Frome Valley Medical Centre

Quality Report

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

Ratings

Overall rating for this service	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Outstanding ☆
Are services caring?	Good ●
Are services responsive to people's needs?	Outstanding ☆
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 Frome Valley Medical Centre on April 29 2015. Overall the practice is rated as outstanding.

Specifically, we found the practice to be outstanding in providing effective and responsive services and good for providing safe, caring and well led services. We found the practice provided outstanding care for older people, people whose circumstances may make them vulnerable and people experiencing poor mental health (including people with dementia).

They provided good care for people with long term conditions; families, children and young people and working age people.

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.
- 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.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice was undergoing a management restructure however 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 several areas of outstanding practice:

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- The practice employed a prescribing coordinator to manage hospital discharges to increase continuity of care to patients after discharge from hospital and to implement effective systems to manage the recall of patients on medication (for blood tests).
- The practice provided additional GP support to local nursing and residential homes including weekly ward rounds, education sessions for staff and advanced care planning.
- The practice ran a monthly multidisciplinary team meeting and virtual ward round for any person registered at the practice who required additional health support. Voluntary and charitable organisations were a part of this team. For example the Independent Mental Capacity Advocacy service.
- The practice had won two awards for clinical innovation for a project for frequent attenders which resulted in increased patient satisfaction and reduced referrals to secondary care and GP consultations. The project has been taken on as a clinical trial by a local university.
- The GP's use the BATHE (Background, Affect, Trouble, Handling, Empathy) programme during consultations to help patients learn skills and develop confidence to manage their own health.
- The practice had proactively engaged with safeguarding concerns and changed working practice in order to identify potential abuse early in residential homes. This included a falls policy which had reduced the number of patient falls by 100%.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

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

We found the practice had reliable processes for safeguarding people at risk of or experiencing abuse. The practice had initiated additional protocols to identify and manage potential abuse in other organisations.

Are services effective?

Outstanding

The practice is rated as outstanding for providing effective services. Our findings at inspection showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence guidelines and other locally agreed guidelines. Data showed that the practice was performing highly when compared to neighbouring practices in the Clinical Commissioning Group. The practice used innovative and proactive methods to improve patient outcomes and it linked with other local providers to share best practice. For example the practice had initiated a virtual ward round where partner agencies including voluntary organisations could admit a patient to a virtual ward for additional health care and support.

The practice had won two awards for clinical innovation for the implementation of a Frequent Attenders project which reduced face to face GP consultations, reduced referrals and admissions and showed an increase in patient satisfaction.

The practice employed a prescribing coordinator whose role was to review hospital discharges. We saw that this system worked well and increased continuity of care for patients.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions

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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?

Outstanding 

The practice is rated as outstanding for providing responsive services. The practice had initiated positive service improvements for its patients. These included the management of patients at risk of falls; patients with a learning disability and patients from the travelling community.

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly and appropriately to issues raised. The practice acted on suggestions for improvements and changed the way it delivered services in response to feedback from the patient participation group (PPG).

Are services well-led?

Good 

The practice is rated as good for being well-led. It had a clear vision and values. Staff were clear about the vision and their responsibilities in relation to this. We inspected during a change in management structure however we saw a clear leadership structure with evidence of an environment in which clinical excellence could flourish. Staff felt supported by clinical leaders during the change in practice governance. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions and regular performance review.

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The six population groups and what we found

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

Older people

Outstanding ☆

The practice is rated as outstanding 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 for those with enhanced needs. Every patient over 75 had a named GP including those in residential and nursing homes. Older people were offered longer appointment times and monthly multidisciplinary team meetings were held for this group.

The practice also held weekly multidisciplinary meetings were an older person who needed increased support of health or social needs could be admitted to a virtual ward where actions would be taken. For example we saw evidence that the virtual ward reduced hospital admission; improved care after hospital discharge and identified patients who required end of life care (who did not have a cancer diagnosis.

We found the practice engaged with the local nursing home providing a weekly ward round with two GP's who had joint responsibility for the residents. We saw evidence that this had significantly improved communication between the home and the practice leading to better personalised care for all residents. All new patients were reviewed on admission, relatives were invited to attend and meet with the GP. Advanced care plans were developed on admission which included patient's wishes and end of life planning. The GP's also provided training for the nursing home staff, for example training was provided on identification and management of a patient who has had a stroke and a head injury. We saw evidence that following the training for staff on stroke identification a resident had had early identification of a stroke by unqualified staff which had led to immediate hospital admission and expedited medicines to allow for a fuller recovery. We saw that the joint working had reduced hospital admissions and visits by the out of hours doctor service. We spoke to the nursing home manager who told us that since the introduction of the ward rounds, communication had excelled and all residents received personalised continuity of care.

We found integrated working arrangements between health and social care. The practice worked collaboratively with charitable and voluntary organisations such as the Princes Carers Trust who ran

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monthly clinics at the practice, Age UK who ran foot clinics and two local befriending groups. These organisations were able to refer patients to the practices monthly multidisciplinary team meeting and virtual ward.

We saw evidence that the practice continued to develop and improve services for older people. For example the practice was engaged with the community health provider in a pilot project for the Better Care Fund initiative which aimed to ensure local people received better care. The practice had also instigated a falls policy to identify at risk patients and refer patients for support. We saw that as a result of this policy there had been a 100% reduction in falls in one care home.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and initiatives had been put in place to allow patients to manage their condition more effectively. For example, the practice had a coordinated review system to reduce the need for separate appointments for each long term condition and patients were able to submit results of self-monitoring through the practice website. Patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a 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 relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with health visitors and school nurses. The practice worked with Off The Record which provided free counselling to young people and No Worries, a scheme where young people could visit any GP practice for advice with no questions asked.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, early morning and late evening clinics were available and a GP was always on the premises during lunch in case working people needed to speak to a GP. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs of this age group.

People whose circumstances may make them vulnerable

Outstanding

The practice is rated as outstanding for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, people from the travelling community and those with a learning disability.

The practice had carried out annual health checks (using an accredited system which included a health action plan) for people with a learning disability and offered longer appointments for this patient group. We saw examples of good and close working relationship developed by the learning disability lead GP with the community learning disabilities team and local learning disability nursing home staff and patients families. This ensured that people with a learning disability received equal access to health care; health issues specific for this population group were taken into account; improved health outcomes and dignity of this group was not reduced due to a patient's ability. We saw evidence to support that the practice achieved this. We saw evidence that the named GP coordinated multidisciplinary end of life care which included robust care plans.

The practice provided flexibility for the local travelling community to allow access to health care. Any appointments not attended were followed up and the practice telephoned patients to remind them of outpatient appointments. The practice provided a fortnightly clinic for patients with substance misuse.

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. We saw that the practice

staff ensured that protection of their vulnerable patients was paramount to the care they provided for example, following concerns for the protection of patients in a local residential home the practice had produced protocols on management of falls which included referral to other agencies.

The practice had engaged with the South Gloucestershire Partnership Against Domestic Abuse (SGPADA) IRIS project (Identification and Referral to Improve Safety for women) to support identification and referral of victims. As domestic abuse impacts on health the practice staff had received training in relation to domestic abuse identification and referral pathways for victims and their families. Police incident reports were cascaded daily to GPs and there were care pathways that ensured identification and onward referral and care of victims of domestic abuse. We saw evidence that Police reports resulted in patient contact and support.

People experiencing poor mental health (including people with dementia)

Outstanding ☆

The practice is rated as outstanding for the care of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia and worked with patients and families to ensure any do not attempt cardiopulmonary resuscitation decisions were appropriate and kept under review. We saw evidence that the practice regularly worked with Independent Mental Capacity Advocates and community health teams to ensure that decisions made for patients were within their best interests. The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. One GP represented the practice at a local dementia study group to ensure GP's remained up to date with best practice.

The practice won two awards for their Frequent Attender project which included allocating each frequent attender a named GP who knew them best; development of bespoke care plans and the use of the BATHE techniques. BATHE represents a series of questions for the patient (Background, Affect, Trouble, Handling, Empathy) aiming to identify the problem and why they were struggling to deal with it, and offering ways to improve their confidence in addressing the issue. Patients were also offered participation in a patient support group, including a quarterly meeting with the programme psychologist and a quarterly newsletter. We saw evidence that the result of the initial project resulted in reduced health costs, better use of health resources and increased confidence and skills of patients in managing emotional / psychological and physical

Summary of findings

symptoms. The project included reflective templates for GP's to complete following consultations; psychologist led patient support groups and high patient satisfaction (measured from patient surveys). We saw evidence that the project resulted in positive health outcomes for patients including increased confidence which reduced reliance on health services. We also saw that the practice utilised the BATHE technique with other patient groups to improve patient care.

Summary of findings

What people who use the service say

We spoke with two patients visiting the practice and two members of the patient participation group (PPG) during our inspection. We reviewed 17 patient comment cards from our Care Quality Commission (CQC) comments box that had been placed in the practice prior to our inspection. We saw the comments were generally positive. Patients told us the practice was clean and hygienic; staff were caring and empathetic whilst treating patients with dignity and respect; staff were helpful and provided a good service. Some patients told us that they experienced problems getting a routine appointment and would have to wait two weeks to see a GP of their choice.

The practice had an active PPG with 24 members. The PPG members we spoke with told us the GP's actively engaged and supported the group and the staff were aware of the different needs of the practice population. The GP partners attended all PPG meetings and were receptive, interested in improving patient experience and proactive. We were told about the PPG survey (January 2015) which was the first one the group had completed and saw the 2015 annual PPG report. We could see evidence during our inspection that the practice was in the process of addressing some of the reports priority areas such as looking at email correspondence and online web consultations, to increase communication methods and lowering the reception desk to prevent discrimination of people in wheelchairs. The PPG told us the quality of medical service was outstanding and gave us examples such as working to improve information received from hospitals with regards to patient discharges, the recall system for regular blood tests and end of life care.

We looked at the NHS Choices website to look at comments made by patients about the practice. (NHS Choices is a website which provides information about NHS services and allows patients to make comments about the services they received). We saw that four out of the five reviews since June 2014 were positive. The practice had responded appropriately to the other review.

We looked at data provided in the most recent NHS GP patient survey (January 2015) and the Care Quality Commission's information management report about the practice. 90% of patients describe their overall experience of this practice as good.

We also looked at the data provided by NHS England for the Friends and Family Test (FFT) in February 2015. The FFT is a feedback tool which offered patients of NHS-funded services the opportunity to provide feedback about the care and treatment they have received. 48 out of 52 (92%) patients would recommend the service they had received to their friends and family.

Outstanding practice

- The practice employed a prescribing coordinator to manage hospital discharges to increase continuity of care to patients after discharge from hospital.
- The practice provided additional GP support to local nursing and residential homes including weekly ward rounds, education sessions for staff and advanced care planning.
- The practice ran a monthly multidisciplinary team meeting and virtual ward round for any person registered at the practice. Voluntary and charitable organisations were a part of this team. For example the Independent Mental Capacity Advocacy service.
- The practice had won two awards for clinical innovation for a project for frequent attenders which resulted in increased patient satisfaction and reduced referrals to secondary care and GP consultations. The project has been taken on as a clinical trial by a local university.
- The GP's used the BATHE (Background, Affect, Trouble, Handling, Empathy) programme during consultations to help patients learn skills and develop confidence to manager their own health.
- The practice provided flexibility in appointments and support for vulnerable patients.

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- The practice had proactively engaged with safeguarding concerns and changed working practice in order to identify potential abuse early in residential homes. This included a falls policy which had reduced the number of patient falls by 100%.
- The practice engaged with other organisations to run additional services such as a carers' clinic, foot clinic and substance misuse clinic.
- The practice had an effective medicine systems to manage recall of patients on medication (for blood tests) and for managing medicines following hospital discharge.

Frome Valley Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The team included a GP, practice nurse and practice manager.

Background to Frome Valley Medical Centre

Frome Valley Medical Centre provides primary medical services to approximately 14,500 patients living in Frampton Cotterell and surrounding villages in South Gloucestershire on the north eastern outskirts of Bristol. The practice has a pharmacy and some complimentary health services within the building. The practice provides primary care to four residential homes and one nursing home as well as a residential site for the traveling community.

The South West UK Census data (2011) shows 96% of the population are recorded as white British. Public Health England's national general practice profile shows the practice has a significantly lower population of patients aged between 20 and 39 years old and a higher than England average group of patients aged over 65. The practice population has low levels of deprivation (8.1%) compared with the local CCG average of 11.2% and England average of 22.1%.

The surgery was purpose built and is owned by the GP partners. The building is set over two floors with patient access to the first floor by lift. It has an access ramp to the entrance of the building and a large car park with disabled parking. There is a separate reception area with an automated arrival system and spacious waiting room.

The practice team includes six GP partners and three salaried GP's (with a total of five female GP's); a nurse manager; two advanced nurse practitioners, three practice nurses; three healthcare assistants; two phlebotomists; prescribing coordinator and administration staff. This accounted for 40 members of staff. At the time of our inspection the practice had commenced a change to the management structure in order to increase efficiency in all areas and improve care systems. This meant that on the day of our inspection the practice did not have a full time practice manager in post. A locum practice manager was in post and available during our inspection. The registered manager was on sabbatical during our inspection and an interim registered manager had been appointed. The practice is an accredited training practice for GP trainees, foundation year trainees and medical students. We saw very positive feedback from a previous student and University with regards to the training provided by the practice.

The practice also worked with community staff including Health Visitors and District Nurses who were based at the practice; a Midwife; Community nurse for older people; an Emergency Care Practitioner (commissioned by South Gloucestershire Clinical Commissioning Group to provide urgent home assessments); a Physiotherapist; Occupational Therapist; Counsellors and a Drug and Alcohol Counsellor. The practice worked closely with two local voluntary befriending groups; Age UK who provide foot care clinics and the Princes Carers Trust who run monthly carers clinics

The practice has a Primary Medical Services contract (PMS) with NHS England to deliver general medical services.

The practice has opted out of providing out-of-hours services to their own patients. Patients can access NHS 111 out of hours and BrisDoc provide an out-of-hours GP service.

Detailed findings

Why we carried out this inspection

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

How we carried out this inspection

We carried out an announced visit to the practice on 29 April 2015 when we spoke with seven staff and four patients, looked at documentation and observed how people were being cared for.

In advance of the inspection we reviewed the information we held about the provider and asked other organisations to share what they knew. We spoke with South Gloucestershire Clinical Commissioning Group, NHS England area team and South Gloucestershire Healthwatch. We sent comments cards to the practice in advance of our visit for patients to complete. We also spoke to Health Visitors, District Nurses and the local nursing home who provide care for patients registered at the practice.

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

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

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

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

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The locum practice manager told us and provided evidence of a detailed complaints process. We saw evidence that an annual complaints review had taken place prior to our inspection which identified common themes and actions. All the practice staff were involved in a feedback session.

The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

We spoke with six GP's and reviewed safety records, incident reports and available minutes of meetings where these were discussed for the last year. This showed the practice had managed these over time and so could show evidence of a safe track record over the long term however, we noted that during the absence of a practice manager continued monitoring of actions after incidents and complaints had been sporadic.

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 12 significant events that had occurred during the last year and we were able to review six of these in detail. Significant events were a standing item on the practice management meeting agenda. The practice had recently appointed a GP as a lead for significant events in order that actions from past significant events and complaints were reviewed. 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 and they felt encouraged to do so.

The locum practice manager showed us the new system used to manage and monitor incidents which would allow for better documentation including actions taken and lessons learnt. Prior to this the management of and access to incidents had been limited to one person which had made ownership by staff difficult. We tracked six incidents and saw records were completed in a comprehensive and timely manner although information was not always collated in one place which included recording of actions and records of updates to staff which was not consistent with good practice. We recognised that a change in management and recent introduction of a new IT system had been put in place to resolve this. We saw evidence of action taken as a result for example discussions with specialist hospital doctors about the incident which included recognising a serious illness when patient symptoms were non-specific and management of common disease. We also saw evidence of two GP's personal learning journals as a result of incidents. 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 pharmacy advisor or GP's to practice staff. Staff we spoke with were able to give examples of recent alerts that involved a change in medicine or practice. They also told us alerts were discussed at clinical meetings and shared with practice staff where relevant to ensure all staff were aware of any that required staff to take action. Any alerts relating to medicines would be implemented by the pharmacy advisor resulting in a change to the medicines formulary on the medical records system.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We saw that the practice were in the process of transitioning training records from a number of locations into one record. We looked at available training records which showed that not all staff had received relevant role specific training on safeguarding children; most staff had received safeguarding adult training and all of the practice staff had attended training in relation to domestic violence as part of participation in the IRIS scheme (Identification and Referral to Improve Safety for women). We spoke to the practice and after the inspection they supplied the information with regards to safeguarding training. We saw that staff were up to date with regards to undertaking relevant training. We asked GP's nurses 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 within each clinical room.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. South Gloucestershire Clinical Commissioning Group (CCG) told us the practice regularly engaged in meetings for safeguarding leads, that 83% of GP's were up to date with level three safeguarding training and that they were fully compliant with a recent safeguarding children audit. All staff we spoke with were aware of who these leads were and who to speak with in the practice if they had a safeguarding concern.

There was an alert 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. GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people were clearly flagged and reviewed.

The practice had a system in place to alert GP's to any attendance at Accident and Emergency by pre-school children. These children were then discussed at the monthly GP and Health visitor meeting along with other children known to be at risk of or experiencing abuse. We saw evidence that GP's engaged with and took seriously their roles in managing vulnerable children who were at risk of harm. GP's had attended multi-disciplinary safeguarding meetings and liaised regularly with the Health Visitor and discussed concerns with educational workers.

We were told about and saw evidence about concerns GP's had about regarding potential abuse of patients in residential care which demonstrated good liaison with partner agencies such as the police and social services. GP's had reported concerns, followed local safeguarding procedures and engaged in multi-disciplinary work. As a result the practice had developed its own reporting template for safeguarding concerns and added any safeguarding concerns to practice meetings.

GP's had attended training on mental capacity and we were told about examples of GP's seeking advice from other agencies when there was concern over the patient's ability to make safe choices. This included linking patients with Independent Mental Capacity Advocates (IMCA)

There was a chaperone policy, which was visible in the waiting room and in every consulting room. (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. Receptionists understood their responsibilities when medical alerts indicated a need for a chaperone. The health care assistant gave examples of how she used chaperones when undertaking treatments. We noted that this was not always documented in the medical records unless the template used required consent documentation.

Medicines management

We checked medicines stored in the treatment rooms and four medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy and we saw evidence of appropriate temperature recording logs. We were told about a recent incident over a weekend with a vaccine fridge which resulted in vaccines being stored at the wrong temperature. Staff were able to explain national guidance around the incident and how they followed policy to ensure that vaccines were not administered in case of suboptimal quality.

Weekly processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. The practice held documentation to show that emergency medicines in clinical rooms had been checked on a weekly basis.

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 evidence that showed nurses and the health care assistant had received appropriate training to administer vaccines.

Good

Are services safe?

There was a good, safe system in place to recall patients who required blood monitoring due to medicines they were taking. We saw that this system worked well and included a double checking process which highlighted when patients had not attended. If patients continued to not attend the GP's would personally telephone them.

The practice had employed a prescribing coordinator whose role was to review hospital discharge summaries. We were told about an example of a patient who had been discharged with multiple changes in medication. The prescribing coordinator had updated the medical records, arranged for district nurses to take bloods for a medicines review and arranged for the prescription to be changed so the patient could receive their medicines in a special container (dosette box) to remind them to take their medicines at the right time. We saw evidence of good communication between this coordinator and GP's.

The practice pharmacist carried out monthly medicines monitoring. For example, computer searches for patients taking medicines to lower blood pressure were routinely undertaken. Patients records were then checked and if a medicines review or blood pressure check had not be undertaken within guidelines then the patient was recalled to the practice.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. Appropriate action was taken based on the results.

The practice stocked emergency contraception so that it could be given to a young person straight away rather than relying on a young person going to a chemist to collect a script which may be a perceived barrier to fast treatment.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance.

We spoke to the independent Pharmacy attached to the building. We were told that the GP's were very receptive to advice on medicines; that they fully engaged with requests and regularly spoke to the pharmacist for advice and support.

Cleanliness and infection control

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

The practice had a lead for infection control. Most staff received training about infection control specific to their role and clinical staff had undertaken additional e-learning. We saw evidence that the lead had carried out an infection control audit in 2015 and that any actions identified were in the process of being completed within timescales.

An infection control policy and supporting procedures for example, evidence of hand washing audits were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. The health care assistant assisted with minor operations and had undertaken a wound care course with a regular update. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

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.

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). A water flushing procedure and risk assessment were in place.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers and blood pressure measuring devices.

There were records for servicing to the boiler and lift.

Staffing and recruitment

Good

Are services safe?

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example vaccination status, references, gaps in employment, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). We looked at five staff files and found one where photographic identification had been seen as part of the recruitment process. Prior to our inspection we checked clinical staff were registered with the relevant professional bodies. We found all staff to be registered.

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. The policy did not include a recruitment check list for example requirements to ask candidates for proof of identification.

The practice had a policy that non-clinical staff did not require a DBS check. We saw that a risk assessment had not been completed with regards to this. We spoke to the practice and after our inspection a risk assessment was undertaken and the recruitment policy updated. The practice provided copies of these. The practice took the decision to ask all staff to undertake a DBS check.

All staff were provided with a staff handbook. Staff we spoke to were able to tell us about whistleblowing and knew where the policy was kept.

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. Reception and administrative staff had been cross trained so that they could assist during team shortages or increased workload. To ensure staff were competent to undertake the role at short notice, all administrative staff were required to undertake three hours' work each week in reception.

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

Monitoring safety and responding to risk

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

We saw a list of sixteen risk assessments and looked at three. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We were told that any risks were discussed at GP partners' meetings. We also saw a disaster recovery plan which was relevant for the practice.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example the health care assistant was able to describe and demonstrate in-depth how to respond to a patient fainting, choking and not breathing.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that staff had received training in basic life support. Emergency equipment for adults and children were available including access to oxygen and an automated external defibrillator on each floor (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 each clinical area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis. We saw evidence that 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. We saw that this required updating due to the changes in the management structure.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that most staff were up to date with fire training

Good

Are services safe?

and that fire alarm tests took place weekly. A fire drill had taken place in 2015. We did not find records for a fire drill in 2014. We spoke to the practice who had since implemented a procedure for regular fire drills.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of clinical meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

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

We saw data that compared performance with local clinical commissioning group (CCG) and national averages and allowed the practice to routinely measure their performance. We found the data for the practice's performance for antibiotic prescribing, was aligned to the CCG average and comparable to similar practices. This demonstrated that the practice was proactive in the monitoring and prescribing of antibiotics.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We saw that multidisciplinary working between the practice, the hospice, social workers, community matron, respiratory nurses, palliative care nurses and other professionals took place to support these patients. Monthly meetings were held to review care for older people, those receiving end of life care, patients with a chronic illness and patients of concern. GP's and advanced nurse practitioners met daily and discussed any patients that they were concerned about.

The practice operated a virtual ward system with monthly meetings. This allowed any member of the multidisciplinary team including voluntary agencies such as Age Concern to admit a patient to a virtual ward where the team would discuss concerns, provide support to improve patient care and allocate actions for the team. We saw evidence of this process including reviews of six patients who were admitted to the virtual ward. We saw that once actions had been completed patients were discharged for on going care as detailed in care plans.

We saw that the practice had an end of life care register and alerts within the clinical records system made staff aware of additional needs. The local CCG data showed that the management of end of life care was average for the local area. We were shown care plans for patients on end of life care including a patient with a learning disability. The care plans we saw showed good practice and included details around preferred place to die, family and professional contact details as well as details on how the patient was when well.

We were shown the process the practice used to review patients recently discharged from hospital. The practice had employed a prescribing coordinator whose role was to review hospital discharge. A discharge summary was added to patient records including changes in medicines and coded appropriately. The GP was then sent an additional summary to highlight any changes in care including any requests to other organisations for example district nurses. We saw that this system worked well and increased continuity of care for patients.

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. We looked at patient records and saw that they were referred and seen within two weeks. The practice secretaries had a system to check each referral to ensure patients had been seen. They also checked for any changes to referral pathways regularly and updated the clinical team.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were 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

In 2011 the practice won a local leadership award from NHS England and in 2013 a GP Enterprise award for innovative clinical care. The practice had undertaken an audit of patients that frequently attended following a team away day where reception staff had highlighted appointment difficulties due to frequent attenders. The audit results led to a Frequent Attenders Project which included a focus group for a small number from the cohort of patients; a protocol for patients with medically unexplained symptoms and a new service delivery for these patients to help them learn new skills and develop confidence to manage their health.

Patients were invited to be involved in the pilot through a patient focus group and each patient was allocated a GP who was trained in a technique (the BATHE programme) to support patients psychologically and use community services for example exercise on prescription, talking therapies and befriending services. The initial pilot reduced face to face GP consultations, reduced referrals and admissions and showed an increase in patient satisfaction. After nine months, the programme had prevented two unplanned admissions and 35 referrals to secondary care. In a user satisfaction survey, 71% of the patients rated the programme as 'very good', 25% as 'good' and 4% as 'fair'. The Frequent Attenders Project was opened up to a larger number of patients. As a result of the project a local university is currently undertaking a clinical trial. We saw evidence to support the project including individual GP's reflections around clinical contact with patients.

The practice was one of the practices in South Gloucestershire that participated in approved NHS research studies through the NHS National Institute for Health. We were told about completed research in the last year around infected eczema and assessment of children with an acute cough. In addition six other research projects were currently being undertaken including patients with depression, atrial fibrillation and psychological support with young people. Staff within the practice held Good Clinical Practice Certificates.

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 to support the practice to carry out clinical audits.

The practice showed us clinical audits that had been undertaken in the last year. The practice was able to demonstrate the changes resulting since the initial audit. For example an audit on patients with blood clots (deep vein thrombosis) showed changes to procedures and patient care were made and the audit was repeated to ensure outcomes for patients had improved. Other examples included audits to confirm that the GPs who undertook minor surgical procedures were doing so in line with their registration and National Institute for Health and Care Excellence guidance.

We were told about a clinical audit following an alert from the Medicines and Healthcare Products Regulatory Agency (MHRA) regarding a medicine used to reduce blood cholesterol. The aim of the audit was to ensure that all patients prescribed this medicine in combination with a particular hypertensive drug were not put at risk of serious drug interactions.

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).

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, in 2013/2014 the practice had achieved 100% of all QOF points including the management of asthma, atrial fibrillation, diabetes, depression, dementia, chronic kidney disease and epilepsy. In addition it scored 100% for palliative care and for meeting the needs of patients with learning disabilities.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a

group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement.

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 all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice had achieved and implemented the gold standards framework for end of life care in 2008. We saw evidence of audits undertaken during that implementation. The practice 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.

One GP in the surgery undertook minor surgical procedures in line with their registration and National Institute for Health and Care Excellence (NICE) guidance. The GP was appropriately trained having undertaken a course two years ago and kept up to date. They also regularly carried out clinical audits on their results and an annual audit which looked at post surgery infection rates, consent and a review of specimens to check for accuracy in diagnosis. The practice had a zero rate of post-surgery infections. We saw evidence that GP's appropriately discussed a late diagnosis skin cancer, reflected on the incident and learnt lessons which changed patient procedures for that type of skin complaint.

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. 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. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example a nurse was being supported to undertake a practice nurse diploma, a health care assistant had undertaken a foundation course in health care and administrative staff had undertaken courses around coding used for clinical diagnosis. As the practice was a training practice, doctors who were training to be qualified as GPs were provided with an induction programme, offered extended appointments and had access to a senior GP throughout the day for support. We received positive feedback from the trainees we spoke with.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, administration of travel vaccines, childhood immunisations and cervical cytology. Those with extended roles for example seeing patients with long-term conditions such as asthma, diabetes and coronary heart disease were also able to demonstrate that they had appropriate training to fulfil these roles. The practice had provided training for health care assistants (HCA) to undertake investigations for chronic lung disease (spirometry) and the HCA were, at the time of the inspection, undertaking training for foot checks for diabetic patients.

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 process 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.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

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 procedure for management of 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. All admissions to the local nursing home received a home visit within a week when an advanced care plan would be written.

The practice held monthly multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs, patients where there was a level of concern from other organisations or those that had been identified through a computer programme as being at high risk of admission to hospital. These meetings were attended by district nurses, social workers, palliative care nurses, community matrons, emergency care practitioners 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.

In addition the practice had a virtual ward where a member of the multidisciplinary team could admit a patient requiring extra support or medical care. The practice had strong links with the Princes Carers Trust who ran monthly clinics at the practice, Age UK who ran foot clinics and two local befriending groups.

Weekly ward rounds were carried out in a local nursing home. There was a fortnightly clinic in the practice for substance misuse which provided the substance misuse lead GP to discuss care with the local drug and alcohol misuse service.

All patients on the learning disability register received an annual review which allowed the development of a close relationship with the multidisciplinary learning disability team including dieticians, physiotherapists and consultants. For example, for the management of end of life care for young patients in the local learning disability nursing home. We saw examples of good and close working relationships from the learning disability lead GP with the nursing home staff and patients families.

We spoke to the district nurse, health visitors and manager of the local nursing home who all provided positive feedback around the communication and support they received from the practice.

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, 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. The practice had also signed up to the electronic Summary Care Record and planned to have this fully operational by 2015. (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 (EMIS) to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We 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 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 drawn up a protocol to help staff, for example with making do not attempt cardiopulmonary resuscitation orders (DNACPR). The nursing home supported by the practice provided complex dementia care which had resulted in all but one patient

having a DNACPR in place. We saw evidence of a thorough process that was undertaken in order for this decision to be made. This included speaking to staff in the home, patients and their families. We saw evidence that advanced care plans and DNACPR orders were shared with other agencies for example the Out Of Hours doctor service and the ambulance service.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. For example, 53% of all patients with a dementia diagnosis had advanced care plans which had been reviewed in the 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 had undertaken mental capacity training to support patients to make their own decisions. The GP's told us that they had good access to other teams for example the memory clinic, learning disability team and mental health team and they would always seek advice around complex capacity decisions. We saw evidence of this and evidence that the GP's regularly worked with Independent Mental Capacity Advocates (IMCA) seeking advice and making referrals when patients had difficulty making decisions. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

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. GP's regularly dealt with patients who were being deprived of their liberty (DoLS) in the nursing home and showed us they had a good understanding of the law.

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure. The practice undertook an annual audit of consent for minor surgery patients.

Health promotion and prevention

It was not practice policy to offer a health check to all new patients registering with the practice. New patients completed a health assessment form and the GP was informed of any health concerns and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental health, physical health and wellbeing. For example, by offering chlamydia screening to patients aged 18 to 25 years; offering smoking cessation advice to smokers and using the BATHE programme during consultations to help patients learn skills and develop confidence to manage their own health.

The practice offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that 58% of 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 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 79% had received a check up in the last 12 months. The practice had also identified the smoking status of 97% of patients over the age of 16 and actively offered nurse-led smoking cessation clinics to these patients with 27 patients having attended since January 2015. Similar mechanisms of identifying 'at risk' groups were used for patients who were receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for cervical smear uptake was 86%, which was better than others in the Clinical Commissioning Group area. There was also a named nurse responsible for following up patients when an inadequate cervical sample had been taken.

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 childhood immunisations were above average for the CCG, with a 97% to 100% attendance rate and again there was a clear policy for following up non-attenders by the named practice nurse.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Patients with more than one long term condition were offered one appointment to review all the conditions together. Health care assistants were ,at the time of the inspection undertaking training to carry out diabetic patients checks such as foot checks have been trained to carry out diabetic checks such as foot checks to allow the practice nurses to spend more time improving diabetes control with patients.

Patients with asthma or high blood pressure were able to provide measurements of tests; they undertake to monitor their disease, via the GP practice website. For example asthmatic patients could submit their lung function tests and these were reviewed by the lead asthma nurse.

The practice had a regular drop in 'No worries' clinic, providing confidential sexual health and relationship advice for 13-20 years olds. Young people could attend the practice and see a health professional without an appointment. We saw that the open access had a positive impact on sexual health of young people. For example one young person had attended to speak to a GP with regards to a sexual health concern and was seen to have an unrecognised pregnancy; another young person came to the clinic to disclose sexual abuse.

The practice ran a monthly carers support group with the carers support centre.

The monthly group also provided free complimentary therapies to carers.

Advice and information was readily available in the practice about a wide range of topics from health promotion to support and advice. The practice website contained information for patients on healthy living, self-help for common illnesses and links to other websites containing health promotion and prevention information.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey (January 2015) which received 127 out of 257 surveys sent out, a return rate of 49%. The results for the practice were above the local Clinical Commissioning Group averages for the area with 85% saying the GP was good at treating them with care and concern; 82% saying the GP was good at involving them in decisions about their care and 95% saying the nurse was good at treating them with care and concern. The NHS Friends and Family Test (FFT) in February 2015 showed that 92% of respondents would recommend the practice which was above the average of 88% given to practices in the area.

We reviewed comments on NHS Choices and saw that patients had awarded 4 stars for treating people with dignity and respect.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 17 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Two comments were less positive about the availability of appointments however they were happy overall with the service they received. We also spoke with four patients on the day of our inspection. They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Two completed CQC comment cards from patients said that the practice cared for, supported, respected and understood them and their diversity. These patients were from the Travelling and Transgender community. This told us that the practice treated all patients fairly and equally.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. 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 / treatment room doors were closed during consultations and that 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 which helped keep patient information private. In response to patient and staff suggestions, a system had been introduced to allow only one patient at a time to approach the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. Staff told us that patients could be taken to an empty consultation room if they wanted to speak to staff in private. We saw a confidentiality statement was provided offering patients the opportunity to speak to staff in a confidential area.

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 or reception manager. The locum practice manager told us he would investigate these and any learning identified would be shared with staff.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour.

We saw that the practice displayed notices offering chaperones. Reception staff were comfortable offering patients chaperones if they were known to be vulnerable or were required to have an intimate examination, for example a cervical smear. Alerts on patient records indicated if a patient required a chaperone due to vulnerability.

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 82% of practice respondents said the GP

Good

Are services caring?

involved them in care decisions and 84% felt the GP was good at explaining treatment and results. Both these results were average for the South Gloucestershire CCG area.

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

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

We saw care plans for patients with long term conditions, end of life care, dementia, those who were at high risk of hospital admission and those who lived in care homes. The care plans were well structured and detailed and patient involvement in agreeing these was evident. We also saw evidence that one GP regularly corresponded with the local Member of Parliament around concerns for patients with social problems and non-medical needs.

Patient/carer support to cope emotionally with care and treatment

The Patient Participant Group survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, the patient survey in January 2015 had identified a 17% increase in the number of patients identified with carer responsibilities. This had resulted in staff offering carers help through access to support services such as the Princes Carers Trust monthly carers' clinic and the practice carers group. These support services took place in the surgery and helped carers to manage their treatment and care when needed. The comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room 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 information available for carers to ensure they understood the various avenues of support available to them.

Reception staff spoke to us about treating patients as individuals and if a patient appeared to be under emotional pressure they would offer that patient a cup of tea.

Staff told us that if families had suffered bereavement, their usual GP contacted them. The practice offered access to organisations and support groups for mental wellbeing such as LIFT Psychology services and local befriending groups. A private counsellor offered appointments at the practice.

In 2013 the practice won a GP enterprise award for innovative clinical care for their BATHE programme (Background, Affect, Trouble, Handling, and Empathy). The programme empowers and supports patients to manage their own health and as an affect increases mental wellbeing and reduces concerns about physical illness.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

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

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). For example the PPG had raised concerns around the height of the reception desk which was not easily accessible for wheelchair users. During our inspection we saw evidence that the reception desk was being lowered to enable access for all.

Following concerns around patients in a care home the practice had implemented changes to the way it delivered care by developing a falls policy. This meant that any patient having two falls would automatically be reviewed by a GP, discussed at the multi-disciplinary meeting if necessary and any concern for welfare reported to the local safeguarding authority. We saw evidence that the falls policy had improved recognition of risk factors for falls and patients who had falls. For example from July until September 2014 there had been seven falls in one care home which has now reduced to zero. Patients who are discharged from hospital following a fall receive a GP appointment to identify risk factors; reduce the risk of falling and if necessary a referral to the community falls service.

The practice had a large number of older people with chronic leg ulcers. In order to improve outcomes for this group the practice set up a clinic with a specialist nurse. Over a six month period the healing rate of leg ulcers had improved with one third no longer requiring treatment.

Tackling inequality and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example the practice recognised the barriers to healthcare for the travelling community. All appointments that were missed were followed up routinely; follow up appointments were always arranged by telephone rather than writing to this group and more flexibility was provided to enable access to GP services. The practice ensured that this community received medical advice if they turned up at the surgery. We were told about an example of a member of the travelling community with mental health concerns. The patient was reluctant to engage with the mental health team so the GP arranged to do joint appointments with the mental health team so that the patient could receive the support they needed. We received positive feedback in our CQC comment cards from a member of the travelling community.

We saw that the practice recognised the needs of other groups with barriers to healthcare such as patients in a nursing home where the doctors carried out a weekly ward round and older people where the practice engaged with voluntary and charitable organisations to provide additional services. Patients with a learning disability had the same named GP who carried out all annual checks to ensure continuity of care. These annual checks were based on national best practice guidance and were carried out with the multidisciplinary team. We saw evidence that the GP used a joint care plan approach with health and social care organisations.

We saw that the practice had some homeless patients that they provided care and support for. The GP's used the BATHE (background, affect, trouble, handling, empathy) technique during consultations to ensure that patients felt listened to and emotionally supported whilst the GP's are able to ensure that focus on managing symptoms.

The premises had been purposely converted 15 years ago and met the needs of patient with disabilities. The practice had disabled parking and the entrance allowed for wheelchair access. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities. A lift provided access to the first floor.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

The practice had access to online and telephone translation services. A hearing loop system was available.

The practice had a register of people who may be living in vulnerable circumstances and a system for flagging vulnerability in individual records. Young people not registered at the practice were able to access appointments through the 'no worries' scheme. One GP had previously worked for a young person's sexual health clinic and they were able to tell us how the access to appointments without booking had a positive impact on sexual health of young people. For example one young person had attended to speak to a GP with regards to a sexual health concern and was seen to have an unrecognised pregnancy; another young person came to the clinic to disclose sexual abuse.

Access to the service

The practice was open from 8 am to 6:30 pm for three days and 7:30 am to 7 pm for two days. The practice was closed on Saturdays. The practice provided on the day appointments with GP's; a telephone advice service for urgent medical advice and five sessions a week for a 'commuter clinic' offering appointments before 8 am or after 6.30 pm which was particularly useful to patients with work commitments. A GP was always on the premises during lunchtime in case of emergencies. Reception staff were trained to triage calls so that life threatening, emergency or urgent calls were dealt with quickly. We were told about a call received from a nursing home where the patient had been taken seriously ill. A GP rang the home back within three minutes and then attended the home within the next ten minutes. This showed us that the practice had a good system to deal with life threatening situations. We spoke to the nursing home who confirmed this and told us that GP's would often visit after evening surgery if there was an urgent concern.

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 (NHS 111) they should ring depending on the circumstances. Information on the Out-Of-Hours service was provided to patients.

Longer appointments were also available for patients who needed them and those with long-term conditions such as learning disability or chronic illness. This also included appointments with a named GP or nurse. Routine visits were made to a local nursing home on a specific day each week, by a named GP. And home visits were made to those patients who needed one. Housebound patients, for example those with long term conditions were able to have a home visit for annual check-ups. The practice also offered a quick access scheme where any young person, including those not registered, would ask to see a GP with no questions asked. Patients at risk due to vulnerabilities could be seen if they attended the practice without an appointment.

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. For example, one patient we spoke with told us how they needed a daily appointment for wound dressings. They told us that the clinic was full however the nurse fitted the patient in in her own time to ensure continuity of care.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system within the practice and on their website. The practice also offered patients the opportunity to provide comments and feedback via the website and a comments box within the practice. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

The practice had 31 complaints recorded for the last 12 months. We saw all the complaints and reviewed a selection in-depth. We found that the practice recorded all complaints including ones that were about other services.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

We identified no themes from the practice complaints log and found the quality of recording and investigation to be satisfactory. We found the responses from the practice to be open and transparent with the appropriate level of apology

The practice reviewed complaints annually to detect themes or trends. We looked at the minutes for the last review which included common themes and an action plan. We saw that lessons learned from individual complaints had been acted on and clinical meetings had taken place as a result of a complaint to review up to date medical guidelines.

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 well-developed mission statement and vision to improve the lives and health of the practice and local community through delivering 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 and renewed yearly. The practice vision and strategy included the development of strong leadership and effective management and the development of excellent communication and information sharing with staff and patients. We found that each part of the strategy was supported with goals.

We spoke with four members of staff who knew and understood the vision and values and knew what their responsibilities were in relation to these. We were told that the practice had an annual away day where staff had discussed that the vision and mission statement.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. The practice had recently introduced an online management and information system which was in the process of being populated at the time of inspection. The system had the benefits of storing policies in one place, providing an audit trail to ensure staff have read policies, record staff training, staff management, complaints, significant events and audits. We looked at some of these policies and procedures and saw they had been reviewed annually and were up to date.

The practice was currently working through a programme of change which had included a change to the leadership structure at a time where senior partners have been absent due to sabbaticals and maternity leave. Although there was a clear leadership structure with named members of staff in lead roles the practice was utilising a locum practice manager until the newly appointed practice manager commenced employment. To encourage continuity a retired GP partner had returned on a temporary basis. We saw evidence that the practice had undertaken difficult decisions in order for them to improve practice leadership and introduce new technology to improve patient care.

The leadership structure included GP partners taking lead roles in safeguarding; learning disabilities; drug and alcohol misuse; diabetes; rheumatology; older people in nursing homes; young people and sexual health. We spoke with ten members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it had performed above national standards with 100% completion for 2013/2014. We saw that the clinical support staff worked well to recall patients and arrange visits to patients' homes including care homes to ensure medical reviews were undertaken. This was supported by evidence that clinical decision making maximised treatment. We saw that QOF data was regularly discussed at meetings and action plans were produced to maintain or improve outcomes.

The practice had an on going programme of clinical audits and research which it used to monitor quality and systems in order to identify where action should be taken for example infection control and medicine audits.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us the risk log, which addressed a wide range of potential issues, for example infection and use of toys for children. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented, for example a fire risk assessment.

The practice held regular partner meetings and weekly management meetings where governance was discussed.

Leadership, openness and transparency

Staff told us that practice meetings were irregular although regular departmental meetings took place. We saw evidence that meeting minutes had not always been recorded. The practice told us that the new IT information management system and leadership changes would improve meeting regularity and recording of minutes and actions. 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 or with management. Staff told us that they always had feedback from management meetings. We also noted that team away days were held every year.

Are services well-led?

Good

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

Prior to our inspection reception staff were given the opportunity to meet and reflect on their work in line with our five key questions. We saw the results of their discussions including a statement that reception staff prepared for us. We saw evidence of strong team work from diligent staff who all wanted to make a difference for patients.

The locum practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example disciplinary procedures and recruitment policy, which were in place to support staff. We were shown the staff handbook that was available to all staff.

We were told about the changes to management structures which had resulted in disruption to staff. This had included a number of changes to the GP team including retirement of a senior GP, a sabbatical and maternity leave. We saw evidence of good leadership and support qualities from the GP's during this time and staff told us that GP's were always approachable and had ensured continuity of care for patients.

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 looked at the Patient Participation group (PPG) annual report from March 2015. A communication and consent survey and 68% of patients who responded were happy with the way the surgery currently communicated and 32% wanted to change the method of communication. As a result of this the practice had commenced a project to implement alternative communication methods.

The practice had an active patient participation group (PPG) which had steadily increased in size. The PPG included representatives from various population groups; for example male and female patients aged 35 and onwards. PPG members included Friends of Frome Valley (a charity set up to raise money to purchase specialised equipment for the surgery); Dementia Friends champions; members of carers' forums and retired patients who had previous executive roles in leading UK charities. The PPG had carried out regular surveys and met monthly. 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 were available on the practice website.

The practice had gathered feedback from staff through staff away days and generally 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. 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 electronically on any computer within the practice.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five staff files and saw evidence of appraisals and personal development plans. Staff told us that the practice was very supportive of training and that the practice provided a training budget. One nurse was undertaking a Practice Nurse Diploma and the practice was providing supporting and mentoring. The health care assistant had undertaken a foundation training course. Staff told us that they could ask for specific training for example one staff member had attended training about confidence boosting.

The practice was a training practice for GP Registrars and medical students. Two GP's took responsibility for induction, training and supervision. Learning and improvement of services was evident from the current and previous research programmes. We saw evidence that the implementation of the research projects had improved patient outcomes and increased clinical knowledge.

We also saw evidence that the practice was committed to improve other organisations knowledge in order to improve care for the practice population. For example GP's had provided training to staff at the local nursing home on a number of topics including identification and care of stroke patients.

The practice had completed reviews of significant events and other incidents and shared them with staff at meetings to ensure the practice improved outcomes for patients. A report on significant events had been compiled which had

Are services well-led?

Good

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

included GP's reflective learning after the event. For example a patient had unexpectedly been admitted to hospital and later died. We saw that the GP had been persistent in seeking answers from other organisations around the cause of death, had reflected on the last contacts with the patient and their family and discussed the event with staff including administrative and reception staff who knew the patient.