Dr C.P.C. Paxton & Partners

Quality Report

Courtside Surgery
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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 Courtside Surgery on 21 April 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, well-led, effective, caring and responsive services. It was also good for providing services for the population groups of older patients, patients 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 and people experiencing poor mental health (including people with dementia).

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned following an appraisal.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- We saw patients were able to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

We saw areas of outstanding practice:

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- The practices patient participation group were very active in the promotion of health awareness and had been instrumental in organising and delivering a number of health awareness events for patients. These included raising awareness of nutrition, men's health, dementia, paediatrics and caring for carers.
- The practice is a member of the Prime Ministers challenge fund "One Care" pilot project which aims to use technology to improve access to primary care, manage demand effectively and improve the quality and consistency of care delivered. These services include the use of online platforms to manage appointments, repeat prescriptions and consultations and integrated patient records with read and write access to patient records across the area.
- The executive partner had a lead role in the Clinical Commissioning Group for IT, their interests place the practice at the forefront of IT usage in GP practices. They were one of the first practices in the country to provide electronic signing in for patients and were early adopters for online services. The use of IT had enhanced access to appointments for patients.

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

Importantly the provider should:

- Review how the sharing of updated guidelines used to support consistent patient care can be evidenced.
- Review the reception area to support patient confidentiality.
- Review how the practices vision and business plan is promoted with staff and patients.
- Review governance arrangements to ensure learning from significant events, complaints and audits is clearly documented and disseminated.

Review how the practices whistleblowing policy can be promoted to all staff.

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 amongst relevant teams 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 from our information management team showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and local guidance from the Clinical Commissioning Group (CCG). Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data from the most recent National GP Patient Survey 2015 showed that patients rated the practice highly 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 England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they were able to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was

Summary of findings

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 relevant staff.

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 their roles and 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 meetings where these were discussed however, some aspects of governance arrangements could be improved. 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 very active and provided a number of educational events on behalf of the practice. 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 had 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.

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. Patients at risk of hospital admission were identified as a priority for appointments and health checks. 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.

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 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.

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

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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 people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks for most people with a learning disability and these patients had received a follow-up appointment with a GP where indicated. It offered longer appointments for people 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.

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 majority of people experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND and locally based 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. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

We spoke with three members of the patient participation group during the inspection and received five comment cards from patients who visited the practice. We saw the results of the last Patient Participation Group report dated March 2015. The practice also shared their initial findings from their current 'friends and family' survey. 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 National GP patient survey published on 8 January 2015 and the Care Quality Commission's information management report about the practice.

The majority of comments from patients were positive and praised the GPs and nurses who provided their treatment. For example; about receiving good care and treatment, about seeing the same GP at most visits and about being treated with respect and consideration.

We heard and saw how patients found access to the practice and appointments easy and how telephones were answered after a brief period of waiting. Some comments from the National GP Patient Survey indicated it was not always easy to get through to the practice during the first hour of the practice opening, with 70% of patients saying it was easy to get through. The most recent GP survey showed 97% of patients found the appointment they were offered was convenient for them. Patients also told us they used the practices online booking systems to get appointments.

Patients told us their privacy and dignity was respected during consultations and they found the reception area was generally private enough for most discussions they needed to make. We saw 89% of patients said they found the receptionists at this practice helpful. Patients told us about GPs supporting them at times of bereavement and providing extra support to carers. A large number of patients had been attending the practice for over 10 years and told us about how the practice had grown, they said they were always treated well and received good care and treatment. The GP survey showed 83% 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 and periodically it was refurbished and improved repeat prescription facilities had been added. They told us during intimate examinations GPs and nurses wore protective clothing such as gloves and aprons and that examination couches were covered with disposable protective sheets. 90% of patients described their overall experience of this practice as good.

Areas for improvement

Action the service SHOULD take to improve

There were areas of practice where the provider needs to make improvements. Importantly the provider should:

- Review how the sharing of updated guidelines used to support consistent patient care can be evidenced.
- Review the reception area to support patient confidentiality.
- Review how the practices vision and business plan is promoted with staff and patients.
- Review governance arrangements to ensure learning from significant events, complaints and audits is clearly documented and disseminated.
- Review how the practices whistleblowing policy can be promoted to all staff.

Outstanding practice

We saw areas of outstanding practice:

- The practices patient participation group were very active in the promotion of health awareness and had

Summary of findings

been instrumental in organising and delivering a number of health awareness events for patients. These included awareness of nutrition, men's health, dementia, paediatrics and caring for carers.

- The practice is a member of the Prime Ministers challenge fund "One Care" pilot project which aims to use technology to improve access to primary care, manage demand effectively and improve the quality and consistency of care delivered. These services include the use of online platforms to manage appointments, repeat prescriptions and consultations and integrated patient records with read and write access to patient records across the area.
- The executive partner had a lead role in the Clinical Commissioning Group for IT, their interests place the practice at the forefront of IT usage in GP practices. They were one of the first practices in the country to provide electronic signing in for patients and were early adopters for online services. The use of IT had enhanced access to appointments for patients.

Dr C.P.C. Paxton & Partners

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 Dr C.P.C. Paxton & Partners

Dr C.P.C. Paxton & Partners, Courtside Surgery, Kennedy Way, Yate, Bristol. BS37 4DQ is located close to the centre of Yate near Bristol. The premises are purpose built and have a privately run pharmacy adjacent to the practice. The practice has approximately 14,100 registered patients. The practice accepts patients from an area North of the M4 which includes, Yate, Chipping Sodbury, Westerleigh, Frampton Cottrell, Wickwar and Hawkesbury.

There are 10 partners who are complemented by two salaried GPs and a team of clinical staff including practice nurses, phlebotomists, and health care assistants. Six partners are female and four are male, the hours contracted by GPs are equal to 6.22 whole time equivalent employees. The two salaried GPs are male and equal to 1 whole time equivalent employees. Collectively the GPs provide 65 patient sessions each week. Additionally there are four nurses including a nurse manager employed equal to 2.78 whole time equivalent employees and three health care assistants/phlebotomists equal to 1.6 whole time equivalent employees employed. Non-clinical staff included secretaries, IT staff, support staff and a small management team including a practice manager. A practice pharmacist employed by the Clinical Commissioning Group supports the practice one day a week.

One of the practice GPs is a South Gloucestershire Clinical Commissioning Group (SGCCG) GP governing body member, with a clinical lead for information management and technology. The practice manager is the SGCCG governing body practice manager representative. The practice has been accredited by the Severn Deanery as a GP training practice; there are two GP trainers.

The practice population ethnic profile is predominantly White British with an age distribution of male and female patients equivalent to national average figures. The average male and female life expectancy for the practice is 81 and 85 years respectively, both figures are slightly above the national average and may reflect the generally lower levels of deprivation in the area. The National GP Patient Survey published in January 2015 indicated 87% of patients said they would recommend the practice to someone new to the area.

The practice has a Personal Medical Services (PMS) contract to deliver health care services; the contract includes enhanced services such as extended opening hours, online access and diabetes services. 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 service is provided by BrisDoc 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 the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as part of our regulatory

Detailed findings

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.

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 such as the South Gloucestershire Commissioning Group and Healthwatch 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 reviewed the information for patients on the practices website and carried out an announced visit on 21 April 2015.

We talked with the majority of staff employed in the practice who were working on the day of our inspection. This included five GPs, two practice nurses, a health care assistant, the nurse manager, the practice manager, the reception manager and four administrative and reception staff. We spoke with three members of the patient participation group and received comment cards from a further five patients.

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, 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, by reporting significant events and safeguarding concerns to lead members of staff.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last twelve months. This review showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last twelve months and we were able to review these. Significant events were discussed at a dedicated significant event meeting which was held monthly to review actions from past significant events. 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.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. They showed us the system used to manage and monitor incidents. We tracked four incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result for example, changing prescribing of A1 blockers for patients who had cataracts (Al blockers are medicines that work by blocking the alpha1-receptors of vascular smooth muscle, thus preventing the uptake of hormones by the smooth muscle cells. This causes vasodilation and allows blood to flow more easily). 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 nurse manager to clinical staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were shared by email and saved to the practices intranet to ensure all staff were aware of any that were relevant to the practice and where they needed to take action. For example, recent medicines guidance about specific medicines now contraindicated in patients with certain established cardiovascular diseases.

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 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 in policies on the practices intranet which we saw.

The practice had appointed a dedicated GP with lead responsibility for 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 had received safeguarding training about adults and children. All staff we spoke with were aware who the lead GP was 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; for example children subject to child protection plans and adults living in vulnerable circumstances. 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 GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as the police and social services. Where the lead GP attended

child protection meetings they wrote up notes about the meetings in patient records. An alert was also placed on the patient record to show other GPs updated notes were available. However this required GPs to open patient notes to see this information rather than awareness being raised through a general communication with the clinical team.

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). All nursing staff, including health care assistants, had been trained to be a chaperone and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. Read codes were used on patient records to identify those who had chosen to use this support or who may have preferred to use this facility.

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.

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 stored and disposed of in line with waste regulations.

We saw records of practice audits that noted the actions taken in response to a review of prescribing data. For example, patterns of thyroid testing and medicines prescribing within the practice. Information was shared with GPs about recommended start doses for thyroid medicines and when testing should be carried out. These changes had been implemented and the new guidance was noted as being complied with.

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 patient group and patient specific directions and evidence that nurses and the health care assistant had received appropriate training to administer vaccines.

All prescriptions for new medicines were reviewed and signed by a GP before they were given to the patient. Repeat prescriptions were managed through a supervised team of prescribing clerks and were often sent electronically to the pharmacist. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard, access to them was restricted and the keys held securely in a separate location. There were arrangements in place for the destruction of controlled drugs.

Practice staff undertook regular audits of controlled drug prescribing to look for unusual quantities, dose, formulations and strength. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

Cleanliness and infection control

We observed the premises to be clean and tidy and clutter free. 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 member of staff with lead responsibility 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. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence of the infection control lead having carried out audits and that any improvements identified for action were completed on time. Minutes of practice meetings showed that the findings of the audits were discussed. We noted that where the cleaning contractor carried out audits there was no evidence of involvement by practice staff which could result issues not being discussed.

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 would use these types of equipment to comply with the practice's infection control policy. For example, during minor surgery or intimate patient examinations. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury. We saw this procedure was available in all treatment rooms.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. Infection control training included hand washing.

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).We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Cleaning materials were managed in accordance with control of substances hazardous to health (CoSHH) guidance. Information leaflets for the products were available to staff. Materials were stored securely. Clinical waste was stored securely in line with Environment Agency guidance.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records such as certificates and stickers on equipment 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, spirometers, blood pressure measuring devices and the fridge thermometer. Storage areas for gasses such as oxygen were clearly marked as was the location of the emergency equipment.

Other equipment for example fire extinguishers were also serviced and tested annually in line with fire safety requirements. Fire alarms and emergency lighting were also routinely tested and serviced in line with the practices fire policy. The security alarm was tested annually and a fire evacuation test had been completed earlier this year.

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. All GPs and nurses were seen to be registered with their relevant organisations.

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 or sickness absence.

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 included six monthly checks of the building, daily checks of the environment, routine medicines management, daily staffing checks and regular equipment checks. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there were clearly identified health and safety representatives. The employer insurance certificate was also clearly displayed and in date.

We saw 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

Good

Are services safe?

long-term conditions. Staff gave us examples of referrals made for patients whose health deteriorated suddenly. The nominated GPs made weekly 'ward round' type visits to patients in local residential and nursing homes to carry out routine monitoring and to use information gathered to update care plans for the most vulnerable patients. Routine visits were carried out at a home for people with a learning disability where patient need was identified. In conjunction with the health visitor and midwife emergency processes were in place for acute pregnancy complications.

Staff gave examples of how they responded to patients experiencing a mental health crisis or due to substance misuse. We saw there were referral mechanisms in place to support these patients as well as services provided on site such as a weekly drug and substance misuse service.

A system was in place to ensure staff safety. The practice had a system which alerted other staff in the practice to a potential problem and who was involved.

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.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. 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 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. This information was made available in staff areas and on the practices intranet.

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 and that they practised regular fire drills.

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 best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. However the guidance was not recorded as having been shared and discussed at practice meetings, which could lead to inconsistencies in approaches to patient care. Recording references to guidelines was not routinely recorded in patient records by some GPs. We noted 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 had lead responsibility in specialist clinical areas such as clinical research, prescribing, cancer, admissions avoidance and alcohol dependency. The practice nurses supported this work through specialisms in the management and treatment of conditions such as diabetes, heart disease and asthma. These skills allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support as a direct result of the benefits of them being a teaching practice. GPs told us this supported all staff to continually review and discuss best practice for a range of disorders and conditions.

The executive GP partner provided us with data from the local CCG of the practice's performance for nonsteroidal anti-inflammatory drugs (NSAIDs), this was comparable to similar local practices. The practice had also completed a review of case notes for patients who were being prescribed with the combined oral contraceptive which showed all were receiving appropriate treatment and regular review if they had a body mass index above 35. The practice used 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 two weeks or sooner by their GP according to identified need.

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, they were referred and seen within two weeks. We saw minutes from meetings where regular reviews of elective and urgent referrals were made, and that improvements to practice were shared with all clinical staff.

Patients were supported to monitor their own conditions through the provision of loaned equipment. The practice provided blood pressure monitoring equipment to patients. The practice also provided access to electrocardiography (ECG) within the practice and had reduced the need for patients to attend hospital for this type of testing (ECG is commonly used to detect abnormal heart rhythms and to investigate the cause of chest pains). We saw this equipment was used routinely where patients were complaining of chest pains during GP consultations.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed 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 and deputy practice manager to support the practice to carry out clinical audits.

The practice showed us eleven clinical audits that had been undertaken in the last three years. The majority of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, pulse checking for patients potentially at risk of strokes. A programme of pulse checking was carried out which identified patients with atrial fibrillation (AF). An electrocardiograph (ECG) had also been carried out for these patients. Changes to medicines had helped reduce the risk of strokes in these patients and an on-going

programme of pulse checking and ECGs was used to identify further at risk patients. Other examples included fragility fractures, bowel screening and care home admissions.

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 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, we saw an audit regarding the prescribing of analgesics and nonsteroidal anti-inflammatory drugs. Following the audit, the GPs, with the help of the CCG pharmacist, carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 99.8% of patients with diabetes had annual retinal screening, and the practice met all the minimum standards for QOF in diabetes/asthma/ chronic obstructive pulmonary disease (lung disease). This practice was not an outlier for any QOF (or other national) clinical targets. Provisional QOF figures shared with us for 2014/15 showed the practice had achieved maximum points for all aspect of the service measured.

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 that 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 and, where they continued to prescribe it they outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a clear understanding of best treatment for each patient's needs.

The practice worked to the Gold Standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

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 or better than other services in the area. For example, antibacterial drug prescribing.

Doctors in the surgery undertook minor surgical procedures in line with their registration and National Institute for Health and Care Excellence (NICE) guidance. The staff were appropriately trained and kept up to date.

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

All staff undertook annual appraisals 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, diabetes management and management of long term conditions. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP and other GPs throughout the day for support.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, about administration of

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Are services effective?

(for example, treatment is effective)

vaccines, cervical cytology. Those with extended roles such as seeing patients with long-term conditions such as asthma, chronic obstructive pulmonary disease (COPD), diabetes and coronary heart disease 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 of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. 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 identified within the last year of any results or discharge summaries that were not followed up appropriately.

The practice was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the policy for actioning hospital communications was working well in this respect. The practice undertook a yearly audit of follow-ups to ensure inappropriate follow-ups were documented and that no follow-ups were missed.

The practice held multidisciplinary team meetings approximately 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 district nurses, health visitors, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. 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 made the majority of referrals last year through 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). Staff reported that this system was easy to use.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. We saw this was a straightforward task and staff we spoke with highlighted the importance of this communication with A&E. The practice had signed up to the electronic Summary Care Record and this was fully operational (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record (EmisWeb) to coordinate, document and manage patients' care; this was supported by other software which integrated into the system. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. Software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Consent to care and treatment

We found that staff we spoke with were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff 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 a process to help staff, for example, with making do not attempt resuscitation orders. This policy highlighted how patients should be 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 dictated it and had a section

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Are services effective?

(for example, treatment is effective)

stating the patient's preferences for treatment and decisions. The practice kept records and showed us the majority of care plans had been reviewed in last year. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies and we saw records which showed these competencies had been considered. (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).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's written consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure. We were shown evidence that confirmed the consent process for minor surgery had been followed in all cases.

The practice had not needed to use restraint in the last three years, and staff were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

The practice had met with the Public Health Local Area 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 practice nurse to 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 and nurses to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering where appropriate, chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers or referring to counselling services.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed 360 patients in this age group took up the offer of the health check. A GP showed us how patients were followed up within two weeks or sooner 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 70% had received a check up in the last 12 months. The practice had also identified the smoking status of the majority 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 as the number of patients who had stopped smoking in the last 12 months had increased. Information from the practice showed the success rate for the last group smoking cessation course had a 40% success rate. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs such as counselling, weight monitoring club referrals and carer support groups.

The practice's performance for cervical smear uptake was 85.6%, which was better than others in the CCG area and above the national average. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend. There was also 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 above average for the CCG with many results showing 100% achievement, again there was a clear policy for following up non-attenders by the named practice nurse.

The practices patient participation group were very active in the promotion of health awareness and had been instrumental in organising and delivering a number of health awareness events for patients. These included awareness of nutrition, men's health, dementia, paediatrics and caring for carers. They were currently planning to

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(for example, treatment is effective)

provide an event about cancer awareness on 29 April 2015 with an on-going programme for the rest of the year. The practice and external organisations actively supported the well-attended events.

Population group evidence

The practice kept a register of older patients who were identified as being at high risk of admission to hospital or who were nearing the end of their life. All had up to date care plans and these were shared with other providers such as the out of hour's service. Older patients who were prescribed multiple medicines all received a structured annual medicines review. The majority (90.5%) of older patients diagnosed with dementia had a face-to-face review in the preceding 12 months.

All patients aged 75 and older were informed of their named accountable GP. The practice had organised their GPs into teams to cross cover each other and improve continuity of care for older patients. They used a risk stratification tool provided by the clinical commissioning group (CCG) to identify the patients most at risk of hospital admission. The practice ensured all high risk patients, had a personalised care plan that was reviewed at regular intervals. For all these patients the practice was able to offer one longer appointment to develop the patients care plan in more depth.

The practice provided an enhanced service to local residential and nursing homes, providing a weekly visit to review all patients with clinical needs. There were nominated GPs with responsibility for individual care homes. They carried out three monthly reviews of all patients living in nursing homes. All new patients were seen by the nominated GP within one week of moving into the home.

Extended hours over and above those contracted enabled all patients to visit the practice at a time convenient to them. Telephone consultations were also available for less mobile, housebound or working patients.

Patients with long term conditions who were at high risk of admission to hospital had a tailored care plan which had been agreed with them. For those patients with chronic obstructive pulmonary disease (COPD) and heart failure, a supplementary section of their care plan advised them about managing their conditions. This added information helped avoid unnecessary hospital admissions. The care plans were regularly reviewed and where appropriate the patient was discussed at regular multi-disciplinary team meetings.

Carers of patients with long term conditions were identified where possible and their details were added to the patients' records.

Nurses had received additional specialist training in a number of long term conditions, including coronary heart disease, hypertension, chronic obstructive pulmonary disease (COPD), asthma, and diabetes. The practice operated a recall and review programme for patients with long term conditions, inviting them to an appointment with the specialist nurses in the month of their birth. Enhanced services for near patient testing were also provided with international normalized ratio INR testing available within the practice (INR is a test of blood clotting, which is primarily used to monitor warfarin therapy). Initiating insulin conversion was also provided within the practice. (The initiation of insulin is an important stage in the management of type 2 diabetes).

The practice shared details of care plans with the out of hours service, and through participation in the One Care consortium (One Care Consortium is provided across the Bristol, North Somerset and South Gloucestershire area delivering innovative ways of using technology to improve access to primary care, and improve the quality and consistency of care delivered) were able to arrange GP review appointments at weekends.

The practice offered health promotion advice for this group of patients through its practice nurses, including the NHS health checks. The patient participation group (PPG) had organised a range of successful patient information events for this group of patients including events about smoking cessation, nutrition and depression.

The practice had an identified GP lead for safeguarding children who met once a month with the local health visiting team. Any pre-school age children on a child protection plan were discussed to ensure the practice was aware of any specific issues or changes relating to these children. Children not on a child protection plan but who were of concern to the health visitors were also discussed to assist in the early identification of need and to ensure an early offer of help was made. All children discussed at these meetings had a code added to their notes to aid

Good

Are services effective?

(for example, treatment is effective)

identification by clinicians. Minutes of meetings were written up by the lead GP and entered on patients records. We saw more detailed minutes of the meetings were available to clinicians via the practice intranet.

The clinical system included alerts on the records of children subject to child protection plans. Notes were reviewed for indicators that increased the risk of a child being vulnerable, for example, adults in the same household with drug and alcohol dependency or serious mental illness. Notifications of domestic abuse were also added to children's records where they lived in the household of the victim.

Regular child development assessments took place through the health visiting team. The practice operated an open door policy for health visitors if they wished to discuss concerns. Where concerns were raised the practice would see the child that day if concerns were immediate. Any child identified as having mental or physical health problems was offered age appropriate information, support and were signposted to other appropriate agencies. Their families were also supported in a similar way.

The practice offered a full range of primary and pre-school immunisation through a regular baby clinic run to coincide with the health visitor clinic on Monday afternoons. Additional clinics were provided when necessary. The surgery operated a recall programme for immunisations for all children in accordance with national specifications for vaccination and immunisation. Contraceptive services for women were routinely provided, in addition to offering coil fitting, implants as well as other forms of contraception. A coil fitting and wellbeing service was also offered for women who would benefit from this service.

The duty doctor prioritised seeing children at the urgent surgery sessions.

Children and young people were treated in an age appropriate way and are recognised as an individual, with their preferences considered. There was a child friendly area in the waiting room.

The practice provided appointments from 7:30 am to 7:40 pm to enable patients of working age to book appointments that were convenient for them. These could be booked online or via a telephone touch tone system 24hrs a day. About one third of all appointments were available by these methods and were promoted in the waiting areas and on the practices website. An urgent assessment clinic approach, through sit and wait appointments was available. The practice ensured working age patients could always be seen when they become acutely unwell.

Online services for repeat prescriptions are also available. Prescriptions were sent electronically to the pharmacy of the patient's choice to improve access to medicines.

The practice offered telephone consultations to patients who were unable to attend the practice due to work commitments. Where clinically necessary, the practice also arranged weekend appointments through the One Care Consortium (One Care Consortium is provided across the Bristol, North Somerset and South Gloucestershire area delivering innovative ways of using technology to improve access to primary care, and improve the quality and consistency of care delivered). The practice also offered a range of further services for example, in house phlebotomy and health checks.

The practice had prompts on their appointment system advising GPs and nurses that a patient would need assisting into the consulting room if disabled or vulnerable. There was good access for patients who used wheelchairs or mobility scooters in and around the practice and a hearing loop and communicator device were available for hearing impaired patients. A separate reception interview room was available for patients who wanted to speak in private to a receptionist or other member of staff.

The practice arranged sign language interpreters for deaf patients which patients could request by email.

The practice had been proactive in considering their population needs, including for people in vulnerable circumstances. They proactively identified deaf patients, patients with learning difficulties, patients with sight loss, patients with poor English language skills and the local fairground owning community.

There were support services for patients with drug and alcohol and substance dependency problems, with a dedicated drug worker and specialist alcohol nurse seeing patients at the surgery each week.

One of the GPs had a lead role for ensuring services were available and appropriate for patients with learning

Good

Are services effective?

(for example, treatment is effective)

difficulties. The designated GP provided direct access by phone for the carers at two main local homes for patients with severe learning difficulties and was always the GP to do home visits to those patients.

Patients were encouraged to participate in health promotion activities, such as breast screening, cytology and smoking cessation. Access to a local support service was also provided to help patients engage where they struggled to understand the benefits of such activities.

The practice supported patients with a diagnosed mental health problem through access to named skilled GPs. Appointments were routinely made with these GPs to support continuity of care. Care was tailored to the patient's individual needs and circumstances with attention also paid to the patient's physical health and wellbeing needs.

For patients with long term mental health problems for example, schizophrenia, the practice arranged a longer annual appointment with their regular GP. During this comprehensive appointment the patient's physical health was reviewed, blood tests were carried out; medicines were reviewed along with their support network and care plan. For patients who took more complex psychiatric medication, their blood tests were carried out more frequently as recommended in care pathway guidelines.

When seeing patients in care homes GPs reviewed the mental health needs of the patients they saw. Patients experiencing a mental health crisis were seen the same day and referrals were made to local specialist psychiatric services. GPs described to us how they routinely liaised with specialist psychiatric services when treating patients with complex mental health problems. A private counselling service was available for patients in the practice if patients choose and they were provided with access to NHS services for example, 'Lift' counselling. On-going staff training and clinical meetings were provided to staff in support of these patients. Recent meetings had involved a consultant psychiatrist who provided an update about antidepressant medicines.

Good

Are services caring?

Our findings

Throughout our inspection we observed a whole practice team who placed the patient at the centre of their work. The practice was aware of the needs of the local population, and through proactive engagement with the patient participation group, provided caring and supportive services. A wide range of appointments as well as sit and wait clinics ensured patients had access to care and support when they needed it. Information from the National GP Patient Survey January 2015 showed 90% and 94% of patients had confidence and trust in the last GP and nurse they saw or spoke with respectively.

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the National GP Patient Survey, January 2015, the March 2015 Practice Patient Participation group (PPG) report and the NHS Choices website. 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 'among the best' for patients who rated the practice as good or very good. The practice was also above average for its satisfaction scores on consultations with doctors and nurses with 84% of practice respondents saying the GP was good at listening to them and 83% saying the GP gave them enough time.

Patients completed Care Quality Commission comment cards to tell us what they thought about the practice. We received five completed cards and all 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. Patient participation group members all told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so 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 conversations taking place in these rooms could not be overheard.

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 practice switchboard was located away from the reception desk and was located in a separate area of the building which helped keep patient information private. In response to patient and staff suggestions the practice encouraged only one patient at a time to approach the reception desk. A separate location was available to electronically sign in for appointments. This was designed to prevent patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained at quieter times. At busier times the queue was such that patients were grouped around the reception area, potentially compromising confidentiality. During our observation of this no patients complained to us or staff about confidentiality concerns. The practices patient participation group (PPG) and practice were working on a solution to this issue.

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 she would investigate these and any learning identified would be shared with staff.

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 77% of practice respondents said the GP involved them in care decisions and 84% felt the GP was good at explaining treatment and results. Both these results were average compared to the South Gloucestershire Clinical Commissioning Group area.

Patient participation group members we spoke with on the day of our inspection told us that health issues were discussed with them and they felt fully involved in decision

Good

Are services caring?

making about the care and treatment they received. They also told us they felt listened to and supported by caring 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.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. The patient participation group (PPG) members we spoke with on the day of our inspection and the comment cards we received were also consistent with these views. For example, the National GP patient survey highlighted that staff responded compassionately (83% stated, with care and concern) when they needed help and provided support when required.

Notices in the patient waiting room, on the TV screen and patient website also 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.

Staff told us that 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/or by giving them advice on how to find a support service. PPG members we spoke with 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 England Area Team and South Gloucestershire Clinical Commissioning Group (SGCCG) 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. These included; making the healthy choice, the easy choice; tackling health inequalities; making the best start in life; fulfilling lives for all; ageing well and accessing the right services in the right place, at the right time.

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, creating a child friendly area of the waiting room, improving access to car parking and finding ways to improve the reception area.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, those with a learning disability, the unemployed, carers and the local fairground community

The practice had a population of 99% English speaking patients though it could cater for other different languages through translation services. The practice had access to online and telephone translation services.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training during their induction period when commencing employment and that equality and diversity was discussed at staff appraisals and team events.

The premises and services had been purpose built to meet the needs of patients with disabilities There were parking spaces for patients with disabilities and level access into the practice. Automatic opening doors assisted access into the building and there was sufficient space for wheelchair users and parents with pushchairs to manoeuvre safely. There were accessible toilets and baby changing facilities. All consulting and treatment rooms had level access and were only a short distance from the waiting area. A privately run pharmacy was located adjacent to the practice and enabled patients to access prescribed medicines easily.

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.

Access to the service

Appointments were available from 7:30 am on weekdays. Appointments were available up to 8:00 pm on Monday, Tuesday and Thursday with the last appointments starting at 7:40 pm. The practice closed at 7:00pm on Wednesday and Friday. Bookable weekend appointments were available via the One Care Consortium which the practice was piloting. Urgent appointments and sit and wait appointments were also available daily.

Telephone calls into the practice were monitored by the reception manager through a call centre system. The telephones were manned at a higher level during peak times such as early mornings with less staff at other times of the day. More staff could be brought in to assist if the need arose. We saw there were very few delays and if they did occur they were for one or two minutes. We heard staff offering a choice of appointments to patients.

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 on the out-of-hours service was provided to patients.

Longer appointments were available for patients who needed them and for those with long-term conditions. This

Good

Are services responsive to people's needs?

(for example, to feedback?)

also included appointments with a named GP or nurse. Home visits were made to 10 local care, nursing and supported living homes on a specific day each week, by a named GP and to those patients who needed one.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

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. We noted that information about advocacy services to support patients who wished to make a complaint was not included in the leaflet. This information was however available on practice noticeboards. 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 for example, posters displayed in the waiting area, a complaints leaflet available in the waiting area and on the practices website. Patient group members 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 a small sample of eight complaints received in the last 12 months and found these were satisfactorily handled, dealt with in a timely way with openness and transparency. We saw letters were sent to patients explaining the outcome of their complaint. However, these letters did not explain to patients where they could take any unresolved issues from their complaints. The practice had not reviewed complaints in the last year to detect themes or trends but had maintained a log of all complaints and a record of actions taken. We were told by the practice manager lessons learned from individual complaints had been acted on but had not been recorded on the complaints log. We saw the practice had responded to complaints on the NHS Choices website.

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 patient centred care, creating a friendly environment for patients and staff, creating a respectful and dignified environment which responds to patients' needs and to work collaboratively with other organisations and the trainees it supports as a teaching practice. The vision was supported by business objectives which covered improvement, up skilling staff, embedding new record systems, continued leadership with IT solutions and expanding service provision.

We spoke with six members of staff and they all knew and understood what their responsibilities were in relation to these, although their awareness of the vision was limited.

Governance arrangements

The practice had a range 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 eight of these policies and procedures and most staff confirmed that they had read each policy and when. All eight policies and procedures we looked at had been reviewed annually and indicated they were up to date. The policies we looked at included the practices policy about Information and Clinical Governance. We noted in the Information and Clinical Governance policy a lack of detail about how the clinical performance of the practice would be monitored, who was responsible and how learning would be shared. For example, how learning from significant events, complaints, guidance and other activities could be used to measure how the practice had performed and to identify if they could have done anything better.

We saw separate documents which showed who was responsible for governance arrangements. We saw evidence of information and guidance received and shared. We observed informal discussions taking place between GPs and nursing staff about patient care and practice issues. We saw minutes from a range of meetings which showed information was shared in individual staff teams. Where minutes were taken there was not always a structured agenda or a system of reviewing the previous minutes. Conversely some meetings were clearly structured and documented for example, periodic educational meetings, significant event and multidisciplinary team meetings. However these aspects of performance were not drawn together and analysed through specific governance meetings. This could result in a loss of opportunity in providing potential improvements in the way the practice functioned. The practice recognised these as potential shortcomings which were explained by recent staff issues. They now had a more stable staff base and agreed to put measures in place to improve the way governance was evidenced.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control, the senior partner leading for clinical research and a partner had lead responsibility for safeguarding. We spoke with eight members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns. They also told us they felt encouraged and supported to attend additional training or gain additional qualifications; training records indicated staff gained additional qualifications.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. Each GP and nurse had responsibilities for different aspects of QOF and enhanced services. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at management meetings and action plans were produced to maintain or improve outcomes. QOF data provided by the practice for 2015 showed they had achieved maximum points in all areas.

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. Audits included areas such as back pain, attendance at health checks and screening, medicines prescribing, fragility fractures and blood pressure monitoring. The majority were complete cycles with about 25% covering more than one cycle. Identifying how learning was shared following these audits was difficult due to informal meetings not being minuted.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us the

Are services well-led?

Good

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

risk log, which addressed a wide range of potential issues, We saw 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 facilities and providing better integration of IT systems across multiple agencies.

Leadership, openness and transparency

We saw from minutes that management team meetings were held regularly, approximately weekly. 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.

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

The executive partner had a lead role in the clinical commissioning group for supporting the use and development of IT within GP practices. As a result of this involvement and the partner's enthusiasm for IT the practice was one of the first to implement touch screen appointment signing in. The practice is a member of the Prime Ministers challenge fund "One Care" pilot project which aims to use technology to improve access to primary care, manage demand effectively and improve the quality and consistency of care delivered. These services include the use of online platforms to manage appointments, repeat prescriptions and consultations and integrated patient records with read and write access to patient records across the area.

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

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received. We reviewed a report on comments from patients between June 2014 and March 2015, which had no common themes. The practice manager showed us improvements that had been made in response to comments which included re-enabling the patient call reminder on the waiting area TV screens.

The practice had a very active patient participation group (PPG) with about 11 active members and a further 20 virtual members. The PPG included representatives from various population groups including, the working population, patients with long term conditions and older patients. Six members of the practices staff were also involved regularly in the PPG meetings. The PPG met approximately every quarter. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys are 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 concerns or issues with colleagues and management. One member of staff told us that they had asked for specific training about supporting diabetes treatment and this had happened. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice. Two GPs we spoke with told us they were unaware of this policy. However, they said they felt confident that if they raised concerns within the practice they would be treated seriously and would be responded to. They knew they could raise concerns to organisations outside the practice if they felt concerns were not responded to.

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 five 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 sessions where guest speakers and trainers attended.

The practice was a GP training practice with two GPs as trainers. There was one trainee in post at the time of our inspection who had access to the trainers as well as other partners for advice and opinion throughout their appointments.