Montpelier Health Centre

Quality Report

Montpelier Health Centre
Montpelier
Bristol
BS6 5PT
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Montpelier Health Centre on 2 December 2014.

We rated the practice as good for providing well-led, effective, safe, caring and responsive services. It was also good for providing services for older people, people with long-term conditions, mothers, babies, children and young people, working-age population and those recently retired, people in vulnerable circumstances who may have poor access to primary care and people experiencing poor mental health.

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns and knew how to report incidents and near misses. Information about safety measures were 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 told us they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about the services provided and how to complain was available and easy to understand.
- The practice had good facilities and was 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 upon.
- The practice was a GP training practice. There was a practice focus on the development of individuals and involvement in research projects.

In addition the provider should:

Summary of findings

- the practice should ensure that all relevant documentation for the recruitment of new staff is retained to show a robust and safe process was carried out.

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 report incidents and near misses. Lessons were learned from incidents and complaints and communicated to staff and actions were put in place in order to prevent reoccurrence. Information about safety measures were 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. Information from NHS England and the practice showed that patient outcomes were average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and treatment and support was planned and delivered to meet those needs. Care plans were in place for patients who had long term care or complex health needs. For patients deemed to be at a higher risk in respect of their ability to make decisions we found that there were systems in place for assessing capacity and decision making. The practice provided information and support to patients for promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and training planned in order to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked well 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. There was support provided to patients and carers to enable them to cope emotionally with their care and treatment. 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. Most patients said they found it easy to make an appointment and there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. The staff and the practice had a very

Summary of findings

flexible approach to providing support to patients and to the local community surrounding the practice. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff understood and supported the ethos of the practice. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted upon. The patient participation group (PPG) was active. The practice was a GP training practice; it also provided practical experience for medical students. There was a focus on the development of individuals and involvement in research projects. Staff had received inductions, regular performance reviews and had attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Just above 3% of the patient population were over 65 years old. Around 1.5% of the practice patients were 75-84 years old and just under 0.5% of patients were over 85 years old. The practice offered proactive, personalised care to meet the needs of the older people in its population. Each patient was provided with a named GP for the over 75 year olds. There was multidisciplinary team working to support patients to remain being cared for in the community and prevent hospital admissions. The practice staff were responsive to the needs of older people, and provided more than the expected number of home visits for patients who homebound and living rural settings.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Information from the Bristol Clinical Commissioning Group (CCG) showed that 46% of the patients had long standing health conditions, which was below the national average of 54%. Nursing staff had lead roles in chronic disease management. Patients at risk were provided with support from multidisciplinary team working with other professionals. Care plans were in place to prevent hospital admissions. Longer appointments and home visits were available when needed. All these patients had at least an annual review to check that their health and medicine needs were being met.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children who were at risk. Immunisation rates were low for some of the standard childhood immunisations. The practice was working with the different cultural groups to ensure the offer of immunisations was taken up. Appointments were available outside of school hours and the premises were suitable for children and babies.

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). 9.2% of the working population were unemployed which is above the national average of 6.2%.The needs of the working age population, those who could not attend the practice during working hours were met by offering

Summary of findings

access through extended hours. The practice offered online services as well as a full range of health promotion and screening that reflects the needs for this age group. The practice also offered NHS Health Checks to all its patients aged 40 to 75 years.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability and annual health checks were offered to provide extra support to them. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people or people seen as at risk. The practice provided access to and information about various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children and were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies. The percentage of patients who had caring responsibilities was just over 11% which is below the national average of 18.5%. The practice had systems in place to monitor and support patients who had caring responsibilities.

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). Patients with poor mental health were offered an annual physical health check. The practice staff worked regularly with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia, and had care plans in place. Patients had access to counselling services. Patients could also access a Post Natal Group and a Wellbeing Arts Group provided on the practice premises.

Summary of findings

What people who use the service say

We spoke with 10 patients in person during the day. We received information from the 17 comment cards left at the practice premises.

Patients said there were enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. Feedback from patients we spoke with confirmed that communication was good between the practice and the attached staff and hosted services.

Patients told us that consent was asked for routinely by staff when carrying out an examination or treatment. They also told us that staff always waited for consent or agreement to be given before carrying out a task or making personal contact and that if they declined this was listened to and respected. Patients we spoke with confirmed their GP involved them in care decisions and they also felt the GP and other staff were good at explaining treatment and results. Patients 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. If they decided to decline treatment or a care plan this was listened to and acted upon.

Information showed that patients were satisfied with how they were treated. Patients said they felt the practice offered a good service, staff understood, and were efficient, helpful and caring. They also said staff treated them with dignity and respect. Patients were positive about the emotional support provided by the practice staff. If they requested urgent attention, patients were always seen on the day of their request, this included patients who required home visits.

Representatives from the Patient Participation Group said the practice listened to the comments patients made about the service. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever made a complaint about the practice.

Areas for improvement

Action the service SHOULD take to improve

- The practice should ensure that all relevant documentation for the recruitment of new staff is retained to show a robust and safe process was carried out.

Montpelier Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team also included a GP Specialist Advisor.

Background to Montpelier Health Centre

Montpelier Health Centre is situated on the edge of Bristol's inner city. The practice had 18,154 registered patients. The practice provides care and support to patients from the surrounding areas and based on information from NHS England, 0.1% of its patients live in residential care or nursing homes.

The practice is located in purpose built premises over two levels. The practice has an additional surgery building, on the same site, Bath Buildings Surgery which opened in November 2013. Patients can attend either surgery if they wish. Montpelier Health Centre has a moderate sized central patient waiting and reception area with consulting and treatment rooms accessible from this area. Bath Buildings Surgery has consultation and treatment rooms over two floors which are accessible by a lift and a reception area on the ground floor. The practice has a primary medical service contract with NHS England. There is a commercial pharmacy on the same site as the GP practice. Montpelier Health Centre shares the main building with other services provided by the NHS such as community nurses, health visitors, and midwives. The Haven, Bristol's Asylum Seeker healthcare project is also accommodated.

Montpelier Health Centre is only provided from one location:

Montpelier Health Centre

Montpelier

Bristol

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The practice supported patients from all of the population groups which are older people; people with long-term conditions; mothers, babies, children and young people; working-age population and those recently retired; people in vulnerable circumstances who may have poor access to primary care and people experiencing poor mental health.

Over 60% of patients registered with the practice were working age from 15 to 44 years; just under 20% were aged from 45 to 64 years old. Just above 3% were over 65 years old. Around 1.5% of the practice patients were 75-84 years old and just under 0.5% of patients were over 85 years old. 15% patients were less than 14 years of age. Information from the Bristol Clinical Commissioning Group (CCG) showed that 46% of the patients had long standing health conditions, which was below the national average of 54%. The percentage of patients who had caring responsibilities was just over 11% which is below the national average of 18.5%. 9.2% of the working population were unemployed which is above the national average of 6.2%. Of the practice population just over 18% were from black and minority ethnic communities which was above the national average of 16%. The practice supports patients from 29 religious or cultural backgrounds, 54% Caucasian, 20% Somali and Caribbean.

The practice consisted of five GP partners who employed nine salaried GPs. Of these fourteen GPs there were four male and nine female GPs. The practice was a training practice for medical and nursing students, newly qualified doctors and GP registrars. There were nine practice nurses including three who were nurse prescribers and a nurse manager. One nurse was also the lead for clinical audit and

research at the practice. The practice employs a clinical pharmacist. Three health care assistants were employed to support the registered nurses delivering care to patients. The practice was open from 8am four days per week and Thursdays from 7.30 am. On Tuesday, Wednesday and Thursdays the practice remained open until 8pm.

On Mondays the practice closed 6:15pm and 5pm on Fridays. The practice closed Wednesday lunchtimes between the hours of 12:30 to 2pm to accommodate staff training and meetings. The practice referred patients to, NHS 111 and BrisDoc out of hour's service to deal with any urgent patient needs when the practice was closed.

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.

We inspected this service as part of our new inspection programme to test our approach going forward. This provider had not been inspected before and that was why we included them.

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

How we carried out this inspection

The practice provided us with information to review before we carried out an inspection visit. We used this, in addition to information from their public website. We obtained information from other organisations, such as the local Healthwatch, the Bristol Clinical Commissioning Group (CCG), and the local NHS England team. We looked at recent comments left by patients on the NHS Choices website.

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

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

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

- Older people
- People with long-term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health.

During our visit we met and spoke with four of the GPs we also spoke with a GP on the telephone. We spoke with the nurse practitioner and two practice nurses. We also spoke with the practice business manager, operations manager and the reception and administration staff on duty. We met with the clinical pharmacist who was on duty and the attending interpreter who worked at the practice regularly. We spoke with ten patients in person (including four members of the Patient Participation Group) during the day. We received information from the 17 comment cards left at the practice premises.

We observed how the practice was run, the interactions between patients and staff and the overall patient experience.

Good

Are services safe?

Our findings

Safe track record

We spoke with five GPs and reviewed information about both clinical and other incidents that had occurred at the practice. We were given information about 10 incidents which had occurred during the last 12 months. These had been reviewed under the practices significant events analysis process. These incidents included poor communication from a hospital, prescribing and a patient's unusual clinical presentation.

Where events needed to be raised externally, such as with other providers or other relevant bodies, this was done and appropriate steps were taken, such as providing information to the Bristol Clinical Commissioning Group (CCG) about medicine prescribing errors.

We were told by the lead nurse responsible for the management of clinical audits and research how national patient safety alerts (NSPA) and other safety guidance was checked and circulated to the relevant staff. The practice operations manager told us how comments and complaints received from patients were responded to. Staff we spoke to were aware of their responsibilities to raise concerns, and how to report incidents or events.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. The records we reviewed showed that each clinical event or incident was analysed and discussed by the GPs, nursing staff and senior practice management. When we spoke with other staff we were told that the findings from these Significant Events Analysis (SEA) processes were disseminated to other practice staff if relevant to their role.

We saw from summaries of the analysis of the events and complaints which had been received that the practice put actions in place in order to minimise or prevent reoccurrence of events. For example, where a discharge from hospital failed and the patient was returned to hospital. The GPs discussed what actions to take should the issue arise again and ensured that concerns were fed back to the hospital discharge team directly. Another event was where a patient became unwell through one health issue and the treatment impacted on their other health needs. GPs identified that greater monitoring and checks should be in place to prevent reoccurrence. There was a system of assessing significant events and complaints for trends and risk areas.

Safety alerts and information was available on the electronic records for staff to readily access. The nurse responsible for coordination of clinical research and audits was responsible for maintaining information and alerting GPs to changes as they occurred.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We asked members of medical, nursing and administrative staff about their most recent training. We were told that all non-clinical staff at the practice had been provided with or were in the process of completing level one training for both safeguarding vulnerable adults and children via e learning. One GP took the lead for safeguarding children and another for safeguarding adults at the practice. All of the GPs had been trained to level three for safeguarding children.

We saw from the training information that additional training had been undertaken by some of the staff. This included GPs participating in SARSAS – Sexual violence awareness (2014) and reception staff in Domestic Abuse training (2011).

Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities. Staff knew how to share information, record information about safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible. All staff we spoke to were aware who the leads were for safeguarding adults and children and who to speak to in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. Staff were alerted with 'pop ups' when patients records were accessed. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans.

The lead safeguarding GP was aware of the patients who had been assessed as vulnerable children and adults.

Good

Are services safe?

Information from the GPs demonstrated good liaison with partner agencies such as the police and social services and they participated in multi-agency working. Weekly discussions took place with health visitors in regard to children identified as at risk. Monthly discussion took place with the health visitors responsible for older people in the local community. Through discussion with staff it was clear that patients at risk were discussed and information shared appropriately with other staff at the practice. Care plans were in place for both children and adults.

We were told about the monitoring and work undertaken when speaking to parents/ representatives of children registered at the practice in regard to FGM (Female Genital Mutilation).They had been made aware of the legal implications if their child had the procedure.

There was a chaperone policy, which was visible on the waiting room and in consulting rooms. There was a chaperone protocol for staff which set out clear steps staff should take and how chaperone support should be recorded in patient's records. Additional training had been provided to some of the administration and reception staff to provide chaperone support to patients. Patients told us they were aware of the availability of chaperones if they required it.

Medicines management

We looked at the systems for medicines used at the practice and the safe keeping on prescription pads and paper.

Staff told us about the practices for safe medicine administration and storage at the practice. We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

The practice had a GP who was the prescribing lead and they were able to describe the processes in place for reviewing prescribing at the practice. We also spoke with the clinical pharmacist assigned to the practice from the Clinical Commissioning Group (CCG) and the work they did in conjunction with each other to reduce waste, ensure appropriate prescribing took place and up to date guidance was shared and used. We heard how this information about the medicines prescribing at the practice was reviewed and discussed in team meetings and clinical audits. Regular checks were made from the patient record system for specific drugs and actions put in place to change prescriptions and to recall patients for checks.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. Nursing staff had access to up to date guidance and directions and we saw that nurses had received appropriate training to administer vaccines

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. We looked at the repeat prescribing arrangement for medicines. No concerns were noted by us. The provider had systems in place and worked well with the pharmacy located on the site. They had a consulting pharmacist who assisted them with on-going monitoring.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with and who wrote in the comment cards said they had found the practice clean, hygienic and had no concerns about infection control.

We were told there was a GP, the operations manager and a nurse manager who shared responsibility for infection control at the practice. We saw that there was an infection control policy that set out staff's responsibilities including the planned audits and training for staff to complete. We were told that e learning was included in new staff's induction training and that e learning was available to all staff. We saw information that some but not all staff had completed annual training updates on infection control.

We spoke with the practice nurse on duty about infection control audits. They were unable to show us documentary evidence of infection control audits carried out at the practice but we were told about what visual checks they carried out daily in clinical and treatment areas. We saw

information to show that cleaning and environmental audits took place monthly which included hand wash facilities and the provision and cleanliness of liquid soap and antiseptic gel dispensers.

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

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal).We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Staff were able to tell us about and show us the systems for safe disposal of clinical waste. The practice had a suitable contract with a clinical waste company.

The practice had set up an isolation room so that they could take precautions if a patient presented with symptoms of an infectious disease. The room was set up with minimal equipment so that it could be cleaned easily and was positioned away from the main areas that patients used. There was a protocol in place for its use and a procedure for staff for its decontamination following use.

Equipment

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

Staffing and recruitment

We looked at documents relating to the recruitment and employment of three new staff. We viewed a copy of the provider's electronic logs or check lists used to show records and information had been obtained for new staff. The 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). However, copies of the proof of identification documents had not always been kept. Clinical staff were required to provide information about their immunisation status such as Hepatitis B (Hepatitis B virus is a viral infection carried in the blood causing inflammation of the liver and potentially long term damage).

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. We saw that new staff were provided with information about their job role and the key policies of the practice. Each member of staff was provided with a staff handbook which informed them of their employment responsibilities. Copies of their contractual agreement were also kept.

Staff told us about the arrangements for planning and ensuring the number of staff and mix of staff needed to meet patients' needs was met. Administration staff had multiple roles to support the staff team and replaced or supported reception staff when required when the practice was busy. 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 enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. This was reflected in the comments made by patients about the staff at Montpelier Health Centre.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. For example identified risks were noted in a health and safety audit. Each risk was assessed and actions recorded to reduce and manage the risk The practice also had a health and safety policy. Health and safety information was displayed for staff to see.

We saw that any risks were discussed within team meetings. Welfare, clinical risks and the risks to patient's

Good

Are services safe?

wellbeing were discussed daily and weekly by the GPs and nursing staff. There were systems for monitoring patients with long term conditions, end of life care and patients being treated for cancer.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator.

When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. Emergency medicines were stored safely and the medicines included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to and who was responsible for what needed to be carried out. For example, contact details of the power supplier and alternative accommodation from which to continue providing a service should it be required.

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

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with told us about their approaches to providing care, treatment and support to their patients. 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. One of the GPs at the practice was a NICE Fellow which enabled them to keep updated with current guidance and disseminate information to colleagues at the practice. This was through practice meetings where the implications for the practice's performance and patients were discussed and actions agreed.

The practice used an assessment tool to help identify high risk patients and it participated in joint working with other health and social care professionals and services to avoid patients unplanned hospital admissions. Care plans were in place for people who had long term care or complex health needs.

The GPs told us they had lead roles lead specialist clinical areas such as caring for patients with long term conditions such as diabetes or heart disease. The practice nurses supported the GP with this work for patients with on-going long term conditions. The practice held nurse led clinics run by the three nurse prescribers and practice nurses were trained to respond to patients attending the practice with minor illnesses. We heard about GPs other interests; such as a GP was a General Practitioner with Special Interests (GPwSI) in Gynaecology and supported other GPs in the Clinical Commissioning Group with any concerns they had. Another GP, an Associate Dean of a local Deanery, led in providing support for GP training at the practice. One GP had a special interest in dermatology and was a specialist advisor to the All Party Parliamentary Group on Skin.

All of the GPs were involved in some aspect of clinical research. The practice employed a Clinical Audit Coordinator practice nurse who took the lead with ensuring the information from the research and audits was managed well. GPs and nursing staff we spoke with were open about asking for and providing colleagues with advice and support. We heard about discussions the GPs and nursing staff had regarding improving outcomes for patients. The records for Significant Events Analysis (SEA) confirmed that this happened.

The intelligent monitoring information we had available and that provided by the practice showed the practice was in line or above with expected national levels of achievement for the year 2013 to 2014. For example, diabetics who had an annual foot examination and patients with a diagnosed with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in their care record,

The information supplied by the practice showed that they had a programme for ensuring the 71 patients who were registered as having a learning difficulty had an annual health check. 58% had been achieved with 39 reviews carried out. There was also a programme of medicine reviews specifically for patients on multiple medicines (polypharmacy) where 89% of the patients had a review carried out. 83% of patients with mental health needs had received a physical check-up.

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

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included child and adult protection, a responsibility (a named GP) for patients over 75 years of age and paediatric care. One GP was the link for improving the care and treatment for patients from ethnic minorities and asylum seekers and worked with The Haven, (a specialist primary healthcare care service provided by another provider for asylum seekers and refugees new to Bristol) that is hosted on the premises of Montpelier Health Centre.

We spoke with GPs and the Clinical Audit Coordinator about how they reviewed and assessed they were meeting patient's needs. Information was provided from the Quality and Outcomes Framework (QOF), significant events, new guidance and feedback from patients generated clinical

Good

Are services effective?

(for example, treatment is effective)

audits. QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures. For example, audits in relation to prescribing specific medicines for treatment for patients at risk of cardiac problems or vascular disease. The audits carried out in 2013 identified that training and guidance needed to be followed in greater depth to achieve the best outcomes for patients. The audit was carried out again in 2014 and highlighted improvements in care of patients had meant the numbers of patients identified at greater risk had been reduce from six to two.

The practice showed us examples of other clinical audits that had been undertaken in the last year. One was in regard to establishing that appropriate monitoring for patients prescribed certain higher risk medicine treatment plans had been carried out effectively. Another was in regard to the care provided to diabetic patients. Each audit had been repeated on annual basis and the findings had led to changes in practice to providing care to patients.

The practice also used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. The practice met minimum standards for Quality and Outcomes Framework (QOF). For example patients with diabetes, asthma, and with a diagnosis of dementia had their care plan reviewed in the previous 12 months. This practice was an outlier (variation in expected figures) for some QOF (or other national) clinical targets. These were in regard to Coronary Heart Disease, seasonal influenza vaccination and cervical smear tests. The practice was aware of these issues and others not included in QOF, such as chlamydia testing, national breast screening and some infant immunisations. The practice had identified that it supported patients from 29 cultural and religious backgrounds and the nature of the transient population made it difficult to attain these targets.

Staff were very positive about the culture in the practice around audit and quality improvement, noting that there was an expectation that all clinical staff should undertake or become involved in the audits carried out.

There was a protocol for repeat prescribing which was in line with national guidance. To comply with this, staff regularly checked that patients who received repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines.

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

The practice also participated in research we were told in the current programme they were looking at child health screening for a genetic condition.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that most staff were up to date with attending mandatory courses such as annual basic life support. Where there were gaps in training, particularly e learning, this was highlighted and planned for individual staff. We noted a skill mix among the GPs with interest in gynaecology, paediatrics, research and palliative care. One GP had a special interest in drug rehabilitation, another led on caring for patients from ethnic minorities and asylum seekers. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

GPs were provided with protected time for learning with five days study leave each year. There was an on-going plan of in house learning with guest speakers; joint training with other members of staff took place on a weekly basis. Lead GPs had obtained the specific training they required such as revisiting safeguarding children training at level three or to provide support and mentor GP registrars and trainee doctors.

Nurse practitioners, practice nurse had defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology and family planning.

Good

Are services effective?

(for example, treatment is effective)

We were told by all levels of staff that they were provided with the time and the opportunity to undertake training and personal development. Staff told us annual appraisals identified learning needs from this action plans were developed and documented.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and to work in a coordinated way to manage the needs of patients with complex needs. The practice had attached staff such as health visitors, midwife's and the district nursing team. The practice hosted The Haven, a specialist service for asylum seekers, Bristol Drug Project, Bath Centre for Psychotherapy and Counselling and these services could be accessed. Patients could also access a Parent Craft Group, Post Natal Group and a Wellbeing Arts Group.

There was multidisciplinary team working for patients identified as at risk through age, social circumstances and multiple healthcare needs. Regular meetings with other professionals such as the community matron, district nursing teams, health visitors, palliative care team and social workers took place. Staff felt this system worked well and there was a team approach to supporting their patients. We obtained positive feedback from the three health care professionals who came in contact with the service. We were told they were a very friendly and open staff team who never failed to provide support to other professionals. We heard how they were able to work very closely with the nurses and the GP's for the busy open access Baby Clinic. This worked well for the diverse patient groups as there were interpreters and representatives from other organisations involved such as the local children's centre and a charity offering support for families affected by Postnatal Depression. We were told the clinic was well attended and received consistently good feedback from families.

We heard how the practice worked with other health care providers in the area such as community health teams in projects in regard to promoting health checks.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner.

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

The practice also had an internal system to shared documents and records relating to the running of the service, clinical protocols, policies and procedures were all available to staff electronically.

Consent to care and treatment

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.

Patients with a learning disability and those with a diagnosis of dementia were supported to make decisions through the use of care plans, which they were involved with. These care plans were reviewed annually or more frequently if changes in clinical circumstances dictated it. The practice had a policy, procedure and information in regard to best interests' decision making processes for those people who lack capacity. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child had the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions including a patient's verbal consent which was recorded in the electronic patient notes.

Patients who told us that consent was asked for routinely by staff when carrying out an examination or treatment. They also told us that staff always waited for consent or agreement to be given before carrying out a task or making personal contact. They also confirmed that if patient's declined this was listened to and respected.

Health promotion and prevention

It was practice policy to offer a health check with the health care assistant or practice nurse to all new patients registering with the practice. New patients' health concerns were identified and arrangements made to add them into any long term health monitoring processes such as the

Good

Are services effective?

(for example, treatment is effective)

diabetes, asthma or heart conditions clinics or reviews. The practice provided information and support to patients to help maintain or improve their mental, physical health and wellbeing. For example, by offering smoking cessation advice to patients who smoke. The practice told us they had three Stop Smoking Advisors and had 60 patients involved. The practice offered NHS Health Checks to all its patients aged 40 to 75 years and 3% of its patients in this age group had taken up this service during the last year.

We were told there was a reasonably high turnover of patients registering at the practice. Information from NHS England showed there was around 11.5% during the year 2013 to 2014. We were told about the high risk groups that were in the community and the services they provided to encourage them obtaining healthcare and support. This included making it easier for homeless patients to register. They also provided information about health care in different language formats, supporting and using on site interpreter services and targeting specific patient groups to promote good health. For example promoting childhood immunisations for Somali children by displaying a poster in the appropriate language.

The practice identified patients who needed additional support. For example, the practice kept a register of all patients with a learning disability who were offered an annual physical health check.

We were told that during 2013 staff from the practice attended a health promotion event at a local taxi service to target Jamaican men who do not attend health checks. During the summer of 2014 one GP and a nurse practitioner went to a local community centre and provided a health talk and showed equipment to a group of Somali women to promote women's health. The practice staff were also involved in a project with a local community trust promoting sports participation, education, health and social inclusion particularly to young people in schools. The practice provided input to promoting different topics such as asthma and sport, weight management, basic life support, diabetes and individual life plans over a year long programme.

Advice and information was readily available in the practice about a wide range of topics from health promotion to support and advice. Information was also available on the practice website or patients were directed to links to other providers for specific advice. For example, young people were guided to the services at the practice, 4YP, which provided advice and sexual health services for younger people.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent information available for the practice on patient satisfaction. This included information from a survey by the practice's patient participation group (PPG) of all the young people, between 13 and 24 years of age who attended the practice in February 2013 (39 responses). We also looked at information from their Friends and Family survey (240 responses) carried out during a three month period in 2014. Information showed that patients were satisfied with how they were treated. For example 87% of the young people found the practice welcoming and friendly.

There were 17 patients who completed CQC comment cards to tell us what they thought about the practice. All of these were positive about the service they experienced. Patients said they felt the practice offered a more than good service and staff were usually understanding, efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with 10 patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. In the treatment suite, where the nursing staff ran clinics, curtains divided the treatment couches and patients' privacy was maintained as best as possible when treatment was being carried out. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff followed the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice main switchboard was situated in another part of the building away from the main reception and waiting room areas in both buildings which helped keep patient information private.

Care planning and involvement in decisions about care and treatment

The feedback from patients showed patients experienced being involved in planning and making decisions about their care and treatment and generally felt the practice did well in these areas. Patients we spoke with confirmed their GP and nursing staff involved them in care decisions and they also felt the staff were good at explaining treatment and results.

Patients we spoke with on the day of our inspection 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. If they decided to decline treatment or a care plan this was listened to and acted upon.

Staff told us that translation services were available for patients who did not have English as a first language. The practice was supported by the Clinical Commissioning Group by the provision of a Somali or Polish translator available during the week to support the high number of patients attending the practice who did not speak or understand English well. We saw notices in the reception areas, leaflets and on the practice website informing patients this service and other translation services were available.

Patient/carer support to cope emotionally with care and treatment

The information from patients showed patients were positive about the emotional support provided by the practice staff. For example, we were told by one patient how they were supported with a new diagnosis and their long term care was explained to them. They told us they were able to speak to the GPs and nursing staff who answered their questions well and were patient with them when they needed reassurance.

Notices in the patient waiting room and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs and other staff if a patient was also a carer. We were told how access to appointments was flexible to patients who were carers, or had difficulty attending the practice because of their mental health needs. We were told how the GPs and health care staff were flexible to providing home visits to reduce the difficulties carers of patients had attending the practice. An example of the extended home visit service was providing influenza immunisations.

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 patients' 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. For example, they provided a flexible approach to homeless patients registering and obtaining health care and support. The practice also recognised the cultural differences of the patient groups attending the practice in regard to the safety of female children or young women. They had undertaken work in speaking to parents/ representatives of children registered at the practice in regard to FGM(Female Genital Mutilation).Parents had been made aware of the legal implications if their child had the procedure

Patients and staff told us that all patients who requested urgent attention were always seen on the day of their request this included patients requiring home visits. There was also a triage service so that urgent requests were assessed and requests were prioritised according to need. The practice had also looked at other methods of providing a responsive service by holding clinics, such as the leg ulcer clinic, on a regular day each week for patients who found it difficult to attend variable appointment times.

There was a computerised system for obtaining repeat prescriptions and patients used both the email request service, or posted or placed their request in a drop box in reception or outside the building. Patients told us these systems worked well for them.

The practice had a Patient Participation Group (PPG) and patients were able to provide feedback about the quality of services at the practice through the PPG. The PPG carried out regular patient surveys and there was evidence that information from these was used to develop services provided by the practice. Representatives from the PPG said the practice listened to them about the comments patients made about the service.

Tackling inequity and promoting equality

The practice had recognised they may need to support people of different groups in the planning and delivery of its services. They had identified they needed to encourage patients from different age groups and ethnic backgrounds to be involved in order to meet their diverse needs and were working with the PPG to achieve this. For example surveying different age groups visiting the practice to find out their opinion of what was provided.

The main premises were built in 1970 and extended in 1997 and met the needs of the population it served at the time of around 12,000 patients. The landlord ensured the building was built to meet the needs of patients with disabilities. Patient areas were all on ground floor level, accessible and suitable for wheel chair users and people with limited mobility. On the first floor administration and meeting rooms were available which allowed the practice to share the premises with attached community teams such as the midwives and district nurses. The practice partnership recognised they required greater facilities for their patient group as they wished to move a service from a second practice premises at Sussex Place. To accommodate the total number of 18,000 patients they built a new building on the site with additional consulting and treatment rooms. It also allowed them to offer facilities to a local pharmacy to provide a service on-site.

There were waiting areas in both buildings which were large enough to accommodate patients with wheelchairs and prams and allowed generally for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Access to the service

The practice was opened at 8.am four days per week, and opened 7.30am Thursday morning to accommodate people who could not attend later during the day. Three days per week the practice was open to 8pm, it closed early on Mondays at 6:15 pm and Fridays at 5pm. The practice was accessible to patients throughout the day, the exception was Wednesday when it closed midday 12:30pm to 2pm for regular training and meeting times for staff. The practice referred patients to another provider, NHS 111, for an out of hour's service to deal with any urgent patient needs when the practice was closed.

Comprehensive information was available to patients about appointments on the practice website, these were also available on display in the practice waiting areas and provided to patients when they registered with the practice. This information included how to arrange urgent

Good

Are services responsive to people's needs?

(for example, to feedback?)

appointments, home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave patients the telephone number they should ring for the out of hours service

Patients were generally satisfied with the appointments system. However, some told us they had found it difficult at times to make an appointment, with a delay of two weeks from booking. They confirmed that they could see a GP on the same day if they needed to. They also said they could see another GP if there was a wait to see the GP of their choice. Comments received from patients showed that patients in urgent need of treatment were able to make appointments on the same day of contacting the practice.

The practice Patient Participation Group (PPG) told us they were aware of the delays in achieving appointments in a timely way for some patients. They had identified there was a high rate of non-attenders, which impacted on providing patients an appointment time of their choice. Both the PPG and practice team were looking at how they could meet the demand for appointments at the practice.

Listening and learning from concerns and complaints

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

Information was available to help patients understand the complaints system. Information was on display in the patient areas and included on the practice website. There were leaflets provided for patients to take away if they wished to with details of how the complaints process worked and how they could complain outside of the practice if they felt their complaints were not handled appropriately. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at the information about the 21 complaints the practice had received in the last 12 months and found generally they were satisfactorily handled and dealt with in a timely way. The complaints ranged from a variety of issues, some were in regard to staff attitude at the first point of contact at the reception desk. Others were in regard to patient expectation for treatment or referral to other healthcare providers. We saw that from all complaints the practice had looked at how it could improve and avoid patients raising similar complaints in the future.

There was a method to identify common areas of complaints. Each complaint or comment was also reviewed. Where potential serious concerns had been identified these were elevated as a significant event and then reviewed in more depth by the management team.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The practice told us their ethos was that it was important as a training practice, to train and develop GPs for the future and equally important to provide an up to date service to the patients they support.

When we spoke with the GPs, the nurses and other staff on duty they all understood what the vision and values were of the practice When we spoke with staff we were told about their focus on promoting good health to patients and a wider population group. We were told about and provided with information about the work the practice did locally with a football club charitable organisation in regard to health promotion for young people. We were told about the practices involvement in health promotion further afield than the local area. They had supported several visits from GPs and health providers from South Africa in regard to developing their own health care system. One GP from the practice had involved local schools and communities around the practice in raising money for health care facilities in Nepal. Children from the local schools have been enabled to visit Nepal and learn about the importance of good healthcare and cultural differences of the population there.

Governance arrangements

The practice had policies and procedures in place to govern how services were provided. These policies and procedures were available electronically, some in hard copy for easy access. Staff were required to record when they had read and understood new or reviewed policies and procedures. There was a system to ensure that policies and procedures were reviewed and updated where required on an annual basis. GPs and nursing staff were provided with clinical protocols and pathways to follow for some of the aspects of their work. For example, the handling of vaccines and medicines or ensuring a consistent approach was made for patient referrals.

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 a GP partner was the lead for safeguarding. There were GP leads for clinical governance, and another led the support for the trainees at the practice. All of the members of staff we spoke with were clear about their own roles and responsibilities. They told us they felt valued, well supported and knew who to go to in the practice with any concerns.

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

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, that appropriate monitoring for patients prescribed certain higher risk medicine treatment plans were carried out effectively. Another was in regard to the care provided to diabetic patients. Each audit had been repeated on annual basis and the findings had led to changes in practice to providing care to patients.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us the risk log, which addressed a wide range of potential issues, such as the environment. The risk log was reviewed and updated in a timely way. Risk assessments had been carried out and where risks were identified action plans had been produced and implemented.

The practice held monthly governance meetings and business meetings where issues were discussed and plans put in place to develop the service.

Leadership, openness and transparency

We heard from staff at all levels that team meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. Salaried and trainee GPs were included in meetings and this was reflected in the conversations we had with them where they felt included and valued in the running and development of the service.

The practice employed a practice business manager as well as an operations manager to enable the business and administration of the service. Their responsibilities included the development and implementation of human resource policies and procedures. We reviewed a number

Are services well-led?

Good

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

of policies, such as those for employing and supporting new staff and found they were up to date and contained the required information. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received. We looked at the results of the annual patient surveys and saw that patients had highlighted a range of issues that they thought could be improved. This included their concerns about accessing appointments. The practice had introduced a triage service to ensure that all urgent patients' needs were attended to.

The practice had a small number of people involved in their patient participation group (PPG). The group, who were supported by the practice staff, told us they were working on increasing the diversity of the group to reflect the population of patients the practice supports. They were developing a virtual group and had also undertaken surveys of younger patients (13 to 24 year olds) to see how they could engage with them.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice. This enabled staff to raise concerns without fear of reprisal.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Staff confirmed that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they were provided with opportunities to develop new skills and extend their roles.

The practice was a GP training practice; it also provided practical experience for medical and nursing students. There was a focus on the development of individuals and involvement in research projects, the aim was to provide an up to date service to the patients registered with them.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients.