The Easton Family Practice

Quality Report

Charlotte Keel Health Centre
Seymour Road Easton
Bristol
BS5 0UA
Tel: 0117 9027138
Website: www.eastonfamilypractice.co.uk/

Date of inspection visit: 4 December 2014
Date of publication: 19/02/2015

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out our inspection on 4th December 2014. We inspected The Easton Family Practice, also known as Charlotte Keel Health Centre as part of our new comprehensive inspection programme. The practice had not been inspected under our new methodology before and that was why we included them.

Overall we found the practice is rated as good. We saw examples of a safe, effective, caring, responsive and well-led practice. Patients reported high levels of satisfaction with the practice during our inspection and this was reflected in the comment cards we also received.

Our key findings were as follows:

- Access to the practice was good with urgent appointments being bookable on the day and less urgent appointments being bookable in advance. There was an online booking system available to patients.
- The GPs held individual patient lists which enabled patients to see a named GP of their choice for the majority of appointments.
- There were systems in place which ensured patient safety and prompt referrals to other services to ensure patients health was maintained or improved.
- The practice had systems in place which ensured a hygienic environment was maintained.
- Patients were treated with dignity and respect by a staff team who understood patients' needs. A translation service was available in the practice to meet the needs of the local population.
- Communication within the practice and to other services outside the practice was effective.
- The leadership of the management team ensured staff were informed and supported to deliver safe and effective care to patients.

We saw several areas of outstanding practice including:

- The practice had access to, and used, an interpretation service based in the practice to help if communicate

Summary of findings

with patients who did not have English as a main language. This supplemented their access to the NHS language line and the ability of one GP to speak five languages.

- The practice provided a drop-in educational sessions about diabetes for patients who did not have English as a first language. Each session covered a different aspect of diabetes such as foot care, diet and eye care.
- The practice worked closely with and referred patients to a local service that assessed and meet the initial health needs of asylum seekers.
- One of the practice nurses in conjunction with a dietician, deliver a programme about diabetes to newly diagnosed patients with type II diabetes. This is provided across the Bristol area.
- The practice carried out joint patient consultations with local mental health teams and worked closely with drug addiction project workers to ensure better outcomes for patients.
- The practice had 401care plans in place for patients with complex needs.
- One of the practice nurses had identified a gap in patient recording which collated information about long term conditions. They developed a form for all staff to use, integrated it into the patient record system and shared with other local practices.

However, there was also an area of practice where the provider needs to make improvements.

The provider should:

Review their system for ordering medicines for the practice to ensure orders are made based on the needs of the practice.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. Patients 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 have been identified and planned. The practice could identify all appraisals and the personal development plans for all 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.

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 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 appointments available the same day.

Summary of findings

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. Learning from complaints was shared with staff and other stakeholders.

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 and met three or four times a year. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

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

People with long term conditions

Good

The practice is rated as good for the care of patients with long-term conditions. There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. Longer appointments of up to 30 minutes and home visits were available when needed. All patients with long term conditions had a named GP and a structured annual review to check that their health and medication needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were average for all standard childhood immunisations and reflected the transitory nature of the population. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. 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. Emergency processes were in place and referrals were made for children and pregnant women whose health deteriorated suddenly.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age patients (including those recently retired and students). The needs of the working age population, those recently retired and students had

Summary of findings

been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of patients whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. It had carried out annual health checks for people with a learning disability. It offered longer appointments for patients who were vulnerable and those with a learning disability. A specialist project worker for a drug addiction service provided appointments to patients one day each week and linked with practice staff to ensure improved outcomes for vulnerable patients.

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). All patients experiencing poor mental health had their care plan reviewed during regular multidisciplinary team and safeguarding meetings. The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with a diagnosis of a dementia.

Summary of findings

What people who use the service say

We spoke with four patients visiting the practice and five members of the patient participation group during our inspection. We received 21 comment cards from patients who visited the practice and saw the results of the last patient participation group surveys. We looked at the practice's NHS Choices website to look at comments made by patients (NHS Choices is a website which provides information about NHS services and allows patients to make comments about the services they received). We also looked at data provided in the most recent NHS GP patient survey and the Care Quality Commissions information management report about the practice.

The majority of comments made or written by patients were very positive and praised the care and treatment they received. For example, about receiving sensitive and caring treatment, about seeing their preferred GP or nurse at most visits and about being involved in the care and treatment provided.

Patients told us and we saw patients generally found access to the practice and appointments easy. Telephones were answered after a brief wait. However, some patient comments indicated it was not always easy to get through to the practice during the first hour of the practice opening. The most recent GP patient survey showed 68% of patients found it easy to get through to the practice by telephone. Patients also told us about using the practices online booking systems or just visiting the practice to get appointments.

We saw thank you cards sent to GPs in the practice. These all thanked staff for their caring approach and their support at times of emotional need and ill health.

Patients told us their care and treatment was effective and delivered in a sensitive and caring way. They told us their privacy and dignity was respected during consultations. However, they found the reception area was at times noisy but sufficiently private for most discussions they needed to make. Patients told us about GPs supporting them at times of bereavement and how they contacted them personally to offer support or comfort. Many older patients told us they had been attending the practice for over 10 years and told us about how the practice had changed and relocated and how they were treated well during periods of change. The GP survey showed 92% of patients said the last GP they saw or spoke with was good at giving them enough time and treating them with care and concern.

Patients told us the practice was always kept clean and tidy. Patients who did not speak English as a first language told us they could always speak with a GP with help from an interpreter and that this service was highly valued. They told us during intimate examinations GPs and nurses wore protective clothing such as gloves and aprons and that examination couches were covered with paper protective sheets. 88% of patients describe their overall experience of this practice as good.

Areas for improvement

Action the service SHOULD take to improve

The provider should;

Review their system for ordering medicines for the practice to ensure clinical oversight of the requirements is made.

Outstanding practice

We saw several areas of outstanding practice, for example,

- The practice had access to, and used, an interpretation service based in the practice to help if communicate with patients who did not have English as a main language. This supplemented their access to the NHS language line and the ability of one GP to speak five languages.

Summary of findings

- The practice provided a drop-in educational sessions about diabetes for patients who did not have English as a first language. Each session covered a different aspect of diabetes such as foot care, diet and eye care.
- The practice worked closely with and referred patients to a local service that assessed and meet the initial health needs of asylum seekers.
- One of the practice nurses in conjunction with a dietician, deliver a programme about diabetes to newly diagnosed patients with type II diabetes. This is provided across the Bristol area.
- The practice carried out joint patient consultations with local mental health teams and worked closely with drug addiction project workers to ensure better outcomes for patients.
- The practice had 401care plans in place for patients with complex needs.
- One of the practice nurses had identified a gap in patient recording which collated information about long term conditions. They developed a form for all staff to use, integrated it into the patient record system and shared with other local practices.

The Easton Family Practice

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to The Easton Family Practice

The Easton Family Practice, Charlotte Keel Health Centre, Seymour Road Easton. Bristol. BS5 0UA; is located a short distance from junction three of the M32 and close to Bristol city centre.

The practice is part of the Bristol Clinical Commissioning Group and has approximately 5,400 patients. The practice shares the Charlotte Keel Health Centre facilities with another practice. Facilities include seven consulting rooms, a phlebotomy room (for carrying out blood tests in) and shared reception and waiting areas, shared treatment rooms. There is level access into the practice and to all patient areas. Toilets are accessible with separate facilities for patients with disabilities and a baby changing area. Parking is available on site and close to the practice. There are a range of administrative and staff areas including a meeting area on the first floor of the building. There is lift access to the first floor. The practice is a registered GP training location.

There are two full time male partners in the practice and two part time female salaried GPs. There is one female registrar GP also working in the practice. In addition there are two practice nurses and a practice manager working in the practice. The practice manager supports 15 reception and administration staff. A business manager works one day a week to support the practice manager.

The patients come from a wide range of backgrounds, with at least 5% who require translation services which are located within the health centre. Approximately 38% of patients come from Black and other ethnic minority groups with about 20% of patients coming from Somali and North African cultural backgrounds. The patient list size is slowly increasing by around 2.5% yearly and is a predominantly a young population. Only 3% of patients are over 75 years. The area has high unemployment and social problems associated with inner city areas such as drug, alcohol use and substance misuse.

The practice has a Personal Medical Services (PMS) contract to deliver health care services, the contract includes enhanced services such as extended opening hours. This contract acts as the basis for arrangements between the NHS Commissioning Board and providers of general medical services in England.

The practice has opted out of providing out-of-hours services to their own patients. This is provided by another organisation and patients are directed to this service by the practice during out-of -hours.

Why we carried out this inspection

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

Detailed findings

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We asked the provider to send us information about their practice and to tell us about the things they did well. We carried out an announced visit on 4 December 2014.

We talked with the majority of staff employed in the practice. This included three GPs and a registrar GP, two practice nurses, the practice manager, the business manager and six administrative/reception staff. We spoke with five members of the patient participation group, four patients visiting the practice during our inspection and received comment cards from a further 21 patients. We also spoke with staff working in the health centre from the other practice as well as health visitors, translators, school nurses and security staff.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, where a patient had presented with verbally challenging behaviour in the busy waiting area. We saw this incident had been reported, investigated and action had been taken. We observed a similar incident at the end of our inspection and saw the practice staff, in partnership with health centre staff had effective approaches in handling these types of incidents.

We reviewed safety records, incident reports and minutes of meetings where these events were discussed for the last 12 months. We saw these occurrences were also discussed during staff appraisals. Documents showed the practice had managed these events and incidents consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice shared the health centre with another practice and learnt from previous incidents and events. To enhance patient and staff safety whilst in the practice, security staff had been employed.

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 were a standing item on the partners meeting agenda and weekly lunchtime meetings. A dedicated audit meeting was held annually to review actions from past significant events and complaints. There was evidence from meeting minutes and from the staff we spoke with that the practice had learned from these and that the findings were shared with relevant staff. For example, providing home visits to housebound patients. 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.

Staff used incident templates on the practice intranet and sent completed forms to the practice manager. We saw the system used to manage and monitor incidents. We tracked three incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example, where an elderly housebound, patient with diabetes had a hypoglycaemic episode which in turn led to a stroke. This had initiated a home visiting service from the community nurse for such patients. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated by the senior partner to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. For example, Ebola outbreak risks for patients traveling to and from Africa. They also told us alerts were discussed at practice meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

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 the majority of staff had received relevant role specific training on safeguarding either through attending training or using online learning tutorials. 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 particularly aware of cultural signs of abuse such as honour maiming and forced marriage. 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 such as the local authority or the police. Contact details of these agencies were easily accessible in the practice and on the practice computer system.

The practice had GPs with lead responsibility for safeguarding vulnerable adults and children. They had been trained to level 3 for safeguarding children and separately for vulnerable adults. They could demonstrate through their training records they had the necessary

training which enabled them to fulfil this role. All staff we spoke with were aware who had lead responsibility, and who to speak to 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 alerts to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans and adults living in vulnerable circumstances.

The practice rarely used chaperones, this was due to the fact that female patients did not choose to see male doctors, as it was culturally incorrect. There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. All nursing staff, including health care assistants, had been trained to be a chaperone. If nursing staff were not available to act as a chaperone, one receptionist had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

A safety system and process had been put in place which enabled all patients to see and communicate with their GP. About 40% of patients were from Black and Minority Ethnic groups (BME) and about 5% of consultations required an interpreter. The practice had access to the health centres interpretation service to supplement one of the practices GPs who spoke 5 languages. These facilities enabled patients to communicate clearly and ensured safe patient treatment.

Medicines management

We checked medicines stored in the shared treatment room and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy which ensured medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice had a prescribing manager who ensured practice staff followed the policy.

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. The system for ordering medicines for the practice was carried out by an administrator and did not account for the stock available or the rate of usage of some items.

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example, patterns of antibiotic, hypnotics and sedatives and anticoagulant prescribing within the practice. The review showed 10 of the 14 patients reviewed had commenced alternative anticoagulant medicines. One patient who was not well controlled on one anticoagulant medicine had not tolerated an agreed change and was now prescribed regular injections to manage their diagnosed condition.

The nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. Both practice nurses were qualified independent prescribers and received regular supervision and support in their role as well as updates in the specific clinical areas of expertise for which they prescribed.

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 as these were tracked through the practice and kept securely at all times.

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. Where the patient participation group had raised the cleanliness of toilets throughout the day, we saw a cleaner had been contracted to clean toilet areas during the day. This was in addition to routine daily cleaning when the practice was closed.

The practice had identified one of the practice nurses to have lead responsibility for infection control. They had undertaken further training which enabled them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual

updates. We saw hygiene and infection control signage in patient and staff areas such as hand washing instructions and reminders of needle stick injury procedures. There was also a policy for needle stick injury.

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. Staff were able to describe how they used these to comply with the practice's infection control policy. For example, we saw one of the nurses wearing protective gloves wiping down surfaces following a patient examination.

We saw hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. Waste bins were foot operated, functioned correctly and had appropriate coloured bin liners to help segregate waste. Clinical waste was disposed of in line with national guidance and was stored securely until removed by a waste contractor. The practice carried out routine infection control audits. The last audit was carried out on 20 November 2014 by the practice nurse, a GP and the practice manager. Where actions had been identified such as, ensuring all pillows in treatment rooms had waterproof coverings, we saw these had been completed.

Equipment

Staff we spoke with told us they had sufficient equipment which enabled them to carry out diagnostic examinations, assessments and treatments. We saw that single use items were used where possible. Staff told us that all equipment was tested and maintained annually and we saw equipment maintenance records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, blood pressure monitors and the fridge thermometers.

Staffing and recruitment

Records we looked at 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 it followed when recruiting clinical and non-clinical staff.

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 that ensured 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. Newly appointed staff were required to read the practices 'briefing folder' to ensure they were aware of policies and current communications. They signed a section to state they had read and understood the relevant contents. Reception staff also signed this folder when updates were added following prompt emails from the practice manager

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. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

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 were managed in conjunction with the premises manager and included annual and monthly checks of the building, the environment, dealing with emergencies and equipment. The practice also had a health and safety policy as guidance for staff. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

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 that any risks were discussed at GP partners' meetings and within team meetings. For example, the practice manager had shared the recent findings from a health and safety meeting with the team which showed further cleaning of carpeted areas would be requested.

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 emergency processes in place for patients with

long-term conditions. Staff gave us examples of regular reviews which highlighted the need for referrals to be made for patients whose health deteriorated suddenly. Staff gave examples of how they responded to patients experiencing a mental health crisis or lapses in behaviour due to substance misuse. We saw how staff handled this type of behaviour in line with practice guidance during our inspection.

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 and included access to oxygen and an automated external defibrillator (AED) (An AED is a portable electronic device that automatically diagnoses the life-threatening cardiac arrhythmias of ventricular fibrillation and ventricular tachycardia in a patient, and is able to treat them through defibrillation. The application of electrical therapy which stops the arrhythmia, allowing the heart to re-establish an effective rhythm). 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 practice had learned from this appropriately.

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

A business continuity plan was in place to deal with a range of emergencies that may have impacted 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 utility company to contact if the heating, lighting or water systems failed.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. The policy covered joint arrangements with the other practice in the health centre. Records showed that staff were up to date with fire training and that they practised fire drills and alarm testing.

Risks associated with service and staffing changes (both planned and unplanned) were required to be included on the practice risk log. We saw an example of this and the mitigating actions that had been put in place to manage this. For example, the process for informing NHS England about the incapacity of a GP and the process for covering other staff who may have long term absence.

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 patient treatment. They were familiar with current best practice guidance and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. The GPs and nurse practitioners had access to local, national and international online resources which allowed them to use evidence-based treatment options to care for patients. They were aware of the Bristol Clinical Commissioning Group's (CCG) integrated care pathways and collaborated with neighbouring practices through the CCG links to enhance such systems, services and pathways.

The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure 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. We saw from records we looked at that where NICE guidelines were referenced this was recorded on patient records.

The GPs told us they took a lead in specialist clinical areas such as infection control, cardiology and dermatology. We saw the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. For example, GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of skin disorders. Our discussions with a range of staff confirmed that this happened.

The practice had completed a follow up review of case notes for patients with coeliac disease which showed all received appropriate treatment and the majority had regular blood tests. The practice used codes on patient notes which enabled computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital, which required patients to be reviewed within four weeks by their GP according to need.

The practice pharmacist had carried out reviews on patients being discharged from hospital with multiple medicines. They were offered surgery appointments or if this was not possible they visited them at their own home to carry out medicines reviews and care plan updates.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. We saw minutes from partners meetings where regular reviews of elective and urgent referrals were made, and that improvements to practice were shared with all GPs and nurses. We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making. This was reflected in the comments made by the patients we spoke with who told us they received prompt referrals to consultants or specialists.

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, managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager or the practices pharmacist to support the practice to carry out clinical audits.

The practice showed us six clinical audits that had been undertaken in the last year. Four of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, increased patient uptake of flu vaccinations following appointment letters having been sent out. Other examples included audits to confirm that the GPs who undertook minor surgical procedures were doing so in line with their registration and NICE guidance.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). QOF is a national performance measurement tool. The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 88% of patients with diabetes had an annual medication review, and the practice met all the minimum

Good

Are services effective?

(for example, treatment is effective)

standards for QOF in diabetes, asthma and chronic obstructive pulmonary disease ((COPD) lung disease). Where the practice was an outlier for one QOF or other national clinical targets it could possibly be accounted for by the sensitive cultural nature of the issue. For example, the uptake of cervical screening in female patients aged 25 and over in an area known to have a higher prevalence of female genital mutilation. The practice worked with interpreters and the local community through educational clinics to improve the take up of this type of screening.

The team made use of clinical audit tools, clinical supervision, appraisals 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 and how clinical staff should undertake at least one audit a year.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question.

The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area. For example, the average daily quantity of hypnotics prescribed for specific age and gender groups. The practice had outcomes that were better than other services in the area. For example, the number of anti-inflammatory medicine items prescribed was now better than the required standard stated in guidance.

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 saw there was a good skill mix among the GPs with one GP having additional diplomas in sexual and reproductive medicine, one with diplomas in children's health and one with diplomas in dermatology and cardiology. All GPs were up to date with their yearly continuing professional development requirements and all either had 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 NHS England can the GP continue to practise and remain on the performers list with the General Medical Council).

All staff undertook 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, the practice pharmacist was supported to attend training about primary care factors that influence hospital admissions to help inform research they are carrying out. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to the senior partner GP throughout the day for support. We received positive feedback from the trainee we spoke with.

The practice used a number of measures to assess clinical competence. For example, the prompt completion of referrals, prompt communication of blood test results and completion of practice notes. They also used the annual appraisal processes to highlight learning needs, as well as clinical meetings to monitor competence. The computerised clinical system allowed for an audit trail between the time tasks were allocated to the GP or nurse to the time the task had been completed.

The senior GP partner took a lead role in mentoring and supporting the GP trainee and the practice nurses where appropriate. Both GP partners supervised and assisted the salaried GPs. Regular weekly meetings provided opportunities for peer discussions and support to maintain best practice and support future decision making. Every two weeks there was an educational/clinical meeting covering subjects such as domestic violence. There were significant event meetings once a month. Important information was communicated during group or one-to-one meetings, or by email.

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,

Good

Are services effective?

(for example, treatment is effective)

cervical cytology and diabetes clinics. Those with extended roles for example, respiratory clinics were also able to demonstrate that they had appropriate training to fulfil these roles.

Staff files we reviewed showed that where poor performance had been identified appropriate action had been taken to manage this.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage complex diagnoses. 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 reading, passing on and acting on any issues that arose 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. There were no instances within the last year of any results or discharge summaries that were not followed up appropriately.

The practice held multidisciplinary team meetings monthly to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by health visitors, community nurses, social workers, school nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and stated 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 which enabled patient data to be shared in a secure and timely way. Electronic systems were also in place for making referrals, and the practice made the majority of referrals last year through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use.

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

We spoke with members of the link worker translation service located in the health centre. They told us and we saw how the practice worked closely with interpreters based in the health centre and shared basic patient information with these staff. The interpreters provided information to the GPs which enabled clear identification of patient symptoms and addicted in the diagnosis and treatment of patients. Where the interpreters assisted during clinics a similar two way information exchange took place.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the GPs and nurses we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff, for example, when to involve an independent mental capacity advocate. This policy highlighted how patients should be regarded as having capacity unless assessed otherwise, supported to make their own decisions and how these should be documented in the medical notes.

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 required it. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity or the understanding to make a decision. For example, we heard how interpreters were used to support patient understanding and how GPs set appointment times to 30 minutes to give patients more time to consider treatment choices.

Good

Are services effective?

(for example, treatment is effective)

All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures. We saw records which showed 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.

Health promotion and prevention

The practice had met with the public health team from the local authority and the clinical commissioning group (CCG) to discuss the implications and share information about the needs of the practice population identified by the joint strategic needs assessment (JSNA). The JSNA pulls together information about the health and social care needs of the local area. This information was used to help focus health promotion activity.

It was practice policy to offer a health check with the health care assistant or the practice nurses to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering smear testing to patients aged 25 - 64 and offering smoking cessation and lifestyle advice to smokers when attending routine appointments.

The practice also offered NHS Health Checks to all its patients aged 40-75. Practice data showed that 48 patients in this age group took up the offer of the health check this year with a significant number of patients not attending booked appointments. The practice had followed up these patients and had fully booked appointments until the end of February 2015. A GP explained to us how patients were followed up within two weeks if they had risk factors for disease identified at the health check and how they scheduled further investigations.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and all were offered an annual physical health check. Practice records showed the majority had received a check up in the last 12 months. The practice had also identified the smoking status of patients over the age of 16 and actively offered nurse-led smoking cessation clinics to these patients. There was evidence these were having some success. Similar mechanisms of identifying 'at risk' groups were used for patients who were drug, alcohol or substance misusers, obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for cervical smear uptake was 59%, which was below others in the CCG area due to cultural values of the local population. There was a policy to offer another appointment and telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend annually. There was a named nurse responsible for following up patients who did not attend screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was in line with other similar practices in the CCG, there was a clear policy for following up non-attenders by the practice nurses and administration staff.

The practice kept a register of older patients who were identified as being at high risk of admission to hospital, who were taking multiple medicines or who were nearing the end of their life. An up to date care plan was in place for these patients and the information was shared with other providers such as the out of hour's service. All vulnerable older patients discharged from hospital had a follow-up consultation where it was required. Follow-up consultations were also made opportunistically during routine appointments.

100% of patients in this age range had been offered cognition testing. A similar percentage of patients with a new diagnosis of dementia recorded had a record of calcium, glucose, renal and liver function, thyroid function tests, serum vitamin B12 and foliate levels recorded. We saw evidence through meeting minutes of multidisciplinary case management meetings having taken place for the most vulnerable patients in this age range. Each patient over 75 years was provided with a named accountable GP.

The practice was proactive in identifying patients who had either a genetic or an increased likelihood towards developing long-term conditions. The practice had 401care

Good

Are services effective?

(for example, treatment is effective)

plans in place for patients with complex needs. These plans were shared with community and secondary care services as well as the out of hour's and ambulance services where appropriate.

Patients with long term conditions had structured annual reviews for various conditions such as diabetes, chronic obstructive pulmonary disease (COPD) and heart failure. Patients with a diagnosis of diabetes had routine access to clinics and other services such as blood testing and advice. The practice also provided drop-in educational sessions about diabetes for patients who did not have English as a first language. We saw an education session during our inspection which focussed on foot care which helped empower patients to learn more about their illness so they could reach appropriate decisions about diet and lifestyle. The patients told us through the interpreters how useful they found the sessions. A dietician worked with the practice nurses to deliver a programme of support to patients who were newly diagnosed with type II diabetes. This was a Bristol wide initiative called "living with diabetes".

The most vulnerable patients with long term conditions had a summary care record which was shared with other providers such as the out of hour's service. We saw from the patient records we looked at there was clear documentation of health promotion and lifestyle advice in the patients notes. We saw evidence through meeting minutes of multidisciplinary case management meetings having taken place for the most vulnerable patients with long term conditions.

Families, children and young patients had access to a range of services within the practice and those provided in the health centre. These included, ante natal services, baby clinics, family planning and sexual health clinics, access to specialist children's dental services and speech therapy.

Immunisation rates for all standard child immunisations such as, infant meningococcal vaccinations and measles, mumps and rubella were in line with those in other local practices however some booster vaccinations had a lower uptake rate due to the movement of patients to other areas and some cultural resistance to immunisations. We saw information was available for young patients visiting the practice about sexual health and the clinics and services available to them, for example, contraception advice. We spoke with the midwives, school nurses and health visitors who worked in or were visiting the practice. All told us about multidisciplinary working with the GPs and nurses in the practice and of regular meetings with the practice.

Working age patients had access to a range of appointments outside of normal practice times. These appointments included late evening appointments. These could be booked via an online facility or by telephone. Health checks were offered when these patients attended routine appointments as were cervical smears and blood pressure checks. The practice provided a range of lifestyle information for this group of patients including how to get support for managing stress at work, depression and other mental health problems. A range of social prescribing was used by the practice to support the working population remain well. For example, where patients were overweight they could be prescribed access to short fitness courses or weight loss groups. For other patients, referrals to walking groups or counselling services were provided to improve their wellbeing.

Flexible appointment times including same day telephone consultations were available to working age patients. The practice routinely saw patients from 8.40 am to 6:00 pm and had extended hours on Tuesday evening. The practice also provided appointments on one Saturday morning each month. The GPs told us they saw patients until the last patient had been seen, this was confirmed by patients we spoke with.

A range of additional in-house services including, phlebotomy (blood tests), spirometry (a test that can help diagnose various lung conditions), international normalized ratio (INR) blood tests monitoring, NHS health checks and minor surgery were provided.

When referrals were required we heard from patients that choice was offered via the Choose and Book system. On-line prescribing and appointments had been introduced.

Patients whose circumstances may make them vulnerable were identified on a register in the practice. The list included those patients from various vulnerable groups for example, patients with learning disabilities, patients who had drug or alcohol problems and children on the at risk register. All patients with learning disabilities received annual follow-up appointments and medicines reviews.

Good

Are services effective?

(for example, treatment is effective)

The practice worked closely with and referred patients to a local service that assesses and meets the initial health needs of asylum seekers and new refugees arriving in Bristol. Asylum seekers were provided with urgent appointments until they were granted asylum or were deported. Similar working relationships were in place for referring patients to a refugee centre in the city.

We saw and heard about evidence of multidisciplinary team working to assist in the care management of vulnerable patients. We saw the local drug project provided a recovery orientated clinic for patients in the practice one day each week. The project worker we spoke with told us the practice actively engaged with and supported the patients accessing the project and made routine referrals to them. They also told us the GPs continued to support patients who could no longer be supported by the project to ensure they had access to relevant health care. We saw evidence of signposting patients to a range of support groups and third sector voluntary organisations for example, Bristol specialist drug and alcohol service, addiction recovery agency and Alcoholics Anonymous.

Patients who experienced poor mental health were provided with a range of services through referrals to locally based services, for example, Child & Adolescent Services (CAMHS) and Adult mental health services. The practice carried out joint patient consultations with local mental health teams to ensure greater continuity of treatment for the patient and improved information sharing for the professionals involved. For example, in the types and choices of treatment available to the patients.

The GPs and practice nurses had received training in learning disabilities, mental health and dementia. The practice was able to evidence a positive dementia detection rate. In keeping with many inner-city practices mental health is a high priority. We saw evidence of early diagnosis of dementia for elderly patients from the care plans the practice produced. For those patients with a diagnosis of dementia, we saw they had advanced care plans in place. We saw referrals to speech and language therapists and psychological services were also made. Carers of these patients were identified and referrals were made to a local carers organisation to enable them to receive support if they required it, as well as the Carer's National Association.

A named accountable GP was available to patients who experienced poor mental health with flexible appointment times including same day emergency appointments and telephone consultations. Staff were trained to be sensitive to patients distress and offered extended appointment times when appropriate. GPs and nurses were informed immediately of any undue distress shown by patients so they could speak with the patient and provide an earlier appointment.

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 GP National Patient Survey, a survey of over 120 patients undertaken by the practice's patient participation group (PPG). The evidence from all 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 'average' for patients who rated the practice as good or very good. The practice was above average for its satisfaction scores on consultations with doctors and nurses with 90% of practice respondents saying the GP was good at listening to them and 92% saying the GP gave them enough time.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 21 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with a total of nine patients and patient participation group members on the day of our inspection. All told us they were very satisfied with the care provided by the practice and said their dignity and privacy was respected.

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 observed that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The reception desk was a short distance from the queuing system which helped keep patient information private. In response to patient and staff suggestions, a system had been introduced to allow only one patient at a time to approach the reception desk. This helped prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and saw that it enabled confidentiality to be maintained.

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

Patients whose circumstances may make them vulnerable or who experienced poor mental health were able to access the practice without fear of stigma or prejudice. Staff treated all patients from these groups in a sensitive manner. Equality and diversity and managing challenging behaviour training had been made available to staff on how to deal sympathetically with all groups of people. An interpreting service was available in the practice and was used by staff to help understand patient's needs.

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 rated the practice well in these areas. For example, data from the national patient survey showed 79% of practice respondents said the GP involved them in care decisions and 85% felt the GP was good at explaining treatment and results. Both these results were in line with the CCG area average performance. The results from the practice's own satisfaction survey showed that 85% of patients said they were sufficiently involved in making 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. We saw GPs worked flexibly which ensured patients had sufficient time

Good

Are services caring?

to be listened to and supported in ways which helped provide effective outcomes for their health and wellbeing needs. Patient feedback on the comment cards we received was also positive and aligned with these views.

We saw that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available and observed staff actively used this service. One GP spoke five different languages which they could use to communicate with their patients or help other GPs communicate with their patients. Where patients spoke languages not spoken by the interpreter service we saw a telephone translation service was also available.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with told us they were positive about the emotional support provided by the practice and rated it well in this area. The comment cards we received were also consistent with this patient information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required. This information was further corroborated by the thank you cards we saw and from comments made by patient participation group members we spoke with.

Notices in the patient waiting room, leaflets and the practices website told people 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 saw written information available for carers which ensured they understood the various avenues of support available to them and saw how the translation service helped them to understand the information.

Staff told us if families had experienced a bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and by giving them advice on how to find a support service. Patients we spoke to who had had a bereavement confirmed they had received this type of support and said they had found it helpful.

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 Area Team and Bristol 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. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. For example,

- Improve health awareness – what can help us feel well
- Prevent illness
- Help people manage their own care effectively
- Reduce hospital admissions
- Provide more community support to help people remain at home

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). For example, the waiting room experience had been improved by introducing a queuing system and by asking patients to be more considerate to others. Reception staff had been provided with updated training in communication. Waiting times were now explained to patients and access to appointments had been improved with GPs working until all patients had been seen. Toilets were now cleaned during the day to improve appearance and hygiene.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, services for asylum seekers, those with a learning disability or travellers, unemployed, carers and those patients whose first language was not English. The practice had access to practice, online and telephone translation services and a GP who spoke five languages. One of the GP partners told us about 5% of their consultations were provided with the assistance of interpreters.

The practice provided equality and diversity training through e-learning for all staff. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months. The most effective ways of working with local ethnic groups and vulnerable patients was discussed at staff appraisals and team events.

The practice actively supported patients who had been on long-term sick leave to return to work by referring them to other services such as physiotherapists, counselling services and by providing 'fit notes' for a phased or adapted return to work.

The premises and services had been designed to meet the needs of patients with disabilities. There was level access into the practice and parking spaces for patients who were disabled. All GP and nurse consulting rooms were on the ground floor, where access was needed to the first floor meeting room or practice managers office, a lift was available. The practice had wide corridors to enable access for patients with mobility scooters. This made movement around the practice easier and helped to maintain patients' independence.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and pushchairs and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice, facilities included baby changing facilities.

The practice provided services for patients whose circumstances made them vulnerable. The practice kept a register of patients they were aware of who lived in vulnerable circumstances and had a system for flagging vulnerability in individual records. Patients were able to register with the practice irrespective of their circumstances, including those with "no fixed abode". Patients not registered with the practice were able to access appointments by speaking with reception staff who arranged for them to see the next available GP or nurse.

Access to the service

Appointments were available from 8:40 am to 6:00 pm on weekdays although we saw and heard how GPs saw

Good

Are services responsive to people's needs?

(for example, to feedback?)

patients until each one visiting the practice had been seen. We saw the practice also offered appointments until 7.15pm on Tuesdays and one Saturday morning surgery each month. The health centre which provided some services to patients was open from 8:30 am to 6:30 pm Monday to Friday.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information about the out-of-hours service was provided to patients.

Standard appointments of 10 minutes were provided to patients however, longer appointments were also available for people who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to local care homes, asylum centres and hostels by a named GP and to those patients who needed these visits.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of their choice due to holidays or other absences. Comments received from patients showed that patients in urgent need of treatment were able to make appointments on the same day of contacting the practice. For example, one patient we spoke with told us how they called the practice that morning and were seen by a GP later that morning.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system. Simple complaints leaflets were available in the practice and information was available on the practices website. Comments and suggestions were also encouraged through forms provided in the waiting areas. 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 eight complaints received since the start of the year which had been provided verbally, in writing or by email. We found all had been managed in line with the practices complaints policy. The complaints had been dealt with in a timely way and the practice had been open and transparent when dealing with the complaint. We saw staff had spoken with the patient involved, had sent an apology or had been invited into the practice to discuss the events leading to the complaint.

The practice reviewed complaints regularly to detect themes or trends. The outcomes of these reviews were discussed at monthly meetings and lessons learned from individual complaints had been acted on. We saw and heard about shared learning from complaints with staff and other stakeholders such as health centre staff to help improve facilities. Minutes of team meetings showed complaints were discussed which ensured all staff were able to learn and contribute to determining any improvement action that might be required.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's strategy and business plan. The practice vision and values included,

- providing high quality general practice services to all patients,
- being a practice where staff would like to be patients,
- being accessible with enough appointments to meet patient's needs,
- treating all patients as individuals, with respect and dignity,
- promoting the health and wellbeing of the local community through the clinical commissioning group (CCG) and working together with other organisations,
- working with the patient representative group to improve the quality of services provided, and
- working as a team.

These values were in the practices statement of purpose and the12 members of staff we spoke with told us they knew and understood the vision and values of the practice. They also told us they knew what their responsibilities were in relation to these and in promoting a patient centred ethos.

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 12 of these policies and procedures, 10 policies and procedures we looked at had been reviewed annually and were up to date. Two policies were in the process of being reviewed to include new ways of working that the practice had introduced.

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 and a salaried GP had lead responsibility for safeguarding vulnerable adults and children. All members of staff we spoke with 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 or ideas for service improvement.

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

The practice nurse told us about a local peer review, practice nurse forum, system they took part in with neighbouring GP practices. The forum provided peer review and learning opportunities. We looked at the information from the last meeting, which showed that the practice had the opportunity to share learning and measure its service against others and identify areas for improvement. For example, delivering, in conjunction with a dietician, a programme about diabetes to newly diagnosed patients with type II diabetes. The program is called "living with diabetes" and is provided across the Bristol area.

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, significant events, patient records, coeliac disease management and palliative care audits. In regard of a significant event audit, a change to the way housebound patients were supported had been implemented.

The practice had robust arrangements for identifying, recording and managing risks. The practice manager showed us the risk log, which addressed a wide range of potential issues, such as health and safety, infection control and maintaining business continuity. We saw that the risk log was regularly discussed at team meetings and updated in a timely way. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. For example, in enhancing staff and premises security by employing security guards.

The practice held regular governance meetings. We looked at minutes from the last meeting and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

Are services well-led?

Good

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

We saw from minutes that team meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. We also heard from the patient participation group about how the GP partners were open and transparent in the way they engaged with the group.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example, recruitment procedures, induction policy and management of sickness which were in place to support staff. We were shown the staff handbook which was available to all staff, it included sections on equality and harassment and bullying at work. Staff we spoke with told us they knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, comments made via forms on the practices website and complaints received. We looked at the results of the annual patient survey and 85% of patients agreed the practice was good, very good or excellent. We saw some aspects were viewed less favourably for example, information about services. We saw as a result of this the practice had updated its website and put more information about services on noticeboards in the waiting areas.

The practice had an active patient participation group (PPG) which had slowly increased in size. The PPG included representatives from various population and ethnic groups, however the members told us they felt younger patients were under represented. The PPG had carried out annual surveys and met two or three times a year. The practice manager showed us the analysis of the last patient survey, which was reviewed in conjunction with the PPG. The results and actions agreed from these surveys were available on the practice website.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any improvements, concerns or issues with colleagues and management. One member of staff told us that they had asked for specific training around diabetes at a staff meeting and this had happened. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. For example, one of the practice nurses had identified a gap in patient recording which collated information about long term conditions. They developed a form for all staff to use. This form was adopted by the practice, integrated into the patient record system and shared with other local practices.

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

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at four staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had staff meetings where guest speakers and trainers attended. Opportunities to attend further training and development were made available and staff could gain skills to take on other roles. For example one member of administration staff had received training to become a health care assistant.

The practice was a GP training practice and currently supported one GP registrar. (A GP Registrar is a qualified doctor who is training to become a GP through a period of working and training in a practice. They will usually have spent at least two years working in a hospital before being placed in a practice and are closely supervised by a senior GP or trainer). The registrar we spoke with commented positively about the supervision and support provided by the GPs in the practice and in the way the practice delivered services to patients.

The practice openly recognised good performance and devotion to work. For example, the practice pharmacist spoke enthusiastically about support she received from the partners and how the practice financed and supported her to attend conferences and courses which were relevant to her role.

There was clear leadership visibility in the practice with the lead GP and the practice manager having regular contact with all the practices staff. The small size of the practice team meant visibility is easier to achieve. The team had a unified vision for the future of the practice with patient centred care at the centre of daily practice.