Broadmead Medical Centre

Inspection report

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

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Overall summary

This practice is rated as Good overall. (Previous inspection 12/2014 – Good)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? - Good

We carried out an announced comprehensive inspection at Broadmead Medical Centre on 10 April 2018 as part of our inspection programme.

At this inspection we found:

- The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- The practice reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence-based guidelines.
- Patients found the appointment system easy to use and reported that they were able to access care when they needed it.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.

We saw some areas of outstanding practice which had been identified on our previous visit were continuing and in addition we found:

- The nurse team from the practice had a programme of regular visits to local hostels to offer health screening and support people to access local health services.
- Transgender patients were supported by the practice. Specifically the practice ensured that patients' record reflected the gender they identified with, and the nurse team liaised closely with the local treatment centres so that they had knowledge and could provide guidance to patients about their treatment and potential side effects.
- The practice had designated appointments on Saturday for patients who had been discharged from prison who required primary care services. This was pre-booked in liaison with the Criminal Justice Intervention team and allowed for continuity for treatment and prescribing.
- The practice temporarily registered relatives of patients at the local children's hospital who were staying away from home. The practice temporarily registered relatives of patients at the local children's hospital who were staying away from home.
- The practice had a pro-active approach to managing new born babies and their mothers and routinely sent a birth card with a pre-booked appointment date to encourage attendance for checks and immunisations which resulted in national targets being met.

The areas where the provider **should** make improvements are:

- The practice should review use of consent forms for any minor surgery or contraceptive insertions to ensure the details of any decisions or discussions are fully recorded.
- The practice should ensure that the procedure for use of stock medicines records is fully implemented by clinical staff.
- The practice should ensure there was a protocol in place for maintaining the security and integrity of content of the consulting rooms.

Professor Steve Field CBE FRCP FFPH FRCGPChief Inspector of General Practice

Population group ratings

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

Our inspection team

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

Background to Broadmead Medical Centre

This service is part of BrisDoc Healthcare Services Limited. BrisDoc is a limited company managed by shareholders all of whom are either GPs from local practices or employed staff of BrisDoc. The Broadmead Medical Centre is an NHS GP practice, located in the centre of Bristol (within Boots The Chemist in Broadmead) and incorporates a nurse lead Walk-In Centre. It was set up in 2009 specifically to meet the needs of the transient population of the city centre including those who were homeless, living in hostels, students and visitors, as well as permanent residents.

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The opening hours for the practice are 8am - 8pm Monday to Friday and 9am - 1pm on Saturday. In addition, the Walk-In Centre is open 11am - 5pm each Sunday and Bank Holiday. The GP practice is available for registered patients only however they have a policy of registering patients who are homeless using the practice address.

There are approximately 9600 patients. The patient demographic is very mixed with a large student population from the University of the West of England. It has a diverse patient group with 33% of people from BME groups. The practice has less than 1% of patients over the age of 75 years, 5% under the age of 14 years and 7% aged between 14 and 18 years old. The majority of patients were in the age range 20 to 59 years. The practice had a yearly turnover of registered patients of approximately 40%.

There is some deprivation being in decile 2 (the second lowest level of deprivation) however there is 2% of the patient population who are homeless who can register at the practice without having a fixed address. They also support patients with drug/alcohol addictions and mental health problems.

The service employs ten part-time salaried GPs (male and female), a practice manager, a pharmacist, seven registered nurses, two health care assistants and a phlebotomist. The clinical team are supported by dedicated administrative and reception staff onsite and the organisational team based at the BrisDoc headquarters.

The practice is part of the 4YP Bristol which supports access to sexual health support and advice for young people.

Broadmead Medical Centre works closely with the Homeless Health Service to support homeless people in and around Bristol city centre.

The practice provides training opportunities for trainee GPs and nurses.

This service is provided under an Alternative Provider Medical Services (APMS) contract.

Out of hours services are accessible through the 111 telephone service.

The Walk-In Centre is a nurse led service staffed by experienced nurse practitioners and paramedics, supported by the practice GPs. Staff are trained to assess, diagnose and treat minor illness; there is a nurse led 'sit and wait' service on Monday – Saturday from 8am-8pm and on Sunday from 11am-5pm. This service is open to the general public. This service is sub-contracted to BrisDoc by the Bristol Community Health Community Interest Company.

The services are registered to provide the following regulated activities:

Maternity and midwifery services

Treatment of disease, disorder or injury

Diagnostic and screening procedures

Family planning

Good

Are services safe?

We rated the practice as good for providing safe services.

Safety systems and processes

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

- The practice had appropriate systems to safeguard children and vulnerable adults from abuse. All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Reports and learning from safeguarding incidents were available to staff. Staff who acted as chaperones were trained for their role and had received a DBS check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.)
- Staff took steps, including working with other agencies, to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The practice carried out appropriate staff checks at the time of recruitment and on an ongoing basis.
- There was an effective system to manage infection prevention and control.
- The practice had arrangements to ensure that facilities and equipment were safe and in good working order. However we found that one consulting room was unlocked when empty and we saw medical records, an unsecured medicine and unsecured prescriptions. This was brought to the attention of the practice manager who took immediate action and introduced a protocol for keeping the rooms locked until a new key fob electronic system is installed.
- Arrangements for managing waste and clinical specimens kept people safe.

Risks to patients

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

- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness, busy periods and epidemics.
- We found that the practice had responded to concerns about staff and patient safety and had installed CCTV in public areas and increased availability of security staff in the evenings and weekends.
- There was an effective induction system for temporary staff tailored to their role.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections including sepsis.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

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

- The care records we saw showed that information needed to deliver safe care and treatment was available to staff. There was a documented approach to managing test results.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made timely referrals in line with protocols.

Appropriate and safe use of medicines

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

- The systems for managing and storing medicines, including vaccines, medical gases and equipment, minimised risks. However we saw emergency medicines were stored in a tamper proof box, but the box was easily accessible to the public in the GP practice. We found that the stock medicine records were not always completed as required by the practie policy when medicines were used, one had been taken and not recorded. These issues were raised with the practice manager for action.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with

current national guidance. The practice had reviewed its antibiotic prescribing and taken action to support good antimicrobial stewardship in line with local and national guidance.

- Patients' health was monitored in relation to the use of medicines and followed up on appropriately. There was a practice pharmacist to optimise medicine prescribing and patients were involved in regular reviews of their medicines.

Track record on safety

The practice had a good track record on safety.

- There were comprehensive risk assessments in relation to safety issues.
- The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture of safety that led to safety improvements.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice.
- The practice acted on and learned from external safety events as well as patient and medicine safety alerts.

Please refer to the Evidence Tables for further information.

Good

Are services effective?

We rated the practice and all of the population groups as good for providing effective services overall.

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

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- The practice were participating in the pilot use of technology to continually monitor blood glucose levels for patients with type one diabetes. This supported patients with more effective control of their diabetes by improving their control of their blood glucose levels.
- Staff used appropriate tools to assess the level of pain in patients.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. The practice used an appropriate tool to identify patients aged 65 and over who were living with moderate or severe frailty. Those identified as being frail had a clinical review including a review of medication.
- Patients aged over 75 were invited for a health check. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan. Over a 12 month period the practice had offered 47 patients a health check. 37 of these checks had been carried out.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Asthma and type one diabetes are prevalent due to the practice demography; staff had additional qualifications for treating and managing these diseases and participated in a virtual clinic scheme in which to discuss difficult to manage patients with specialists in diabetes treatment. The performance data for QOF was also significantly positive for asthma at 90% which was higher than the clinical commissioning group and national averages. This showed how these skills positively impacted on outcomes for patients.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice was able to demonstrate how they identified potentially vulnerable patients with commonly undiagnosed conditions such as diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension by visiting local hostel accommodation and screening the residents.

Families, children and young people:

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

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

- The practice's uptake for cervical screening was 57%, which was lower than the 80% coverage target for the national screening programme. The practice was aware of this and ensured that all non-attenders are followed up with a telephone call, and also offered opportunistic

screening. However, the vulnerabilities and complexities of many of the patient population meant attendance was difficult for them, and the high patient turnover impacted on the success of the screening programme.
- The practices' uptake for breast and bowel cancer screening was lower than the national average. The practice was aware of this and ensured that all non-attenders are followed up with a telephone call.
- The practice had systems to inform eligible patients to have the meningitis vaccine. For example, before attending university for the first time.
- All new patients were asked to attend for a health check. Patients had access to on-going health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- The practice registered 125 people who worked in the city but lived elsewhere to facilitate access to primary health care.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. There were 2% of patients who were of no fixed abode and registered with the address of the practice.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice identified patients who met the criteria for latent TB and had successfully offered screening to 17 patients to identify any disease.

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

- The practice assessed and monitored the physical health of people with mental illness and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe. The practice held a monthly meeting with the consultant psychiatrist to identify and agree a plan of treatment for all high risk patients.
- 100% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This is comparable to the national average.
- 69% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This was below the national average; the practice stated this was due to the transient nature of their population.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example, 83% of patients experiencing poor mental health had received discussion and advice about alcohol consumption. This is comparable to the national average.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- The practice offered annual health checks to patients with a learning disability.

Monitoring care and treatment

The organisation had an overall programme of quality improvement activity which reviewed the effectiveness and appropriateness of the care provided. We saw there was a clinical audit being planned to audit urinary tract infections in children and saw one completed two-cycle GP clinical audit, and a GP reflective practice document. The nurse team had undertaken audits of practice which monitored the effectiveness of their skills such as cervical smear taking and aseptic technique; the clinical team at the Walk In Clinic had a competency framework in place which all clinicians were assessed against. Outcomes for patients at the centre were recorded and reported as part of their contract performance. The practice were part of the clinical commission group medicines optimisation programme and participated in medicines audits.

- Overall exception reporting was 9.1% compared to the CCG average of 8.6% and national average of 5.7%. However, we found the overall exception rates for some indicators were significantly higher than the clinical

Good

Are services effective?

commissioning group or national averages. The practice stated that they had a 40% yearly turnover rate of patients which impacted on their ability for continuity of care for the management of long term conditions; and that many patients who had multiple conditions were either non-compliant with prescribed treatments, or had been receiving the maximum level of prescribed treatment but which had not exerted the expected level of control of the condition. We reviewed the exception process and found that patients were excepted appropriately.

- The practice used information about care and treatment to make improvements such as using National Early Warning Score (NEWS) scoring for sepsis identification.
- The practice was actively involved in quality improvement activity.

Effective staffing

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

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

Coordinating care and treatment

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

- We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment. The practice used a common clinical IT platform (EMIS Web), which allowed for other providers such as Out of Hours services and hospitals to access patient records via Connecting Care enabling seamless transfer of care.
- They are part of the development of an IT Digital Roadmap which should allow for shared records interoperability with community teams.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for people with long term conditions and when coordinating healthcare. They shared information with, and liaised, with community services,homeless services, student services, social services and carers for housebound patients and with health visitors and community services for children who have relocated into the local area.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

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

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their own health, for example through social prescribing schemes.
- Staff discussed changes to care or treatment with patients and their carers as necessary.

Good

Are services effective?

- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking and tackling obesity campaigns.

Consent to care and treatment

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

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We found the practice did not use consent forms for any minor surgery or contraceptive insertions, but recorded directly on the patient's record their verbal consent and noted any guidance given which met current guidance.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately through their regular audit of clinicians records .

Please refer to the Evidence Tables for further information.

Good

Are services caring?

We rated the practice as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from patients was positive about the way staff treat people.
- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.

Involvement in decisions about care and treatment

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

- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.
- The practice proactively identified carers and supported them.

Privacy and dignity

The practice respected patients' privacy and dignity.

- There was some availability of a private room for patients who wanted to discuss sensitive issues or appeared distressed and the practice had plans in progress to create more office space.
- Staff recognised the importance of people's dignity and respect. They challenged behaviour that fell short of this.

Please refer to the Evidence Tables for further information.

Good

Are services responsive to people's needs?

We rated the practice, and all of the population groups, as good for providing responsive services except for people who circumstances make them vulnerable population group which was rated as outstanding.

Responding to and meeting people's needs

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

- The practice understood the needs of its population and tailored services in response to those needs.
- Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.
- The facilities and premises were well sited for the services delivered as they were in the centre of the main shopping area of the city. However we observed there were space constraints for both the practice with limited office and staff room space. The waiting area for the Walk In Clinic was restricted and during our visit we observed it was overcrowded as no additional space was available for pushchairs or patients with limited mobility..
- The practice made reasonable adjustments when patients found it hard to access services such as home visits.
- The practice provided effective care coordination for patients who are more vulnerable or who have complex needs. They supported them to access services both within and outside the practice.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

Older people:

- All patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GP and practice nurse also accommodated home visits for those who had difficulties getting to the practice.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment and consultation times were flexible to meet each patient's specific needs.
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.

Families, children and young people:

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary. Children were prioritised when using the Walk In Clinic.
- The practice had a pro-active approach to managing new born babies and their mothers and routinely sent a birth card with a pre-booked appointment date to encourage attendance for checks and immunisations.

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

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, extended opening hours and Saturday appointments.
- The practice liaised with the local university well-being service to facilitate timely referral and assessment in secondary care services such as assessment for attention deficit hyperactivity disorder (ADHD).
- The Walk In Clinic regularly saw students whose first language was not English and had staff available who spoke different languages as well as information available in several languages.
- The practice was aware of an unmet need in minor surgery of skin tag removal which is no longer available through NHS services, and purchased equipment for electrosurgery. Ten patients had been treated so far using this system.

People whose circumstances make them vulnerable was rated as outstanding because:

Good

Are services responsive to people's needs?

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.
- The practice had allowed homeless patients who attended for appointments to sleep in the waiting area while they were waiting. The practice was flexible with appointment timings so people were not disturbed.
- The practice hosted service for substance misuse services for three days each week.
- Registered patients who were vulnerable and who may have chaotic lifestyles could access the Walk In Clinic for on- going treatments such as wound dressing.
- The nurse team from the practice had a programme of regular visits to local hostels to offer health screening and support people to access local health services.
- The practice liaised with the Health Link service to arrange support for vulnerable patients to attend appointments in secondary care.
- Transgender patients were supported by the practice. Specifically the practice ensured that patients' record reflected the gender they identified with, and the nurse team liaised closely with the local treatment centres so that they had knowledge and could provide guidance to patients about their treatment and potential side effects.
- The practice had designated appointments on Saturday for patients who had been discharged from prison who required primary care services. This was pre-booked in liaison with the Criminal Justice Intervention team and allowed for continuity for treatment and prescribing.
- The practice temporarily registered relatives of patients at the local children's hospital who were staying away from home.

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

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice held GP led dedicated monthly mental health reviews with a consultant psychiatrist. Patients who failed to attend appointments were proactively followed up by a phone call from a GP.

Timely access to care and treatment

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

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- Patients found it easy to get through to the practice by phone and reported that the appointment system was easy to use.

We found that during February 2018, the Walk In Clinic saw 1761 patients and 93% of these patients were seen within two hours. We saw that the waiting time to be seen was displayed at the reception desk. The clinical staff prioritised children and those in greatest need.

Listening and learning from concerns and complaints

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

- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. The practice learned lessons from individual concerns and complaints and also from analysis of trends.

Please refer to the Evidence Tables for further information.

Good

Are services well-led?

We rated the practice and all of the population groups as good for providing a well-led service.

Leadership capacity and capability

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

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- BrisDoc had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

Vision and strategy

BrisDoc as an organisation, had a clear vision and credible strategy to deliver high quality, sustainable care which was reflected in the practice and Walk In Clinic.

- There was a clear vision and set of values. The practice had a realistic strategy and supporting business plans to achieve priorities. The practice developed its vision, values and strategy jointly with patients, staff and external partners.
- The Walk In Clinic was sub-contracted to BrisDoc and subject to a six monthly contract review as part of the local agenda for change programme.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them. Staff commented that they felt the service embodied the organisational vision.
- The strategy was in line with health and social priorities across the region. The practice worked in partnership with the 'Local Transformation System' with other GP practices in the Bristol inner city and east region, and planned its services to meet the needs of the practice population.
- The practice monitored progress against delivery of the strategy.

Culture

The practice had a culture of high-quality care.

- Staff stated they felt respected, supported and valued. They were proud to work in the practice and the Walk In Clinic.
- The practice focused on the needs of patients. This was reinforced by the staff and management team who were committed to person focused care.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. BrisDoc as a provider, through corporate policies and guidance, showed awareness of and compliance with, the requirements of the duty of candour. We found this was demonstrated by the practice in their response to complaints and incidents.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed, although noted that depending on the issue there may be a delay in resolution. For example, staff told us they had fed back to the practice manager concerns about the impact of patients who were aggressive toward them and other patients. Action taken was installation of CCTV and additional security guard time.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff were considered valued members of the practice team. They were given protected time for professional development.
- The practice actively promoted equality and diversity. Staff had received equality and diversity training.
- There were positive relationships between staff and teams. There was a daily team meeting to promote communication between all of the staff; in addition there was a programme of planned meetings which supported the governance of the service.

Governance arrangements

BrisDoc had a clear corporate structure of responsibilities, roles and systems of accountability to support good governance and management. The head office retained oversight of the governance of the practice and Walk In Clinic. There was managerial, clinical, HR and administrative processes and support available for the practice and Walk In Clinic.

Good

Are services well-led?

- There were local processes and systems in place to support good governance, for example, there was a programme of meetings which was clearly set out, at which aspects of the governance of the service were reviewed. There was also a system of reporting to head office issues such as incidents or significant events. These fed into the governance system on a corporate level.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control
- We saw there was a systems audit process in place for policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.
- The clinical audit process was not fully embedded in the practice.

Managing risks, issues and performance

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

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through review of their consultations, prescribing and referral decisions. BrisDoc had a peer review process for this, that used a Royal College of General Practitioners (RCGP) template for good record keeping, for all clinicians. Practice leaders had oversight of national and local safety alerts, incidents, and complaints.
- The practice had plans in place and had trained staff for major incidents.
- The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

The practice acted on information.

- Quality and operational information was used to ensure and improve performance.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The practice used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice submitted data or notifications to external organisations as required such as contractual performance statistics.
- There were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

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

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture.
- The active patient participation group had been relaunched in January 2018 with the intention of it being a patient led group.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement such as being involved in the clinical commissioning group programme to train health care assistants to undertake frailty assessments and review patients at risk of a stroke.
- Staff knew about improvement methods and were developing skills to stream patients to the most appropriate service like the self-referral physiotherapy service.
- The staff team had a wide range of skills and experience and used them to improve joined up services, for example, a member of staff worked with the Terence Higgins Trust and used their knowledge to inform and support staff and patients in respect of HIV.

Good

Are services well-led?

- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.

Please refer to the Evidence Tables for further information.