Fallodon Way Medical Centre

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Fallodon Way Medical Centre on 26 March 2015. Overall the practice is rated as Good.

Specifically, we found the practice to be well led and good for providing safe, effective, caring responsive services.

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- The practice used innovative and proactive methods to improve patient outcomes, working with other local providers to share best practice. For example, it had appointed a care coordinator to monitor the needs of older people.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the Patient Participation Group (PPG).
- 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
- The practice had a clear vision which had quality and safety as its top priority. A business plan was in place, was monitored and regularly reviewed and discussed with all staff. High standards were promoted and owned by all practice staff with evidence of team working across all roles.

Summary of findings

- All GPs and the care coordinator were involved in a daily meeting when the patients who had requested visits were discussed and the best person to conduct the visit was identified in order to provide continuity of care.
- The practice provided a service to a women's refuge and ensured staff understood the implications of confidentiality for patients with a PO Box address.

We saw an area of outstanding practice including:

- There were express clinics on two mornings each week with a GP. This meant patients could book and attend within 48 hours.

The provider should:

- Carry out fire drills on a regular basis so that staff know how to respond in the event of fire.

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 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 staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

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

All GPs and the care coordinator were involved in a daily meeting when the patients who had requested visits were discussed and the best person to conduct the visit was identified in order to provide continuity of care.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent

Summary of findings

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.

The high number of urgent appointments available each day ensured patients whose circumstances made them vulnerable and whose lives were less ordered were able to access appointments easily. There were express clinics on two mornings each week with a GP.

The practice provided a service to a women's refuge and ensured staff understood the implications of confidentiality for patients with a PO Box address.

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 inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and it had appointed a care coordinator to monitor the needs of older people. The practice provided a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

All GPs and the care coordinator were involved in a daily meeting when the patients who had requested visits were discussed and the best person to conduct the visit was identified in order to provide continuity of care.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

All GPs and the care coordinator were involved in a daily meeting when the patients who had requested visits were discussed and the best person to conduct the visit was identified in order to provide continuity of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

Summary of findings

A midwife held clinics in the practice each week. The community health visitors held clinics in local churches to make them more accessible. The practice had a protocol to ensure children who were unwell would be seen by a GP rather than a nurse.

Working age people (including those recently retired and students)

Good

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

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations.

Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

The practice provided a service to a women's refuge and ensured staff understood the implications of confidentiality for patients with a PO Box address.

There was a high number of urgent appointments available each day which ensured patients whose circumstances made them vulnerable and those whose lives were less ordered were able to access appointments easily.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.

Summary of findings

The practice had told patients experiencing poor mental health how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

We received 26 completed comments cards from patients. All except one 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. Patients referred to being privileged to be a patient in the practice, having superb help from reception staff to book appointments for tests and a high quality service. One comment was less positive referring to feeling 'rushed' in their appointment. Other patients told us they never felt 'rushed' and felt staff always had time to listen.

We also spoke with seven patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. They spoke about the ease with which they were able to access appointments and being called by their preferred name. We spoke with a patient who was accompanied by their support worker. They told us the GP always spoke with them and not their carer. Another patient who was attending an appointment with the midwife told us they and the GP involved their partner in discussions about their pregnancy. One patient who did not have an appointment visited the practice specifically to speak with us. They referred to being 100% happy with the service.

We received feedback from one of the care homes supported by Fallodon Way Medical Centre. They told us they had received care and support from the practice for many years. The manager told us they felt the practice proved to be safe and effective by offering support when required. They said the GPs always listened and offered caring advice and guidance in the care of those who lived in the home. They told us they felt Fallodon Way was well led and approachable.

Areas for improvement

Action the service SHOULD take to improve

Carry out fire drills on a regular basis so that staff know how to respond in the event of fire.

Outstanding practice

There were express clinics on two mornings each week with a GP. This meant patients could book and attend within 48 hours.

Fallodon Way Medical Centre

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 specialist advisor GP, CQC inspector and other specialists including a practice nurse and practice manager.

Background to Fallodon Way Medical Centre

Fallodon Way Medical Centre is a partnership of four GP partners providing services to over 8650 patients in and around Henleaze in the north west area of Bristol. It is one of the least deprived areas of the country and life expectancy is over 81 years for males and 85 years for females. The patient group is of mainly white origin with 2.5% of patients classing themselves as being of non-white ethnicity.

There are four GP partners and three associate GPs, three practice nurses and two healthcare assistants along with, a care coordinator. They are supported by an administration and reception team of 15 staff. Some of the GPs have additional qualifications and special interests including care of the elderly, dermatology, men's health, paediatrics and cardiology along with women's health and contraception. One of the GPs has an interest in sports and exercise medicine.

Vasectomy and minor skin surgery was available at the practice.

The practice has affiliated staff including district nurses, midwives, health visitors and associate community matron and community nurse for older people. There are two visiting pharmacists available for consultations.

The practice has contracted with Brisdoc to provide Out of Hours services. The practice core opening hours are from 8.00 am until 6.30pm on Monday to Friday so meets the GMS contract.

Why we carried out this inspection

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

How we carried out this inspection

Prior to our visit we reviewed the information we held about the practice and looked at the practice website. We looked at the NHS Choices website, contacted the NHS England area team Bristol North and West Clinical Commissioning Group and local Healthwatch. We also contacted local care homes.

During our visit we spoke with a range of staff including GPs, the practice manager, nurses, healthcare assistants

Detailed findings

and administrative staff. We also spoke with patients who used the service. We observed how people were being cared for and talked with carers and/or family members and reviewed records.

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)

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. Patient safety alerts were received by the practice manager and disseminated to other staff in the practice.

The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, there was an incident where a patient's diagnosis was recorded on their relative's record by mistake. It was identified by a member of staff, the test result was checked with the laboratory and the records were amended.

We reviewed safety records, incident reports and the minutes of meetings where these were discussed for the last year. This showed the practice had managed these consistently and could demonstrate 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, incidents and accidents. There were records of significant events that had occurred during the last year and we were able to review these. Significant events was a standing item on the practice governance meeting agenda and additional dedicated meetings were held when required to review actions from past significant events and complaints.

The review of significant events for 2014/15 showed there were 12 significant events recorded for the period. The review showed what action the practice had taken and how learning was implemented. For example, we saw there was a mix up involving home visits for patients with the same name. The mix up was resolved and there was discussion with reception staff to ensure patients were properly identified and alerts were added to medical records.

There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

We were told new guidelines and alerts were disseminated to staff by the practice manager. One of the nursing staff we spoke with told us that new guidelines and significant events were discussed at practice meetings.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who the leads were and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). Nursing staff, including health care assistants, had been trained to be chaperones and had criminal background checks with the Disclosing and Barring Service (DBS)GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GPs were aware of vulnerable children and adults and held monthly meetings with health visitors to discuss individual cases.

Good

Are services safe?

The practice leads were responsible for updating other practice staff as necessary and of ensuring that appropriate action was initiated where this was a practice responsibility.

When possible GPs attended child protection case conferences and serious case reviews and if unable to attend sent a report to support the meeting. The practice maintained a register of patients considered to be vulnerable and followed up vulnerable patients when they failed to attend appointments.

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 and we saw records to show each of the fridge temperatures were recorded.

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

We saw records of audits that noted the actions taken in response to a review of prescribing data. For example, patterns of anti-coagulant and urinary incontinence and over active bladder prescribing within the practice. The audit of urinary incontinence and over active prescribing followed National Institute for Health and Care Excellence (NICE) guidelines and new regimes were initiated if appropriate.

The nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses and the health care assistant had received appropriate training to administer vaccines.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance and these were tracked through the practice and kept securely at all times.

We spoke with the member of staff with responsibility for prescription form management who showed us the process by which blank prescription forms are ordered, received and kept safe. On receipt of a new stack they were recorded in a folder that clearly showed stock movement in the practice. Blank prescriptions were kept in a locked cupboard and the key was kept in the safe overnight. Consulting rooms were locked overnight so prescription paper was kept securely. Signed prescriptions were kept in locked containers in the reception area.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. We saw staff had annual update training in relation to infection control.

We saw evidence that the infection control lead had carried out an audit of arrangements in January 2015 any actions identified were being completed. For example staff whose immunisation status was not known had blood tests to check their immune status.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was no formal policy for needle stick injury however this was being addressed with the Clinical Commissioning Group. Staff knew the procedure to follow in the event of an injury.

Hand washing guidance was displayed above sinks in treatment rooms to remind staff of good hand hygiene techniques. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in

contaminated water and can be potentially fatal). The policy specified the tests to be carried out if and when equipment containing reservoirs of water were introduced to the practice.

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 of March 2015. A schedule of testing was in place. We saw evidence which showed calibration of relevant equipment, for example weighing scales, spirometers and blood pressure measuring devices was carried out on the same date.

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Staffing and recruitment

We looked at two staff files which contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards and procedures it followed when recruiting clinical and non-clinical staff. The policy included a link to the guidance available from the NHS for when recruiting staff including those from overseas.

Records of induction were maintained including records of informal discussions and progress reports. Induction records showed significant policies had been reviewed including those for information governance, safeguarding and health and safety.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Staff told us the practice was happy to pay overtime for additional hours.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified lead for health and safety.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw risk assessments in relation to fire safety and legionella were recently reviewed.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example, there were processes in place so children who were ill could be seen immediately through the urgent appointments system. The urgent appointment system enabled access to appointments for patients with poor mental health and those with less orderly lives. The practice had achieved greater success in reviewing patients with long term conditions enabling their conditions to be monitored more safely.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. The notes of the practice's significant event meetings showed that staff had discussed a medical emergency concerning a patient and that the practice had learned from this appropriately.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and

Good

Are services safe?

hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

There was a business continuity plan, held in the practice and off site, to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training however they had not practiced a fire drill since 2013.

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. We looked at the minutes of nurse meetings and saw new guidelines were discussed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. GPs and nursing staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of respiratory disorders. Our review of the clinical meeting minutes confirmed that this happened.

The practice had increased the recalls of patients with long term conditions to enable more effective management of their care by re-calling patients during their birthday month to ensure they were contacted. It also completed a review of case notes for patients with type-2 diabetes to ensure they were all receiving appropriate treatment in line with NICE guidance. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of patients with suspected cancers referred and seen within two weeks.

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.

Management, monitoring and improving outcomes for people

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

The practice showed us 13 clinical audits that had been undertaken in 2014/15. These were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, we saw an audit of medicines optimisation in care homes with nursing resulted in more appropriate doses and changes to medicines in line with Clinical Commissioning Group (CCG) guidelines. Other examples included audits to confirm that the GPs were prescribing in line with National Institute for Health and Care Excellence (NICE) guidance.

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, 82% of patients with diabetes had a cholesterol check, and the practice met all the minimum standards for QOF in diabetes, asthma and chronic obstructive pulmonary disease (lung disease). The practice had appointed a QOF coordinator to monitor achievements.

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

Good

Are services effective?

(for example, treatment is effective)

The practice had implemented the gold standards framework for end of life care. It had a palliative care register and had regular monthly meetings to discuss the care and support needs of patients and their families.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the doctors with five having additional diplomas in sexual and reproductive medicine, and one with a diploma in children's health we noted one GP had an additional diploma in sports medicine.

All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff had annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example chaperone training.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties, for example, administration of vaccines and cervical cytology. Those with extended roles saw patients with long-term conditions such as asthma, Chronic Obstructive Pulmonary Disease (COPD), and diabetes were also able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those 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. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. The record of significant events showed there were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

The practice held multidisciplinary team meetings every month to discuss the needs of complex patients, for example those with end of life care needs. The multidisciplinary team included community staff, hospice staff and the practice care coordinator. In addition there were monthly multidisciplinary team meetings with the community matron and district nurses, monthly meetings with the health visitor or midwife and monthly meetings to discuss unplanned hospital admission avoidance with the practice care coordinator. In addition the practice lead held monthly meetings with the health visiting team to discuss individual cases of child safeguarding. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice used the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital).

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

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and

Good

Are services effective?

(for example, treatment is effective)

were able to describe how they implemented it in their practice. One of the GPs was the lead for dementia care and all GPs carried out reviews for patients with poor mental health and patients with learning disabilities.

Staff told us they would always ask for consent before giving treatment and if a patient declined would refer them to one of the GPs.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

We were told of an occasion when a patient called at the practice to obtain their spouse's blood test results. Staff explained they were unable to reveal the results as they were confidential between the surgery and the patient. The practice obtained consent from the patient to disclose the blood test results.

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure. One of the GPs provided minor surgery through a city wide organisation which provided some private health care. In these cases the patient signed a form to indicate they understood and gave consent to treatment.

Health promotion and prevention

The practice maintained a register of patients identified as being at high risk of unplanned hospital admission and end of life care. We saw they had up to date care plans. Multi-disciplinary team meetings were held to discuss the care needs of patients included in the register.

National patient data from the Quality and Outcomes Framework (QOF) showed 80 % patients with diabetes had an annual foot examination and 86% had annual influenza immunisation.

Immunisation achievements for children were similar to other practices in the Clinical Commissioning Group (CCG) area. In some cases they were slightly lower and others higher.

The practice provided a pregnancy information pack and community midwives held surgeries in the practice twice each week. Patients who had a miscarriage were contacted by a GP to offer support. Young people had access to 4YP (for young people) urgent services and there were three GPs who were able to fit intra-uterine devices (coils).

Unlimited urgent appointments enabled immediate access to a GP for children who were unwell.

Online booking for appointments and repeat prescriptions was available and telephone consultations were aimed at providing a responsive service to the working aged population and students. In addition extended hours appointments enable patients to see a GP without taking time from work. QOF indicators showed a higher percentage of women aged between 25 and 65 years whose notes recorded cervical screening in the past five years was 84% compared to the England average of 81%.

The practice maintained a register of patients with learning disabilities and regularly carried out reviews of the healthcare needs of this group. It provided a service to a women's refuge and ensured staff understood the implications of confidentiality for patients with a PO Box address.

The practice offered a number of urgent appointment slots for patients whose lives were less orderly.

A door bell and braille signage was installed at the front door to assist some patients in entering the building. Patients with disabilities including hearing loss and visual impairment were 'flagged' on the electronic records system so staff could offer them assistance.

The practice supported a care home for people living with dementia. It provided a weekly visit and carried out reviews and dementia care planning.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey 2013/14 and reviews posted on NHS Choices. The evidence from these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated higher (94%) than the England average of 86% by patients who rated the practice as good or very good for their overall experience of the practice. The practice was also above the England average for its satisfaction scores on telephone accessibility was 90% compared to the England average of 75%.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 26 completed cards all except one 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. Patients referred to as being privileged to be a patient in the practice, having superb help from reception staff to book appointments for tests and receiving a high quality service. One comment was less positive referring to feeling 'rushed' in their appointment. Other patients told us they never felt 'rushed' and felt staff always had time to listen.

We also spoke with seven patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. They spoke about the ease with which they were able to access appointments and being called by their preferred name. We spoke with a patient who was accompanied by their support worker. They told us the GP always spoke with them and not their carer. Another patient who was attending an appointment with the midwife told us they and the GP involved their partner in discussions about their pregnancy. One patient who did not have an appointment visited the practice specifically to speak with us. They referred to being 100% happy with the service.

The practice was conducting the Friends and Family Test. The results showed that 91% of 23 respondents were likely or very likely to recommend the practice. One patient had indicated they were unlikely and the other did not answer the question.

We saw a range of letters and thank you cards addressed to the practice. Patients were thankful for treatment and referrals to secondary care. Patients were grateful for the support they received for smoking cessation and weight loss. There were compliments about intimate screening and general thanks. Patients referred to excellent service, awesome treatment and referred to how fortunate they felt to be treated by such caring, friendly and professional staff.

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

We saw staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk and was shielded by a glass door which helped keep patient information private. In response to patient and staff suggestions, a system had been introduced to improve confidentiality at the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff.

The high number of urgent appointments available each day ensured patients whose circumstances made them vulnerable and whose lives were less ordered were able to access appointments easily.

We saw how reception staff were obliging when dealing with patients. A patient required a supply of hearing aid batteries and was able to obtain them from the practice effortlessly instead of having to travel to the audiology department at the hospital. A new patient completed their application form easily with the support of the receptionist. There was an electronic patient 'arrival screen' which meant patients did not have to stand and wait at reception unnecessarily.

Good

Are services caring?

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 87% of practice respondents said the GP involved them in care decisions and 88% felt the GP was good at explaining treatment and results. Both these results were above the England average. Feedback from other sources indicated patients felt they were involved in decisions about their care.

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

Staff told us that translation services were available for patients who did not have English as a first language.

The practice appointed a care coordinator to provide support to clinical staff in the practice to ensure frail elderly patients obtained the support and care necessary to reduce the risk of unplanned hospital admissions and to support and enable safe and timely discharge from hospital.

The practice held a monthly meeting to discuss patients nearing the end of life. Care planning for these patients was in line with the Gold Standards Framework.

The practice recalled patients with long term conditions such as asthma and diabetes in order to monitor their health. Patients were sent a letter inviting them for blood tests and they had a follow up appointment two weeks later with a practice nurse. A midwife held clinics in the surgery on Thursday and Friday each week The community health visitors held clinics in local churches to make them more accessible for practice patients. The practice had a protocol to ensure children who were unwell would be seen by a GP.

Patient/carer support to cope emotionally with care and treatment

Feedback from the patients we spoke with on the day of our inspection and the comment cards we received indicated patients were happy with the level of emotional support they received. For example, these highlighted that staff responded compassionately when they needed help and provided support when required. The practice records highlighted when patients were elderly or had disabilities so that staff could give them assistance.

Notices and leaflets in the patient waiting room told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them. The practice promoted the Henleaze Carer's Group and had information about the Carers Support Centre for young carers in Bristol and South Gloucestershire.

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 NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). These included training staff in confidentiality, establishing monthly befriending meetings and installation of a door bell for patients who needed assistance. A notice with information in Braille was also placed at the front entrance.

Tackling inequity and promoting equality

The practice provided equality and diversity training through e-learning provided by the local medical committee. We saw records to show this was completed and staff we spoke with confirmed that they had completed the equality and diversity training.

The premises were purpose built and met the needs of patients with disabilities. There were designated parking spaces for disabled drivers and there was a ramp to the front door. There was a bell for patients who required assistance to summon help. The practice had a wheelchair for use inside for those who had restricted mobility.

We saw that the waiting areas were 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.

The practice could cater for patients whose first language was not English through telephone translation services.

We met with the practice performance coordinator who told us about the registers maintained in the practice. They said they helped them to arrange re-call appointments for patients with learning disabilities, poor mental health and diabetes. There were notice boards in the staff area listing patients who required extra care.

Access to the service

The practice area covered Henleaze, Westbury Park, Westbury-On-Trym, Stoke Bishop and some parts of Redland. Patients were able to contact the practice between 8:00am and 6:30pm Monday to Friday. They provided extended hours appointments every third Saturday of each month for pre-booked appointments with a GP or one of two healthcare assistants and early morning appointments were available on Thursday mornings and later evening appointments were available from Monday to Thursday.

We saw there were published standards for response to requests for assistance. For emergency telephone contact there was an immediate response. Requests for emergency appointments were fulfilled within six hours, home visits were provided on the day of request and telephone call back was provided within 24 hours. We were told the practice never refused a request for a same day appointment. The practice aimed to provide routine appointments with any GP within three days and with a named GP within three weeks.

There were express clinics on two mornings each week where patients could drop in without an appointment and pre-bookable appointments with a GP every day.

Patients could book appointments and order repeat prescriptions through the practice website.

We observed the daily meeting when requests for home visits were discussed. All GPs and the care coordinator were involved and the patients who had requested visits were discussed. During the meeting the best person to conduct the visit was identified in order to provide continuity of care.

Listening and learning from concerns and complaints

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

We saw that information was available to help patients understand the complaints system displayed in the waiting area and on the practice website. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at 10 complaints received in the last 12 months and found they were reviewed, actions were taken and learning from individual complaints had been acted upon.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review of complaints for 2014/15 and no themes had been identified.

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 website showed Fallodon Way Medical Centre aspired to be a professional, friendly organisation dedicated to providing high quality personalised medical care to all members of the practice community.

The statement of purpose for the practice stated the practice aimed to ensure patients were confident and satisfied with the standard of clinical care they received and that it met their needs. It outlined how the practice would engage with the patient participation group (PPG) to ensure services were designed to meet the needs of patients. It showed a commitment to working with other service providers involved in patients' care and how it would continually review practice through effective clinical governance.

We saw the practice development plan for 2014 - 2016. It covered three key areas identified as 'core business', 'resources' and 'enablers'. The core business included quality and governance along with patient experience. The resource plan included staffing and the facilities. The enablers were listed as information technology and finance. We saw the practice had achieved some of its objectives.

Staff we spoke with demonstrated an understanding of the vision and values of the practice and how their role and responsibilities contributed towards them.

The practice development plan for 2014 – 2016 was written in the context of the mission statement and listed its objectives and measures to be taken to achieve them. We saw there were timescales for each of the tasks related to the objectives and that some of these had been met.

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. We looked at nine of these policies and procedures and all nine policies and procedures we looked at had been reviewed annually and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and the senior partner was the lead for safeguarding. We saw a document titled the 'Who to turn to' system. It identified 'key' responsibilities of staff so staff could instantly see who would be the appropriate person to go to in relation to medical conditions, practice issues and governance.

We spoke with 13 members of staff including GPs, the practice manager, nursing staff, care coordinator, administrative and reception staff. 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 and in some cases above the England average. We saw that QOF data was reviewed and action plans were produced to maintain or improve outcomes. The practice had significantly improved its achievements for 2014/15 raising the score to 98% from 83% in the previous year. This was achieved by improving the patient recall and review process for patients with long term conditions and by monitoring indicators which had to be achieved within a certain time frame.

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. We saw audits in relation to prescribing and noted they had clear aims and were to check the practice was operating according to National Institute for Health and Care Excellence (NICE) guidelines. The outcomes from the audits were recorded and actions were taken where needed.

Clinical governance meetings were held every two months or more frequently if needed because of new guidance, a serious complaint or significant event.

Leadership, openness and transparency

We saw from minutes that staff meetings were held regularly. For example we saw the minutes of nursing staff meetings showed there had been discussion in relation to equipment, vaccinations, health and safety and patients with additional needs.

The practice manager was responsible for reviewing policies and procedures. They showed us a control schedule which showed when policy reviews were due. We saw the practice had adhered to this and noted the safeguarding children policy had been reviewed on 18 March 2015.

Are services well-led?

Good

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

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

The practice had an established patient participation group (PPG) with 52 members. It engaged with the PPG face to face, at regular bi-annual meetings, and in writing. The PPG was representative of the practice population with members over the age of 85 years and some of diverse ethnic background. Membership of the PPG was advertised within the practice and local community and new volunteers came forward. The PPG actively tried to recruit volunteers under the age of 25 years as it recognised this group of patients were not represented.

The PPG set out an action list each year to include suggestions for improvement. The list for 2014/2015 showed actions had been achieved including the provision of additional bicycle racks, establishing the social meeting service for isolated older patients and the installation of the doorbell for patients who required assistance.

We met with four members of the PPG. They told us the practice listened to their suggestions and they felt a measure of the success of the group was reflected in the way the practice responded. They had a designated notice board space in the waiting room to inform patients about the work of the group and regularly met patients in the waiting room to gain their views.

Management lead through learning and improvement

Staff told us the practice supported them to maintain their clinical professional development through training and mentoring. We looked at the schedules of training for 2013 and 2014 which showed staff had completed a wide range of courses some of which were on line and others by attending organised training. The schedule of training for 2015 showed training was booked and some had been completed.

We looked at two staff files and saw records of reviews between the staff member and their line manager, were dated and signed. We saw the practice had an appraisal policy and this formed part of the governance system. It stated all staff would have an annual appraisal that would be formally recorded and kept on file. We saw these for the staff whose files we looked at. They were signed and included a review of training.

The practice was a GP training practice with one of the GPs currently providing training and clinical supervision for two foundation doctors.