isolation and had started a volunteer befriending scheme.
- People's emotional and social needs are seen as being as important, and the Pioneer Group had been successful in their application for inclusion on a social prescribing programme.
- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information; we observed that staff printed off advice and guidance information for patients routinely as part of the consultation.
- 100% of respondents to the most recent NHS GP patient survey (July 2017) said they had confidence and trust in the last GP they saw or spoke to.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment. They were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information that they are given).

- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment. They used their website and texting system to promote community activities such as the walks for health.
- The practice had a strong community presence and were part of the local community action plan. A representative from the practice attended the community forums to promote access and inclusion. The practice was used by the community as a voting station for people to vote on community projects.
- A GP partner undertook liaison and training with local schools and children's centres to promote health education for young people and new parents.
- The practice were part of the Bristol Community Toilet Scheme where they were part of a scheme to allow members of the public to use their toilet facilities where there may be no public toilet availability.
- The practice proactively identified carers and supported them.
- Bereaved patients were contacted and offered support by the patient's usual GP or the practice care coordinator.

Privacy and dignity

The practice respected patients' privacy and dignity.

- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Staff recognised the importance of people's dignity and respect. They challenged behaviour that fell short of this.

Please refer to the Evidence Tables for further information.

Outstanding ☆

Are services responsive to people's needs?

We rated the practice, and all of the population groups, as outstanding for providing responsive services.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The services were flexible, provided informed choice and ensured continuity of care. The practice understood the needs of its population and tailored services in response to those needs. For example, the practice had a large working age population and offered extended hours appointments. 90% of respondents in the NHS GP patient survey (July 2017) were happy with the practice opening times.
- Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.
- The facilities and premises were appropriate for the services delivered. The practice hosted a range of services, such as the hearing aid clinics, psychological therapy appointments, substance misuse and alcohol services, so that these were accessible to patients locally.
- The practice made reasonable adjustments when patients found it hard to access services; they had employed a paramedic specifically to undertake home visits for patients unable to visit the practice. The practice recognised that there were poor public transport services in the local areas and worked to deliver a volunteer patient transport service. The service not only supported patients to attend the surgery but also to hospital appointments.
- There was a proactive approach to understanding the needs and preferences of different groups of people and to delivering care in a way that meets these needs, which promoted equality. For example, the practice experienced an issue with a traveller family and followed this up by undertaking a joint visit to the traveller site with the link officer in order to generate better relationships with the community. In addition, a misunderstanding with a patient with gender dysphoria resulted in a whole staff training programme being sourced and implemented.
- The practice provided effective care coordination for patients who are more vulnerable or who had complex needs. They supported them to access services both within and outside the practice. There was a care coordinator employed by the practice to support and signpost patients to appropriate services.
- The practice was successful in a bid for inclusion on a social prescribing project. This had resulted in 175 patients being referred since March 2017. The project used the Short-Warwick-Edinburgh Mental Wellbeing Scale when people started and finished their interactions; there was a significant increase in well-being from an average score of 17.4 to 20.5.
- There were innovative approaches to providing integrated person-centred pathways of care that involved other service providers, particularly for people with multiple and complex needs. Nurses were encouraged to develop skills for key interests such as the a nurse for the healthy homes education programme for people with learning disabilities to manage and prevent obesity and associated conditions.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home, in a care home or supported living scheme.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- The practice had planned, regular visits to care homes by GPs; we found that two GPs were allocated for each home to promote continuity of care. The practice had collaborated with the homes so that they had access to patient's electronic records whilst on-site which meant records were completed contemporaneously.
- The service had established integrated working with a regular morning meeting to which any attached healthcare professional could go. Clinicians planned joint visits with community staff. There was a direct telephone line to the service for healthcare professionals to access support and advice.

People with long-term conditions:

- The provider had introduced specialist services to optimise care for patients with long term conditions; an example was diabetes care where they changed the approach to treatment. Patients with poor control were

Are services responsive to people's needs?

more intensively followed up; difficult to manage patients were referred for inclusion in the virtual clinic with secondary care specialists. The impact of this was that they could demonstrate to date a 6% improvement in reduced long term blood glucose levels and similar reductions in the other target ranges.
- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- The practice invited health care professionals to attend their daily meeting as well as holding regular meetings to discuss and manage the needs of patients with complex medical issues and those who may be of concern to clinicians.
- The practice had developed more specialist services such as a designated wound care service to promote best practice and better outcomes for patients.

Families, children and young people:

- The practice had been successful at applying for inclusion on a project to improve uptake of the measles, mumps and rubella (MMR) vaccine. This was an Innovation Fund opportunity through Public Health England to improve the current uptake of MMR dose 2 to protect the health of local children. This is a local priority in the South West.
- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child under the age of 10 were offered a same day appointment when necessary.
- The practice were an accredited 'Young People Friendly' practice with information targeted at young people.
- The practice had been part of the Bristol 4YP (for young people) for promotion of contraception and sexual health, and since central funding had been withdrawn, were continuing to offer the scheme to young people funded by the practice. They also supplied condoms under the C card scheme whereby young people can receive free condoms.
- One of the GP partners offered health education sessions to parents at the children's centre.
- The practice had undertaken basic life support (BLS) training with pupils from a local school to promote awareness of and establish links with the practice.
- The service had the Paediatric Handi-app available to download through their website and Facebook page which provided expert support to parents/carers looking after children with the most common childhood illnesses.
- There were ring-fenced minor illness appointments each afternoon after school hours.

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

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, extended opening hours and Saturday appointments.
- The practice was working with their local GP cluster to develop seven day availability for appointments.
- The health pod allowed patients to monitor their blood pressure which was then recorded directly on their records which meant that for some treatment such as contraception, six monthly appointments were not needed.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice had 140 patients registered with a confirmed diagnosis of a learning disability. They had undertaken a programme of working with patients with a learning disability and their carers to promote well being called the Healthy Homes project. This included a teaching session about wellbeing, healthy diet, diabetes and the benefits of exercise. Eight of the patients involved were tested for pre-diabetes, with the results that three (37.5%) were shown to be at risk of developing diabetes and received appropriate treatment. The programme will be repeated on an annual basis.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.
- The practice hosted a range of health care professionals such as substance misuse services to support local based health care services.

Outstanding ☆

Are services responsive to people's needs?

- A GP and nurse led on services for people with learning disabilities and ensure accessible information was available.
- The service had information available for vulnerable patients about how to access various support groups and voluntary organisations. We observed the service had information discreetly available relating to domestic abuse, and ensured staff had attended training in this topic.

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

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice had a high prevalence of patients with dementia and so had a dedicated clinical team for patients with dementia who worked collaboratively with the community dementia team.
- They had applied to be a 'Dementia Friendly' accredited practice.
- The service had complex patients with dual diagnosis mental illness and addiction. They had a one hour appointment on a Saturday which was booked by the clinician to review complex and/or poly-pharmacy patients.
- GPs who were skilled in specialist areas used their expertise to offer additional services to patients such as shared care prescribing and provide support for community detoxification from alcohol misuse. Patients on the opiate substitution waiting list were entirely managed by GPs.
- The service invited the psychiatric teams to attend their clinical meetings to discuss patients care plans.

Timely access to care and treatment

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment. They could apply for online access to test results.
- Waiting times, delays and cancellations were minimal and managed appropriately.

Patients with the most urgent needs had their care and treatment prioritised. There was an Urgent Care team which comprised of two duty GPs, a nurse practitioner, a paramedic, a care coordinator, consulting GPs and administrative support. There was an open surgery that started at 11am daily. Any patient was able to access these appointments; patients were seen by one of the GP's available to cover open surgery that day.

- Patients reported that the appointment system was easy to use; 78% of respondents in the NHS GP patient survey (July 2017) were able to get an appointment when needed.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. The practice learned lessons from individual concerns and complaints and also from analysis of trends. Investigations were comprehensive and the service used innovative ways of looking into concerns, including using external professionals to make sure there was an independent and objective approach. For example, we saw evidence of an investigation into patient care which involved two GPs and was reviewed by the clinical commissioning group. The practice had also contacted the family of the patient and offered a face to face meeting and support, whilst able to demonstrate the learning and changes/ recommendations made following the incident.

Please refer to the Evidence Tables for further information.

Outstanding ☆

Are services well-led?

We rated the practice as outstanding for providing a well-led service.

The practice was rated as outstanding for well-led because the leadership, governance and culture were used to drive and improve the delivery of high-quality person-centred care.

There was compassionate, inclusive and effective leadership with an embedded system of progression and development which aimed to ensure that there was a whole team approach to service delivery.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- The Pioneer Group leadership were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them. Leaders at all levels demonstrated the high levels of experience, capacity and capability needed to deliver excellent and sustainable care. They took responsibility and were accountable for their area of service provision. Each location had a senior partner for leadership supported by an operational practice manager.
- Leaders were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership. The organisation was holacratic with defined decision-making pathways.
- Comprehensive and successful leadership strategies were in place to ensure and sustain delivery and to support the organisational culture. The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice. The leadership of the service did not fear change and looked for ways in which it could be made to improve the service for patients. For example, the provider saw the seven day primary care initiative was an opportunity to change work patterns and develop integrated 'out of hospital' care.

Vision and strategy

The vision and strategy was part of the wider organisational strategy which covered three locations to give patients better appointment availability and access to specialist services.

- There was a clear vision and set of values. The practice had a realistic strategy and supporting business plans to achieve priorities. The practice developed its vision, values and strategy jointly with patients, staff and external partners.
- Leaders had a shared purpose, and worked hard as a team to deliver and motivate staff to succeed. Staff were aware of and understood the vision, values and strategy and their role in achieving them. All of the staff were aware of it told us they worked together to make the strategy a reality for patients.
- The strategy and supporting objectives and plans were challenging and innovative, while remaining achievable. For example, a key part of their strategy was to support the organisation by best use of the skill mix and technology. We observed that staff were supported and encouraged to develop their skills and use them to be innovative such as the introduction of the 'F12' key to the electronic records platform to promote safer care.
- Strategies and plans were fully aligned with plans in the wider health economy, and there was a demonstrated commitment to system-wide collaboration and leadership.
- The practice planned its services to meet the needs of the practice population. For example, the Bristol area had experienced a number of measles outbreaks and they had applied for innovation funding to proactively increase the uptake of MMR2 vaccination.
- There was a systematic and integrated approach to monitoring, reviewing and providing evidence of progress against the strategy and plans. Plans were consistently implemented, and had a positive impact on quality and sustainability of services the practice monitored progress against delivery of the strategy through regular meetings and feedback sessions.

Culture

The practice had a culture of high-quality sustainable care.

- Staff told us they felt respected, supported and valued, they were proud of the organisation as a place to work and spoke highly of the culture.
- The practice focused on the needs of patients.
- Leaders and managers acted on behaviour and performance consistent with the vision and values.

Outstanding ☆

Are services well-led?

- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff at all levels were actively encouraged to speak up and raise concerns, and all policies and procedures supported this process. They had confidence that these would be addressed. The provider had a formal arrangement with a manager outside the organisation who acted as an independent contact for any staff whistleblower.
- There were processes for providing all staff with the development they need. There was a mentoring process for new staff and clinical staff such as nurse prescribers, salaried GPs and the paramedic. We found evidence that appraisal was embedded for all staff and investment in staff development was a priority for the practice. The organisation maintained an appraisal outcome summary which took account of objectives, training needs and completion dates. This supported the business planning process.
- Staff were supported to meet the requirements of professional revalidation where necessary. For example, there was support for professional development with trained nurses and managers allowed up to a week of paid leave each year.
- The service ran a mentoring scheme for salaried GPs who were aligned with experienced GP partners for support and training.
- The service used innovative and proactive methods to improve patient outcomes, working with other local providers to share best service. For example, the service had worked in partnership with the One Care Limited to develop integrated IT systems across the service. They won two Innovation Awards from NHS England South for best use of technology and for the best practice merger.
- We were told that the leadership of the service had an inspiring shared purpose, and worked hard to deliver and motivate staff to succeed. An example of this was that salaried GPs were included in the duty doctor system alongside a more experienced partner who provided support to them in a challenging role.
- All staff were considered valued members of the practice team. They were given protected time for professional development in addition to evaluation of any clinical work.
- There were high levels of satisfaction across all staff, including those with particular protected characteristics under the Equality Act. There was a strong organisational commitment and effective action towards ensuring that there was equality and inclusion across the workforce. Staff had received equality and diversity training. Staff felt they were treated equally and included in the decisions and development of the service.
- The practice actively promoted equality and diversity, and there were positive relationships between staff and teams.
- There was a strong emphasis on the safety and well-being of all staff. The provider had external support available, such as counselling to promote staff well-being.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management. There was embedded team-working and support across the organisation and a common focus on improving the quality and sustainability of care.

- Governance arrangements were proactively reviewed and reflected best practice.
- Structures, processes and systems to support good governance and management were clearly set out, understood and effective.
- A systematic approach was taken to working with other organisations to improve care outcomes. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities; there was a clear structure with reporting processes at each level.
- Practice leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended. For example, there was a programme of audit across the organisation which encompassed all of the functions. We saw that any new process were audited for success and impact, such as the introduction of the paramedic for home visits which showed 47 successful visits had been achieved.

Managing risks, issues and performance

Outstanding ☆

Are services well-led?

There were clear and effective processes for managing risks, issues and performance.

- There was a demonstrated commitment to best practice performance and risk management systems and processes. There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety. For example, the urgent care and open surgery both provided safety netting for patients who had been unable to book an appointment.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Practice leaders had oversight of national and local safety alerts, incidents, and complaints.
- The organisation reviewed how they functioned and ensured that staff at all levels had the skills and knowledge to deliver high quality care. The service had undertaken the Score Survey with all staff in 2017 and used the results to change how the practice was working.
- The service had planned to undertake a job matching exercise during the summer to ensure skills were effectively utilised and rewarded.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was a wide ranging programme of audits to review and improve quality.
- The information used in reporting, performance management and delivering quality care was consistently found to be accurate, valid, reliable, timely and relevant. For example, data reporting for the quality and outcomes framework showed a continuation of or improvement of performance.
- There was clear evidence of action to change practice to improve quality.
- The service invested in innovative and best practice information systems and processes. We found they had invested in IT searches to identify where patients had not been correctly coded for inclusion on disease registers.
- The practice had plans in place and had trained staff for major incidents.
- The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care. For example, the introduction of the workflow optimisation process was led by a GP partner and the practice manager so that the clinical and non-clinical aspects of the process could be addressed using their specialist knowledge.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- There was a commitment at all levels to sharing data and information proactively to support improvement.
- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The practice used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care. They had employed an external IT organisation to audit the coding of disease in the electronic patients record system which found incorrect coding. This meant there had been under identification of patients (approximately 5%) who met the criteria to be part of the review of programme for long term conditions. Patients were invited to attend the practice for a full assessment.
- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high-quality sustainable services.

Outstanding ☆

Are services well-led?

- There were informal, formal and on-going regular sessions of constructive engagement with staff and patients. A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on.
- There was an active patient participation group (PPG).
- The service was transparent, collaborative and open with stakeholders about performance.
- We received 24 completed comment cards from patients; they had also advertised the inspection on the organisation Facebook page which had received 106 visits.
- Innovative approaches were used to gather feedback from patients and the public, including people in different equality groups, and there was a demonstrated commitment to acting on feedback.

Continuous improvement and innovation

There was evidence of systems and processes for learning, continuous improvement and innovation.

- The service takes a leadership role in its health system to identify and proactively address challenges and meet the needs of the population. The senior partner was a director at the One Care Limited, an organisation for primary care improvement and commissioning and had accessed additional services for patients.
- The business partner was the lead for the locality 'cluster' development for more integrated care services such as the improved access programme.
- There was a clear, systematic and proactive approach to seeking out and embedding new and more sustainable models of working. Within the cluster they were promoting the use of other primary care sites on their website to ensure patients were aware of what primary care services they could access.
- There was a record of sharing work locally, and nationally. A comprehensive library of information had been sourced or written by staff which covered a range of themes including top tips for specific conditions.
- The service took part in research which contributed to the service remaining up to date with latest developments in clinical care.
- The service was successful at providing GP training both at pre- and post-graduate levels and participated in the Introduction to Medicine course for sixth formers run by North Bristol Trust. It was rated as an A* training practice. They had four educational supervisors and one clinical supervisor for training GPs, F2s, and doctors with GMC conditions to practice, returners to general practice.
- There was a focus on continuous improvement was seen as a way for the organisation to evolve. Improvement methods and skills were used across the organisation, and staff were empowered to lead and deliver change.
- Staff knew about improvement methods and had the skills to use them. By taking part in research, the practice had identified new ways to use technology to improve the quality of care.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to review individual and team objectives, processes and performance.

Please refer to the Evidence Tables for further information.