Broadmead Medical Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Broadmead Medical Centre on 8 December 2014. Overall the practice is rated as good.

Our key findings 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 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.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day both in the practice and walk-in centre.
- People who were of no fixed abode and those who were unable to make a same day appointment with their own GP were able to be seen in the walk-in centre.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management.
- The practice proactively sought feedback from staff and patients, which it acted on.

We saw several areas of outstanding practice including:

- The practice held a register of patients living in vulnerable circumstances including people with no fixed abode and those with a learning disability. It had carried out annual health checks for people with a learning disability and offered longer appointments for them.

Summary of findings

- 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.
- The practice liaised with substance misuse services and a refuge to provide outreach services for patients who were reluctant to visit the practice.
  - Some patients lived in hostels for the homeless and failed to access health care so the practice nurses held clinics in the hostel.
  - The practice provided Saturday support to the Criminal Justice Intervention Team. When people were released from prison on a Friday they could be seen at appointments if their own GP practice was closed on Saturday. This enabled them to be given support with medicines for the weekend.
- The walk-in centre provided opportunities people whose circumstances may make them vulnerable to have same day appointments and appointments at weekends.
- Some reception staff could speak other languages such as Somalian which provided assistant to patients from Somalia and an interpreting service was available.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

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

Are services effective?

Good

The practice is rated as good for providing effective services. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

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

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Bristol Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.

Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The walk-in centre provided opportunities for healthcare for the homeless and people who were unable to get a same day appointment with their own GP.

The practice had good facilities and was well equipped to treat patients and meet their needs.

Summary of findings

Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Bristol Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.

Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The walk-in centre provided opportunities for healthcare for the homeless and people who were unable to get a same day appointment with their own GP.

The practice had good facilities and was well equipped to treat patients and meet their needs.

Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. It had registered under 1% of patients over the age of 70 years. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

The weekend opening hours enabled older patients to have appointments or home visits.

People with long term conditions

Good

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

The weekend opening hours enabled patients with long term conditions to have appointments or home visits.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. It had registered 4% of the patient population was under the age of 10 years and 5% aged between 10 and 19 years. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk.

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.

The walk-in centre provided opportunities for families, children and young people to have same day appointments and appointments at weekends.

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 majority of the patients registered with the practice were in the age range 20 to 59 years. The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs of this age group.

The walk-in centre provided opportunities for working age people to have appointments before or after work. It also provided this group, those recently retired and students to have same day appointments and appointments at weekends.

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 people with no fixed abode and those with a learning disability. It had carried out annual health checks for people with a learning disability and offered longer appointments for them.

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.

As an inner city practice it had a diverse patient group with slightly more than 50% white British, 28% other white, 8%of African descent 9% of Asian background and 4% Chinese people. Some reception staff could speak other languages such as Somalian which provided assistant to patients from Somalia and an interpreting service was available.

The practice liaised with substance misuse services and a refuge to provide outreach services.

The walk-in centre provided opportunities people whose circumstances may make them vulnerable to have same day appointments and appointments at weekends.

Summary of findings

People experiencing poor mental health (including people with dementia)

Good

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

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

The walk-in centre provided opportunities for people with poor mental health, including people with dementia, to have same day appointments and appointments at weekends.

Summary of findings

What people who use the service say

During our visit we spoke with 17 patients. Some of these were in the walk in centre and others in the general practice. Patients referred to receptionists as friendly, polite and professional. Others described them as very welcoming and one patient said they felt they were discrete as they spoke with them quietly so others would not overhear the conversation.

Two patients told us they had used the walk-in centre because they were unable to have an appointment at their own GP practice. They said they did not mind having to wait as they were being seen immediately. Two other patients who used the walk-in centre said they were happy to see a nurse for minor ailments. Patients told us their problems were resolved and one patient added they had nothing but praise for the service. Two patients were of no fixed abode and spoke about the convenience of the service.

One patient visiting their GP said they always found it easy to book an appointment. Another patient told us they were always able to see their regular GP.

We sent comments cards to the practice in advance of our visit and received 16 completed cards.

Most of the cards were positive about the practice and the walk-in centre. Five patients indicated they felt the service as good, four described nursing staff as helpful and three referred to staff being friendly.

Two patients using the walk-in centre referred to having to wait a long time however, one patient said they were seen quickly.

Two patients referred to receptionists as being helpful however two patients said more customer training should be provided.

Three patients referred to the hygiene and cleanliness of the practice and walk-in centre however, one patient commented that the chairs in the practice needed to be cleaned.

Patients indicated the GP listened and was understanding, they received more care and attention than expected in the walk-in centre and they were dealt with well.

One of the patients who had initially visited the walk-in centre and was now registered with the practice referred to being treated with respect at all times. Another patient said the walk-in service was fantastic and would recommend it to others.

Outstanding practice

The practice liaised with substance misuse services and a refuge to provide outreach services.

The walk-in centre provided opportunities people whose circumstances may make them vulnerable to have same day appointments and appointments at weekends.

Some patients lived in hostels for the homeless and as some had chaotic lifestyles and failed to access health care the practice nurses held clinics in the hostel and provided services to young people in their 'home'.

The practice actively audited the consultations of all GPs and nurses regularly to ensure consistent high standards were maintained. They did this by using the template and toolkit produced by the Royal College of General Practitioners.

The practice provided Saturday support to the Criminal Justice Intervention Team. When people were released from prison on a Friday they could be seen at appointments if their own GP practice was closed on Saturday. This enabled them to be given support with medicines for the weekend.

Broadmead Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was made up of a CQC lead inspector and a GP specialist advisor.

Background to Broadmead Medical Centre

The Broadmead Medical Centre is commissioned by Bristol Clinical Commissioning Group and operates as part of BrisDoc Healthcare Services Limited. It is a limited company managed by shareholders all of whom are either GPs from local practices or employed staff of Brisdoc. The practice is located within the Mall Galleries shopping centre in the Broadmead area of the city centre.

Broadmead Medical Centre was opened in July 2009 as a new practice. Since that time the patients registered with the practice have grown from zero on day one, to over 7,000 by the beginning of December 2014. To meet the growing demand of the practice there is an agreed expansion of a further two consultation rooms and rooms for administration staff. We were told the expansion would be completed by March 2015.

In April 2012 the practice was subcontracted by Bristol Community Health to provide the walk-in centre. This is a minor illness, walk in service available to non-registered patients. Registered patients may also attend this service, if appropriate. The walk-in centre was nurse-led, by staff who could provide prescriptions, with the support of an on-call GP. Broadmead Medical Centre had a contract under the Alternative Provider Medical Services (Amendment) Directions 2014 and as such met every three months with NHS Bristol Clinical Commissioning Group (CCG).

This inner city practice had a diverse patient group with slightly more than 50% white British, 28% other white, 8%of African descent 9% of Asian background and 4% Chinese people. Some reception staff could speak other languages and an interpreting service was available.

There is a passenger lift between the ground level and the first level, nurse led walk-in centre. There is a further passenger lift up to the GP practice. There is a dedicated route out of the building should a patient need to be carried out by stretcher following a collapse.

The GP practice has four consulting rooms and rooms for triage and treatment. In addition this was where the administrative offices were situated. The walk-in centre has three consulting rooms. There is a wheelchair accessible WC with baby changing facility and an induction hearing loop at each reception desk.

There were seven GPs employed in the practice and to support the walk-in centre, three of whom are male. Most of the GPs had special interests that included palliative care, cancer care, paediatrics, sexual health, mental health, addictions, homeless healthcare and urgent care.

As an inner city practice it has a diverse patient group with slightly more than 50% being white British, 28% other white, 8%of African descent 9% of Asian background and 4% Chinese people.

The practice had less than 1% of patients over the age of 70 years, 4% under the age of 10 years and 5% aged between 10 and 19 years old. The majority of patients were in the age range 20 to 59 years.

All of the patients over the age of 75 years had a named GP and were on the practice unplanned admissions register to ensure they had regular reviews and care plans in place.

Asthma and type one Diabetes is prevalent due to the practice's make up of younger patients and those who are

more vulnerable because of their circumstances. Two of the practice nurses had additional qualifications in Diabetes management and one had a qualification in managing Asthma.

There were 1% of patients who were of no fixed abode and registered with the address of the practice.

The Out Of Hours service information was listed in the practice leaflet. BrisDoc provided this service.

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 visited the service on 8 December 2014. Prior to our visit we requested some documents from the provider to assist with our planning and looked at the provider's website. In addition with met with the NHS England Local Area Team and NHS Bristol Clinical Commissioning Group along with, the Avon Local Medical Committee and Healthwatch Bristol. None of these organisations raised any concerns about the services provided at Broadmead Medical Centre.

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? a
- 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)

During our visit we spoke with a range of staff including GPs, the practice manager and their deputy, nurses, a healthcare assistant and receptionists and spoke with patients who used the service. We observed how people were being cared for and talked with carers and/or family members. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

Brisdoc had established a health and safety steering group that had devised a strategy for 2014/15 in order to raise health and safety awareness within the organisation. It considered issues such as lone working and driving. There was a plan for each month with set dates for completion, had raised awareness of safety issues and improved safety for patients, staff and visitors to the practice.

Risk assessments were in place including those for health and safety, security, staff (display screen equipment), Control of Substances Hazardous to Health (COSHH) and fire safety. The practice manager told us the fire evacuation process had been tested and worked. Staff we spoke with confirmed they attended fire safety training and there were identified fire wardens.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events.

There were records of significant events that had occurred since the practice opened and we were able to review these. Significant events were a standing item on the practice meeting agenda and a dedicated meeting was held three monthly to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff.

A member of staff told us there was a good protocol to follow if mistakes were thought or known to have been made. The protocol explained how mistakes should be notified. They said they would feel safe and comfortable to admit they were unsure if they had made a mistake or admit they had made one. They told us how patient records were scrutinised during nurses meetings and how explanations were given for how records could be improved. They said the practice had a culture of 'learning' and not one of 'blame'.

Reliable safety systems and processes including safeguarding

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

The practice had a lead GP for child protection and safeguarding vulnerable adults. We looked at the BrisDoc policy for safeguarding children. It made reference to the relevant legislation, gave definitions and indicators of abuse, guidance on reporting and the contact details for the local child protection team. The safeguarding vulnerable adults policy contained similar information along with definitions of who may be considered a vulnerable adult. The policies had each been revised in 2014 and indicated the training requirements of staff. Staff we spoke with confirmed they knew what to do if they suspected abuse and had completed the training. GPs and nurses were required to complete child protection training at level three and other staff completed training at level one. There was a noticeboard in the practice dedicated to safeguarding. On it there was a message to staff that read "saying nothing is not an option".

If a receptionist had concerns about a child they could check the child protection register and alert the GP or nurse. When reports of child protection case conferences were received they were sent to the allocated GP. The same happened when reports were received from Multi Agency Risk Assessment Conferences (MARAC) in respect of suspected domestic abuse.

The BrisDoc whistle-blowing policy outlined its guiding principles, procedure for reporting and instructions for escalating a report. Staff we spoke with were aware of the whistle-blowing policy and their responsibility to report concerns about the behaviour of a colleague. Some staff had reported concerns in the past.

Good

Are services safe?

We saw the chaperone policy displayed. A chaperone is a person who acts as witness during a consultation or examination to offer protection to the staff and patients. Staff were trained to act as chaperone if needed.

The practice had a zero tolerance to aggression and violence and trained staff in managing conflict and aggression. In addition it employed a uniformed guard between 6pm and 8pm daily.

The computer system had an alert function so staff could be summoned if needed.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

There were dedicated fridges for the storage of vaccines with a system for checking they were at the correct temperature. When we looked at the records of checks we saw occasions when the temperature had not been recorded. This was treated as a significant event by the practice. The provider should ensure the temperatures of the fridges are checked at the specified frequency and that accurate records are maintained in order to ensure patients were administered safe vaccine.

Other medicines were stored appropriately. No medicines with special storage requirements were kept in the practice. Where these were prescribed patients could get them from the in-store pharmacy.

The practice worked with the Bristol Clinical Commissioning Group pharmacists to monitor prescribing of medicines. Each month they carried out at audit to ensure that best practice guidance was followed in respect of prescribing. One of the achievements of the collaboration was the addition of laminated guidance in consulting rooms showing the tests needed before certain medicines could be prescribed.

The GPs carried medicines with them when they did home visits. When the bags were not in use they were locked securely away.

There were two designated receptionists who prepared repeat prescriptions. If they had any queries about patients' requests they were referred to the GP. If patients were dispensed medicines in monitored dosage system packages the receptionist liaised with the nominated pharmacy. Prescription documentation was kept securely at all times.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Most of the 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 dedicated lead for infection control. We saw the infection control policy and policy relating to the wearing of personal protective equipment and clothing. In addition there was a policy for the management of contamination and inoculation injury.

Staff received infection control training. There were audits of infection control arrangements and monthly hand hygiene monitoring. The treatment rooms had disposable curtains and we saw hand washing guidance displayed. There were cleaning schedules for each of the treatment rooms with records to show the cleaning had been completed. The practice had spillage kits for blood and other bodily fluids.

We checked infection control arrangements using an audit tool and found all areas to meet good hygiene standards.

Reception staff had a protocol to follow for patients presenting with fever or history of fever in the past 24 hours. This was so staff could ask them if they had been in one of the countries affected by Ebola. The protocol asked reception staff to consider two questions relating to the patient's condition and take one of two options of booking them in as usual or isolating them.

When there was a measles outbreak in the South West in 2014 all staff in the practice had their immunisation status checked and were given the measles vaccination, if they were not immune. We were told this made staff feel safe and ensured business continuity as no staff had taken time off work.

The practice held a contract with an external company for cleaning. There were risk assessments for the products the cleaners used and they recorded on a cleaning schedule to confirm the schedule was met.

Good

Are services safe?

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 all equipment held in the practice was calibrated in October 2014. This included the electrocardiogram, defibrillator, spirometer and pulse oximeter. The calibration also included the Doppler ultrasound machine (used to estimate blood flow through the body).

We saw there was a code of practice for handling liquid nitrogen. This was stored safely and there were arrangements in place for delivery and collection.

Staffing and recruitment

We inspected the BrisDoc arrangements for the recruitment of staff as part of the inspection of the Out of Hours service it provided in February 2014. The same arrangements were in place for the Broadmead Medical Centre and Walk-in Centre. There was a clear recruitment and selection policy, which the provider kept under review to ensure the policy, covered all of the standards set out in the NHS Employers safer recruitment guidelines. A standard operating procedure ensured that the recruitment processes were consistent, streamlined, quick and unambiguous and ensured all employment checks had been completed and were up to date.

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

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

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

The staffing policy enabled the practice to ensure the number of staff employed had grown in line with the number of patients registered with the practice and to check the practice had sufficient staff to meet patients' needs. Each of the four GPs told us their work load was manageable.

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.

Risk assessments were in place including those for health and safety, security, staff (display screen equipment), Control of Substances Hazardous to Health (COSHH) and fire safety. The practice manager told us the fire evacuation process had been tested and worked. Staff we spoke with confirmed they attended fire safety training and there were identified fire wardens.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. There were emergency medicines, defibrillator and supply of oxygen in the practice and walk-in centre. The medicines were kept in sealed boxes and checked daily. All of the practice staff attended training in resuscitation and dealing with medical emergencies, yearly. We were told the training was carried out in the practice so staff were able to use the practice defibrillator during the training so they were familiar with its use.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We 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.

Reception staff in the walk-in centre had guidance on checking symptoms. The guidance included a flow chart and alerted them to when they should telephone the 999 service for an ambulance to avoid any delay in a patient being seen in an emergency situation.

The GPs told us they take a 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. Nurses in the walk-in centre referred to each other if they needed a second opinion. If they needed further advice they referred to the on-call GP.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed the culture in the practice was one in which patients were cared for and treated based on need. The practice took account of patient's age, gender, race and culture as appropriate.

For patients with co-morbidities such as asthma and diabetes, checks were carried out for these illnesses at the same time for patient's convenience. We were told about one patient who emailed the practice nurse with their blood sugar level reading and the nurse advised the person by email of their insulin dosage.

Each patient registered with the practice had a named GP. Some patients preferred to see the same GP and this was accommodated as far as possible.

Management, monitoring and improving outcomes for people

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

Clinical meetings were held every two weeks. Alternately they focused on patients and operational issues. At the operational meetings staff discussed significant events, complaints, the 'Friends and Family Test' results and unplanned hospital admissions. During the patient focussed meetings there were visiting speakers such as the specialist nurse for the homeless. Health visitors attended these meetings in order to discuss children who were 'at risk'. We were told there were approximately 40 children identified as being 'in need' but these were not necessarily listed on the 'at risk' register.

We looked at the summary of audits undertaken in the practice during the last year. It showed there had been audits of medicines including antibiotic use, the triage service, safeguarding children and the cold chain supply. The summary showed the outcomes form the audits and the actions to be taken and dates for review. We saw actions were completed.

We also looked at an audit of waiting times in the walk-in centre. It showed more than 99% patients were seen within two hours. The audit also showed the average waiting time to be less than an hour.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the doctors. Most of the GPs had special interests that included palliative care, cancer care, paediatrics, sexual health, mental health, addictions, homeless healthcare and urgent care.

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

Good

Are services effective?

(for example, treatment is effective)

called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

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

Practice nurses performed defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, the administration of vaccines and cervical cytology. Those with extended roles for example, seeing patients with long-term conditions such as asthma, chronic obstructive pulmonary disease, diabetes and coronary heart disease were also able to demonstrate that they had appropriate training to fulfil these roles.

The deputy practice manager arranged locum GP cover when needed. They told us they had established a number of contacts and had no problems arranging cover when needed.

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. Each morning GPs looked at the Out Of Hours reports for the previous night. 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.

One of the nurses we spoke with told us they wanted to work in an innovative practice. They said the practice was always looking for new development opportunities. The nurse told us how the practice provided a range of outreach services including working with the Somali community and in a hostel for young women aged between 16 and 25 years.

Some patients lived in hostels for the homeless and some had chaotic lifestyles and failed to access health care. Practice nurses held clinics in the hostel and provided services to young people in their 'home'. This included screening for Chlamydia and offering sexual health education and management. We saw there were Chlamydia home testing kits for patients. Practice nurses also provided smoking cessation advice and general health awareness.

We were told the practice worked closely with local drug and alcohol recovery services providing shared care to aid patients' recovery. The practice had initiated a series of regular meetings for multi-disciplinary teams involved in the care of vulnerable patients. The first of these meetings was scheduled for January 2015. There was a shared care worker based in the practice for two sessions each week.

The practice provided Saturday support to the Criminal Justice Intervention Team. When people were released from prison on a Friday they could be seen at appointments if their own GP practice was closed on Saturday. This enabled them to be given support with medicines for the weekend.

Midwives were attached to different clinics around the vicinity. One of the nurses told us it was sometimes difficult to identify which clinic to refer a patient to if they were pregnant. There were no district nurses or health visitors attached to the practice and referrals were made to other clinics for this support.

There was a dedicated member of staff for scanning documents into patient's records. These included test results and patient discharge correspondence that were seen by the named GP or on-call GP if they were unavailable. Patients could obtain test results by telephone or by making an appointment to speak with a GP. The walk-in centre did not provide tests for patients registered with another practice. There was a dedicated member of staff who dealt with choose and book hospital appointments for patients.

The practice held multidisciplinary team meetings every month to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was

Good

Are services effective?

(for example, treatment is effective)

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.

When patients were seen in the walk-in centre a summary of their consultation and treatment was sent to their own GP.

If a patient presented at the walk-in centre on three occasions during a designated space of time their own GP was contacted to make an appointment for them so they could have continuity of treatment.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record 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.

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. 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).

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved with..

The practice had a named consultant who dealt with mental ill health. One of the GPs told us they felt the practice was particularly suitable for patients with poor mental health as sometimes this was related to lifestyle and patients often needed treatment at short notice. They also told us they had arranged counselling for patients in the past. One of the GPs told us they tried to understand patients underlying needs if they became aggressive in order to identify which specialist service to refer them onto.

The practice had links with the Child and Mental Health Service (CAMHS) due to the prevalence of the use of cannabis in young people. This gave young patients speedy access to the service when they were suffering poor mental health.

Health promotion and prevention

The arrangements for new patients to register with the practice were outlined in the practice leaflet. It explained that to register applicants must live within the practice boundary area.

The practice had 80% of new patients medical records summarised into the practice system.

It was practice policy to offer a health check with the health care assistant to all new patients registering with the practice. We were told that 94% of new patients accepted the offer. The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. The practice offered advice and guidance on a range of services to encourage a healthy lifestyle. These included smoking cessation, weight management, alcohol and drug support and the young people sexual health service.

The practice maintained a register of patients who were part of the avoidance of unplanned admissions to hospital enhanced service. They had care plans and were called for regular review. The practice had an information technology support officer who managed the systems for patient recalls and blood testing for repeat medicines.

One of the walk-in centre nurses said they felt 50% of their role was in prevention and promotion of good health. In addition there was a range of informative leaflets for patients to take away with them and self-help material displayed. These included leaflets relating to memory loss, cancer and sexual health.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients completed CQC comment cards to tell us what they thought about the practice. We received 16 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 but there were no common themes to these. We also spoke with 17 patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

The practice leaflet included a statement relating to equal opportunities. It stated the practice aimed to treat each patient equally, to promote equality of opportunity and to not tolerate any form of discrimination. It said all visitors to the practice or walk-in centre would be treated with dignity and respect.

Some of the receptionists spoke other languages and could communicate with patients if their first language was not English. An interpreter service was also available..

The practice leaflet outlined the practice confidentiality policy and stated all staff had received confidentiality training and had signed a confidentiality agreement. The leaflet explained that no information would be released to a third party without the patient's written consent. We were told patients had the right to not disclose to receptionists the reason for the need for an appointment showing respect for patients' right to privacy.

There was an electronic appointment check-in system in the GP practice which gave patients a range of languages to choose from when booking in for an appointment. In the walk-in centre staff kept patients informed of the waiting time they could expect.

Care planning and involvement in decisions about care and treatment

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

To encourage children of patients from overseas to become involved in the child immunisation system the practice worked closely with the child health team utilising interpreters to promote understanding and the cooperation of parents.

We spoke with the head receptionist who told us receptionists in the walk-in centre aimed to get as much information from patients as possible and try to prevent further distress. They told us they could send on-screen messages to the nurses to seek advice if needed.

The practice receptionists were trained to provide advice and support to young people under the age of 24 years. This service was confidential for registered patients and patients who were registered at another practice who required sexual health support and education. The practice staff referred patients to other specialist services for some contraceptive and sexual health advice One of the GPs held a clinic to fit intra-uterine devices.

The practice equal opportunities statement stated the practice aimed to ensure it established patient's health needs to enable them to make informed decisions.

Those who used the walk-in centre were required to complete a registration form to provide essential details including, the name of the GP they were registered with.

Patient/carer support to cope emotionally with care and treatment

One of the receptionists was the practice 'Carers Champion'. They maintained a list of patients who had caring responsibilities so this could be taken into account during any consultation. There was a dedicated 'carers' notice board in the waiting room of the GP practice and carers were given priority appointments.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient focus group. For example it consulted the patient focus group about whether staff should wear uniforms. The group felt they should and staff continued to wear them.

The practice was situated on the first and second floors of the building with most services for patients on the first floor. There was lift access to the first and second floors. The practice had provided turning circles in the wide corridors for patients with mobility scooters. This made movement around the practice easier and helped to maintain patients' independence.

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

The practice had English speaking patients and patients using other languages. The practice could cater for other different languages through translation services.

Access to the service

The practice was open every day of the week. From Monday through to Saturday the opening hours were from 8am to 8pm. On Sunday the practice was open from 11am to 5 pm.

Appointments were available at all times when the practice was open. For urgent, same day appointments patients would be contacted by telephone by the triage nurse who would be able to deal with the problem or make an appointment with a GP or nurse or provide a prescription.

The walk-in centre was also open every day of the week and those using the service could 'sit and wait' to be seen. The walk in centre was open from 8am to 8pm from Monday to Saturday with the 'last patient' time set at 6pm. The walk in centre was open from 11am until 5pm on Sunday with a 'last patient' time set at 3.30pm. Setting the 'last patient' time meant everyone would be seen on the day. The nurses worked through the list of patients chronologically, prioritising patients with urgent symptoms as necessary.

The practice operated an online appointment consultation booking system and an online service for repeat prescription requests. Appointments could also be made by telephone or in person. There was a posting box in the practice reception area and patients could expect their repeat prescription to be ready for collection after 48 hours. Reminders about flu immunisation or cervical cytology were attached to repeat prescriptions.

The practice records system allowed for patients to be sent a text message to remind them their appointment was due. This system also had the facility for patients to decline appointments by sending a text message to the practice in return.

Patients who requested a same day appointment were telephoned by the triage nurse who then saw them or booked them in for an appointment with a GP. There were appointments available with a GP or nurse throughout the day for emergencies. Anyone who presented at the walk-in centre with chest pain or other urgent symptoms were seen immediately.

Any children under the age of two years were automatically given a same day appointment and for children between two and five the triage nurse consulted with a GP for a treatment advice. We saw a young child was prioritised when they were brought to the walk-in centre as it was considered they needed to be seen urgently.

All of the practice nurses were independent prescribers and were able to assess, treat, prescribe medicines and discharge patients for those patients who did not need to see a GP.

The practice allocated time for GPs to telephone patients for a consultation and these could be booked in advance. One of the GPs told us the practice had received positive feedback about the telephone consultations they provided.

We were told the GPs did very few home visits. However, each day there was time built in to visit patients. If there were no requests, the time was allocated as extra same day appointments.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice reported a low number of patients who did not arrive for their appointment. We were told this was possibly because patients with mobile telephones were sent text messages to remind them of their forthcoming appointment.

All patients entitled to an influenza immunisation were contacted by text message. If there was no reply this was recorded on their medical record and they were contacted by telephone or letter. Similarly when patients reached 40 years of age they were sent a message inviting them to make an appointment for an over 40's health check.

Listening and learning from concerns and complaints

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

The complaints procedure was outlined in the practice leaflet. It told patients their concerns would be recorded and acknowledged within two working days. The practice would respond with an evaluation within 10 working days. If the patient remained unsatisfied a meeting would be offered to discuss the situation.

We saw the practice maintained a log of complaints. We looked at the log of complaints for 2013/14 and saw it differentiated between those about the GP practice and those related to the walk-in centre. There was a summary of the event, recorded actions taken and lessons learnt. There were a total of 18 complaints received in the last year.

One of the GPs told us when the practice received feedback indicating patients found it difficult to get an appointment within 48 hours it sought ways to manage this. The practice held an away day to review appointment scheduling. As a result it set up a triage service to enable appropriate streaming of patients requesting on the day appointments and increased the number of same day appointments available.

All telephone calls made to the practice were recorded which enabled monitoring of calls and respond to any complaints of rudeness, inappropriateness or unsatisfactory service by reception staff during telephone consultations. We were told this provided a useful source of evidence when investigating complaints.

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 Brisdoc statement of purpose outlined the key strengths of the service as being locally sourced, practice based GPs, a model of shared ownership, high level of practice engagement and constructive working with commissioners. In addition, it recognised the strong focus on clinical governance, GP education and training as being key strengths.

The quality policy stated that through a consistent approach to quality, patients received the highest standard of care. For Broadmead Medical Centre this translated to a common vision, commitment of all staff, good communication, care and cohesiveness.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at eight of these policies and procedures including those for staff recruitment, induction, training, and safeguarding children and adults and saw they had been reviewed annually and were up to date.

The GPs and practice manager had been employed since before the practice opened and this provided consistent management arrangements. We were told by one of the GPs that this consistency enabled effective management of change, as required.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and the senior partner was the lead for safeguarding.

The practice actively audited the consultations of all GPs and nurses regularly to ensure consistent high standards were maintained. They did this by using the template and toolkit produced by the Royal College of General Practitioners.

Broadmead Medical Centre had a contract under the Alternative Provider Medical Services (Amendment) Directions 2014 and as such met every three months with NHS Bristol Clinical Commissioning Group (CCG). The practice was subject to a higher level of review than other GP practices and the CCG monitored the quality of its services.

The practice submitted monthly data reports relating to its performance, information in relation to any identified risks and complaints. These reports were then considered by the board of directors and other corporate groups within Brisdoc.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes. Each GP was responsible for an area of the Quality and Outcomes Framework (QOF). For example there were GPs with responsibility for diabetes, cancer and epilepsy management. QOF alerts were built into the practice records system.

Leadership, openness and transparency

Staff we spoke with were confident about the management of the service and knew who to report to. They spoke of being in a cohesive team, having a deep respect for what colleagues do, enjoying their work. One member of staff described a “vibrant” team.

There was a schedule of meetings to enable effective communication among the staff group and wider organisation. Multi-disciplinary team meetings were held with the various community teams which supported the practice. These were to discuss complex patients, those being cared for in the community and the ‘children in need’ or ‘at risk’.

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

The practice had an active patient focus group that met every three months to discuss issues relating to the practice and to listen to patient feedback. There was also a virtual patient group who were involved in campaigns relating to the practice. This was set up in order to gain a variety of patients’ perspectives. One of the issues related to the wearing of uniforms by staff who worked in the practice. The practice considered all views and it was the consensus of the group that staff should continue to wear them because it meant staff were easily identifiable and it presented a more professional image.

We saw the records of the patient forum meeting held in September 2014. It showed the patient forum considered feedback from the ‘Friends and Family Test’, staff uniforms, telephone consultations and patient values.

Are services well-led?

Good

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

The practice carried out a survey in October 2013 on behalf of Bristol Community Health. We saw the action plan in response to the questionnaires received. The survey provided a benchmarking against 927 practices and overall the practice rating was 87%. It was rated in the top 25% in respect of opening hours and telephone access. In most areas if was rated in the middle 50% of all practices. It was rated as within the lowest 25% in relation to the comfort of the waiting room, being able to see a GP within 48hours and waiting time. Staff responsible for addressing actions in respect of the plan were identified and the plan showed all actions were completed.

All of the comments the practice received in the Friends and Family Test were positive.

Management lead through learning and improvement

The Brisdoc training and development policy indicated the organisation was committed to ensuring that all staff had equal access to training to perform their role to the standard required. It stated that no staff would be denied access to any training by reason of discrimination. The policy outlined how annual personal development reviews would provide the opportunity to discuss training and development with their manager.

Staff confirmed they had annual appraisal that was reviewed at the mid-year stage. They said they found the process enjoyable and useful as it identified a learning plan.

Team meetings were held for admin staff and receptionists. Managers meetings considered issues relating to the management of the practice and walk-in centre.

Each day there was protected time between 1pm and 2pm for the GPs to get together for peer review, audits and to discuss complex patients. The manager attended practice managers meetings for GP surgeries in the inner city and east areas of Bristol and the lead nurse and registered manager attended meetings for the same group. The registered manager also attended the BrisDoc quality management and clinical governance forum where patient satisfaction, significant events and any emerging themes were discussed.

Staff told us about the training opportunities they had. One nurse told us how the practice was funding their completion of a diploma in asthma management. Another nurse told us they believed BrisDoc to be good at developing staff. They told us about the insulin conversion training they had completed and the training in management of asthma and diabetes.