Kingswood Health Centre

Quality Report

Alma Road,
Kingswood ,
Bristol, BS15 4EJ
Tel: 0117 3012080
Website: http://www.kingswoodhealthcentre.co.uk

Date of inspection visit: 16 August 2016
Date of publication: 14/10/2016

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?	Outstanding
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 Kingswood Health Centre on 16 August 2016.

Overall the practice is rated as good, with the domain of responsive rated as outstanding.

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

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- Risks to patients were assessed and well managed.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment; there was an active patient group.
- Information about services and how to complain was available and easy to understand; the practice website was very informative and easy to navigate, and received approximately 3000 visitors per month.
- Improvements were made to the quality of care as a result of complaints and concerns.
- Patients said it was easy to make an appointment with a named GP 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.
- 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.
- The provider was aware of and complied with the requirements of the duty of candour.
- The practice were proactive in many areas of service development to improve access to treatment for patients; they were involved in an ophthalmology pilot which gave patients rapid access to assessment and treatment for a range of eye conditions.

We saw areas of outstanding practice:

Summary of findings

- The practice worked collaboratively with a community based alcohol advisory service to provide community detoxification from alcohol for patients which allowed swifter access for patients who required this type of treatment.
- The practice employed a sexual health and contraceptive nurse who adjusted their working shifts according to when patientscould attend appointments. This was the only post of this kind in the area; the nurse also followed up those women whose circumstances make it imperative that they have adequate contraceptive advice for example, thoseat risk of sexual exploitation working as sex workers.
- The practice also supported the "interim beds pilot project" with South Gloucestershire Council in nursing and residential homes. These 20 beds were for patients (not necessarily registered with the practice) who were medically fit for discharge from hospital, but who needed a further period of rehabilitation or recovery before they returned home. The care the practice offered as part of the pilot included a weekly review, responsive care if patients became acutely unwell, and the management of their medicines as well as advice and support to the home staff team.

The areas where the provider should make improvement are:

The practice should ensure that the record of the emergency equipment detailed exactly what had been checked.

The practice should introduce a failsafe system which ensured all equipment was calibrated.

The practice should monitor the protocol for use of patients' own medicines in the practice to ensure it is fully embedded.

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.

- There was an effective system in place for reporting and recording significant events
- Lessons were shared to make sure action was taken to improve safety in the practice.
- When things went wrong patients were informed as soon as practicable, received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- Risk management was comprehensive, well embedded and recognised as the responsibility of all staff.
- We found some areas within the practice which needed amendment such as the medicine protocol for use of the patient's own supply within the practice and ensuring there was a failsafe system to ensure all equipment is calibrated.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to the national average.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- The practice used innovative and proactive methods to improve patient outcomes and worked with other local providers to share best practice.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care.

Summary of findings

- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Outstanding ☆

The practice is rated as outstanding for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and The South Gloucestershire Clinical Commissioning Group to secure improvements to services where these were identified. For example, they were involved in an ophthalmology pilot which gave patients rapid access to assessment and treatment for a range of eye conditions.
- There were innovative approaches to providing integrated patient-centred care. For example, the practice was active in the One Care consortium which gave patients direct access to same day physiotherapy assessment which had been used for 100 patients since it started in November 2015.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day. The practice offered a range of appointment types to balance routine access with urgent care. They had 13 early morning phlebotomy appointments per week reserved for people who could not attend the practice during normal working hours.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Patients can access appointments and services in a way and at a time that suits them. For example, the practice employed a sexual health and contraceptive nurse who adjusted their working shifts according to when patients could attend appointments. This was the only post of this kind in the area. Information about how to complain was available and easy to understand and evidence showed 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 being well-led.

Summary of findings

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- 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 was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken
- The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active.
- There was a strong focus on continuous learning and improvement at all levels.
- The clinical team met every day to discuss clinical queries, referrals and arrange home visits by the most appropriate person to provide the best care for the individual patient.
- The practice had reviewed their staffing establishment and had employed a wide range of health care professionals to meet demands for services. This included a nurse practitioner, a clinical pharmacist and an acute care paramedic.

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.

- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- The practice had registered 226 patients in eight residential and nursing homes with a named GP lead for each home. Five of these care homes had weekly GP clinics.
- The practice held an annual review of all patients in care homes in conjunction with the clinical commissioning group pharmacy team and the South Gloucestershire community active ageing service.
- The practice employed a paramedic practitioner who was able to visit patients in their own home.
- The practice hosted the community nurses, the community matron and active ageing team on site and had an “open door” approach for discussing complex patients. The practice undertook the enhanced service for admission avoidance, there was a fortnightly “virtual ward” meeting at the practice which included members of the community nursing team and community matron, the rehabilitation team, social workers and an Age UK support worker.
- The practice used emergency care practitioners from the community healthcare services to undertake some home visits. This was initiated by the duty doctor who triaged requests for home visits.
- The practice supported the “interim beds pilot project” with South Gloucestershire Council in nursing and residential homes. These beds were for patients who were medically fit for discharge from hospital, but who needed a further period of rehabilitation or recovery before they return home. The care the practice offered as part of the pilot included a weekly review, responsive care if patients became acutely unwell, and the management of their medicines.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions.

Summary of findings

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- Longer appointments and home visits were available when needed.
- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.
- There were weekend review appointments available for patients in order to prevent any potential hospital admissions and for those who have difficulty accessing appointments during the week.
- The practice had employed a clinical pharmacist to work with older patients and those with long term conditions to promote medicines .
- The practice used emergency care practitioners from the community healthcare services to undertake some home visits. This was initiated by the duty doctor who triaged requests for home visits.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people.

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw positive examples of joint working with midwives, health visitors and school nurses. Health visitor clinics were held at the surgery once a week, these were run at the same time as the immunization clinic for patient convenience.
- The practice offered access to sexual health advice for both registered and unregistered patients.
- The practice had a nurse practitioner and paramedic practitioner who saw patients with minor illness.
- The practice operated a minor injuries service.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students).

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care such as daily phlebotomy clinics from 8.20am. They offered a range of appointment types to balance routine access with urgent care.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.
- The nursing team ran an evening travel clinic.
- The practice offered NHS health checks to patients aged 45 – 74, and were currently at the beginning of a new five year cycle. Of patients invited for health checks, approximately 70% attended their appointment.
- The practice operated a “sit and wait clinic” to see any additional patients in the morning ensuring that they were always able to offer patients an appointment if their need was urgent.
- There was a text reminder service for appointments, with the option to cancel appointments and provide the practice with the Friends and Family test feedback.
- The practice offered a variety of health promotion clinics and social prescribing such as weight management sessions.
- The practice employed a sexual health and contraceptive nurse who adjusted their working shifts according to when patients could attend appointments. This was the only post of this kind in the area; the nurse also followed up those women whose circumstances make it imperative that they have adequate contraceptive advice for example, those at risk of sexual exploitation working as sexual workers.

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 offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.

Summary of findings

- 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.
- The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability. The practice responded to chaotic circumstances of vulnerable individuals who arrived without an appointment by including them in the duty GP system and seeing unregistered patients as temporary residents to ensure they had access to health care.
- The practice had engaged with the local research network on the HepCATT study, a trial designed to evaluate interventions to increase the diagnosis and treatment of vulnerable and at risk patients with Hepatitis C.
- The practice had 246 (2%) of patients registered as a carer who could access support at the practice from a member of the carer's support centre based at the practice.
- Patients with severe anxiety or autism were known to reception staff and offered the opportunity to wait in the patient information room until they are called for their appointment.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients. The practice hosted a substance misuse service; they had a dedicated GP who had additional knowledge and skills, and worked closely with the service.
- The practice hosted an alcohol misuse worker who worked closely with the practice to support patients to undergo a community based detoxification programme.

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 patients experiencing poor mental health, including those with dementia.
- The practice signposted patients to the South Gloucestershire dementia prescription programme.
- The practice 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.

Summary of findings

- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia. They had recruited patients to participate in research programmes related to antidepressant prescribing.

Summary of findings

What people who use the service say

The national GP patient survey results were published on July 2016. The results showed the practice was performing in line with local and national averages. 250 survey forms were distributed and 116 were returned. This represented 1% of the practice's patient list.

- 66% of patients found it easy to get through to this practice by phone compared with the clinical commissioning group average of 68% and the national average of 73%.
- 89% of patients were able to get an appointment to see or speak to someone the last time they tried compared with the clinical commissioning group average of 92% and the national average of 76%.
- 91% of patients described the overall experience of this GP practice as good compared with the clinical commissioning group average of 86% and the national average of 85%.
- 82% of patients said they would recommend this GP practice to someone who has just moved to the local area compared with the clinical commissioning group average of 78% and the national average of 79%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 15 comment cards which were all positive about the standard of care received. Patients commented about the availability of appointments, the excellent quality of care received from the staff at the practice, and the high quality of the overall service they experienced. Patients observed they were satisfied with the care they received and thought staff were approachable, committed and caring.

The practice worked with the patient participation group to obtain responses to the friends and family test. The published results for June 2016 were that 92% of respondents would recommend the practice which was the third highest for the South Gloucestershire Clinical Commissioning Group.

Kingswood 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 included a GP specialist adviser and a nurse specialist adviser.

Background to Kingswood Health Centre

Kingswood Health Centre is an urban practice providing primary care services to patients resident in Kingswood and Staple Hill.

The practice operates from one location:

Alma Road,

Kingswood ,

Bristol, BS15 4EJ

The practice owned its purpose built site which housed the practice and additional NHS and private healthcare services. All patient services for the practice are located on the ground floor of the building. The practice has a patient population of approximately 12,000 with a higher than average population aged over 65 years.

The practice has eight GP partners (male and female), two salaried GPs, a practice manager, a nurse practitioner, a paramedic practitioner, a clinical pharmacist, five practice nurses, three health care assistants and a phlebotomist. Each GP has a lead role for the practice and nursing staff have specialist interests such as diabetes and infection control.

The practice is open between 8am and 6.30pm Monday to Friday. Extended hours appointments are offered between 6.30pm and 7pm Monday to Friday and between 8.30am and11am, for pre-booked appointments, on two Saturdays in every month.

The practice had a Personal Medical Services contract (PMS) with NHS England to deliver general medical services. The practice provided enhanced services which included admission avoidance, facilitating timely diagnosis, support for patients with dementia and childhood immunisations.

The practice is situated within the fifth less deprived decile. People living in more deprived areas tend to have greater need for health services. (The lower the Indices of Multiple Deprivation

(IMD) decile, the more deprived the area.)

The general Index of Multiple Deprivation (IMD) population profile for the geographic area of the practice is in the fifth least deprivation decile. (An area itself is not deprived: it is the circumstances and lifestyles of the people living there that affect its deprivation score. Not everyone living in a deprived area is deprived and that not all deprived people live in deprived areas).

The practice is GP training and teaching practice although there were no trainees in place at the time of our inspection.

The national GP patient survey (July 2016) reported that patients were more than satisfied with the opening times and making appointments. The results were comparable to local and national averages.

The practice has opted out of providing Out Of Hours services to their own patients. Patients can access NHS 111

or BrisDoc provide the out of hours GP service. information for patients on how to access these services is available via the practice website and their telephone answering service when the practice is closed.

Patient Age Distribution

Patient Age Distribution

0-4 years old: 6.2%

5-14 years old: 10.6%

15-44 years old: 40.2%

45-64 years old: 24.3%

65-74 years old: 9.4%

75-84 years old: 6.4%

85+ years old: 2.9%

Patient Gender Distribution

Male patients: 48.9 %

Female patients: 51.1 %

Other Population Demographics

% of Patients from BME populations: 4.9 %

Patients at this practice have a lower than local average life expectancy for men at 79 years and comparable average for women at 86 years.

The practice hosts other services onsite such as:

- Optical services.
- NHS based community nursing services.
- Chiropractic, physiotherapy and sports therapy.
- NHS accessed counselling services.
- Onsite pharmacy.

We had inspected this GP practice in August 2013 as part of our routine inspection programme.

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. The 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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 16 August 2016. During our visit we:

- Spoke with a range of staff including nurses, the management team, GPs and community staff based at the practice.
- Observed how patients were being cared for and in the reception area and observed at the daily clinical meeting.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.'

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

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

We also looked at how well services were provided for specific groups of people and what good care looked 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)

Detailed findings

- people whose circumstances may make them vulnerable
- people experiencing poor mental health (including people with dementia).

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.

Good

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, as soon as reasonably practicable, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice carried out a thorough analysis of the significant events.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, following an outbreak of influenza at one of the care homes the practice reviewed all care home patients to ensure they had received a pneumococcal vaccinations and this was coded on the patient record. We also saw that the practice always informed patients of any adverse event, even if they were not aware of it and provided feedback about the investigation and outcome. We saw an example of this for a delayed referral which resulted in an apology to the patient and a change of protocol. Where necessary the practice raised and shared adverse events with National Reporting and Learning System (NRLS) and an acute trust such as when there was continuing delay to the rapid access chest pain clinic.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs and nurses were trained to child protection or child safeguarding level 3.
- All staff had received training in tackling domestic abuse as part of the South Gloucestershire Clinical Commissioning Group (CCG) initiative. They had a system of alerts on the medical records for patients at risk of, or with a history of, domestic violence and for those families who are a cause for concern due to safeguarding children

  concerns.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy.
- The practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.
- We reviewed the arrangements for managing medicines, including emergency medicines and vaccines, used in the practice (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat prescriptions which included the review of high risk medicines. We found the practice held medicines on behalf of patients for administration by the practice nurses (injections). The protocol for managing this was unclear and we raised

this as an area for clarification to ensure prescribed medicines are only used for the named patient. Post inspection the practice provided us with a very clear protocol which aligned to their medicines management policy.

- The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing.
- Blank prescription forms and pads were securely stored and there were systems in place to monitor their use.
- The nurse practitioner was qualified as an independent prescriber and could therefore prescribe medicines for specific clinical conditions. They received mentorship and support from the medical staff for this extended role.
- Patient Group Directions (PGD) had been adopted by the practice to allow nurses to administer medicines in line with legislation. We reviewed these and found that the core PGD (which covered the authorisation of staff, documentation, audit requirements and general guidance on best practice required to safely administer vaccines) was out of date, and two other specific PGDs were unavailable. We raised this with the practice who responded with confirmation that two PGDs were no longer required and the core PGD had been in circulation for signing during the inspection and not stored in the appropriate file. Health care assistants were trained to administer vaccines and medicines against a patient specific prescription or direction from a prescriber.
- We reviewed four personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office which identified local health and safety representatives. The practice had up to date fire risk assessments and carried out regular fire drills. We saw records which indicated all electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. We noted two items had been missed for clinical calibration which the practice were made aware of and took action to remedy. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty. The practice manager monitored the same day access availability to ensure safe staffing levels.
- The practice had a system for monitoring Medicines and Healthcare products Regulatory Agency (MHRA) alerts were read by GPs who confirmed receipt of the information and that they had implemented any required actions.
- The practice used regular locum GPs for whom they undertook appropriate checks to ensure they were suitable to be employed, for example, checking the GMC register and the NHS England performer's List.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. We found first aid equipment and accident book were available; the practice provided a minor injury service and always had specially trained staff available to deal with any patients with minor injuries.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their

Good

Are services safe?

location. All the medicines we checked were in date and stored securely. We noted the record sheet for checking did not indicate which items had been checked, for example, it did not indicate if both of the practice oxygen cylinders had been checked. This was raised with the practice for amendment so the record was clear about what had been included in the checking process. This was confirmed by the practice as a completed action.

The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were implemented through peer sampling of patient records and through the root cause analysis of significant events and complaints.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 99.4% of the total number of points available. The combined clinical domain QOF exception rate was 13% with the CCG rate of 9% and slightly higher than the national average of 9%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

This practice was not an outlier for any QOF targets. Data from 2014/15 showed:

- Performance for diabetes related indicators was similar to the national average. The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months was 79% and the clinical commissioning group average of 77% and the national average of 78%.
- Performance for mental health related indicators was similar to the national average. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months was 92% and the clinical commissioning group average of 94% and the national average of 88%.
- The percentage of patients diagnosed with dementia whose care has been reviewed in a face-to-face review in the preceding 12 months was 89%

There was evidence of quality improvement including clinical audit.

- We looked at two clinical audits completed in the last two years; both of these were completed audits where the improvements made were implemented and monitored. For example, an audit of safe citalopram prescribing in patients aged 65 years or over, identified on the first cycle in November 2015 that 31 patients required some type of intervention to ensure the Medicines and Healthcare products Regulatory Agency guidance was fully implemented. The re-audit in March 2016 demonstrated a significant reduction in the number of patients requiring a review which showed they had made appropriate changes to their practice.
- The practice participated in local audits, national benchmarking, accreditation, peer review and research. They had recruited patients to research studies (led by the University of Bristol), regarding effectiveness of antidepressant medication (Prescribing Antidepressants (PANDA) and the MIRtazapine trial (MIR)).

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, the nursing staff who reviewed patients with long-term conditions had completed disease specific diplomas, and those undertaking minor injury treatments had attended appropriate training.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could

demonstrate how they stayed up to date with changes to the immunisation programmes, for example, by access to on line resources and discussion at practice meetings.

- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included on-going support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. All staff had received an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services. We were told patient correspondence from other health and social care providers was scanned into patient records once the GPs had seen the results. This ensured the patient records were current and held electronically to be accessible should they be needed, for example, for a summary care record to take to the hospital.
- Community nurses teams could access a restricted area of the patient records remotely for any test results and to add details of their visits.
- Patients' blood and other test results were requested and reported electronically to prevent delays. The GPs operated a buddy system so that the results were reviewed on the day they were sent to the practice to minimise any risks to patients, and so that any necessary actions was taken.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan on-going care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The practice had updated their knowledge about mental capacity and capacity assessments through a clinical training session and was involved in working with patients and their families to the best interest guidance. We saw an example of this documented for a patient with end stage dementia where escalation of interventions was indicated and the patients wishes and rights upheld.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients could access the health information room or were signposted to the relevant service.

Childhood immunisation rates for the vaccinations given were higher than South Gloucestershire Clinical Commissioning Group (CCG) averages. For example, childhood immunisation rates for the vaccinations given to

Good

Are services effective?

(for example, treatment is effective)

under two year olds ranged from 86% to 99% compared to the CCG average from 84% to 99% and five year olds from 96% to 99% compared to the CCG average from 93% to 99%.

Patients at the practice were encouraged to access appropriate screening. For example, patients, aged 60-69 who were screened for bowel cancer in last 30 months (2.5 year coverage, %) was 62% whilst the CCG was 61% and the national average 58%. Similarly female patients aged 50-70, who were screened for breast cancer in last 36 months (3 year coverage, %) was 77% with the CCG average of 78% and the national average of 72%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Of patients invited for health checks, approximately 70% attended their appointment. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified. The practice included the Alcohol Use Disorders Identification Test Consumption (Audit-C) tool to identify patients with potential alcohol problems in their new patient registration health assessment. The practice hosted an alcohol support worker who visited weekly and offered support to patients by phone and face to face.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Same sex clinicians were offered where appropriate.

All of the 15 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with a member of the patient participation group (PPG). They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comments highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 91% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 90% and the national average of 89%.
- 91% of patients said the GP gave them enough time compared with the CCG average of 90% and the national average of 87%.
- 96% of patients said they had confidence and trust in the last GP they saw compared with the CCG average of 96% and the national average of 95%
- 82% of patients said the last GP they spoke to was good at treating them with care and concern compared with thenational average of 85%.
- 99% of patients said the last nurse they spoke to was good at treating them with care and concern compared with the national average of 91%.
- 88% of patients said they found the receptionists at the practice helpful compared with the CCG average of 86% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients told us 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 available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

Children and young people were treated in an age-appropriate way and recognised as individuals. Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages. For example:

- 83% of patients said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 86% and the national average of 86%.
- 76% of patients said the last GP they saw was good at involving them in decisions about their care compared with thenational average of 82%.
- 88% of patients said the last nurse they saw was good at involving them in decisions about their care compared with thenational average of 85%.

The practice provided facilities to help patients be involved in decisions about their care:

- Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available. Patients were also told about multi-lingual staff who might be able to help them.

Good

Are services caring?

- Information leaflets were available in easy read format.
- The practice had a loop system for those patients with a hearing impairment. They also made specific arrangements with patients to facilitate communication with the practice such as direct email contact. Patients who had any need for additional support to attend their appointments, for example, those with hearing or visual impairment were collected from the waiting room rather than being called via screen/tannoy systems located in the patient waiting areas.
- Patients with severe anxiety or autism were known to reception staff and these patients were offered the opportunity to wait in the patient information room, which is a quieter area until they are called for their appointment.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website. Support for isolated or house-bound patients included signposting to relevant support and volunteer services.

The practice had identified 246 (2%) of their patients as carers. They had close ties with the Carer's Support Centre, who provided a volunteer who met patients in the reception area fortnightly. Carers had the opportunity to have a carer assessment at the practice with the local carer support organisation. Carer's packs were sent to patients with helpful information and the carer's support centre offered appointments to carers for a needs assessment. The practice's computer system alerted GPs if a patient was also a carer. A member of staff acted as a carers' champion to help ensure the various services supporting carers were coordinated and effective. For example they maintained the carer list and liaised with the Carer's Support Centre. Older carers were offered timely and appropriate support.

The practice provided additional support to carers in the following ways:

- Patient records were notated to indicate they were carers.
- Carers were routinely offered flu vaccines.
- Appointments were flexible to meet the needs of carers.

Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood its population profile and had used this understanding to meet the needs of its population.

- The practice had developed an on-site "ophthalmology pilot" which gave patients rapid access to assessment and treatment for a range of eye conditions which had been running since May 2014.
- In addition they ran a weekly skin clinic led by a GP with an interest in dermatology to provide rapid dermoscopy and minor surgery. The clinic is run 46 wks per year and in each clinic there were eight slots for GP's to book patients into which allowed for 368 appointments per year. We saw the clinic outcomes were closely monitored and that it had resulted in a significant reduction in numbers of patient referred to secondary care at 3.3 per 1,000 in the year 2014-15 (range 3.3 – 10.6 per thousand) when compared to practice with similar patient numbers within the same clinical commissioning group.
- The practice was part of the One Care Consortium and had direct patient access to same day physiotherapy assessment which had been used for 100 patients since it started in November 2015. The consortium also enabled the practice to offer weekend review appointments, in order to prevent hospital admissions and to provide a service for those patients who had difficulty accessing appointments during the week.
- The practice employed a sexual health and contraceptive nurse who adjusted their working shifts according to when patients could attend appointments. This was the only post of this kind in the area; the nurse also followed up those women whose circumstances make it imperative that they have adequate contraceptive advice for example, thoseat risk of sexual exploitation working as sex workers.
- The practice operated a minor injuries walk in service which the local community could access which meant they did not have to travel to designated centres.
- The practice had 226 patients in eight residential and nursing homes with a named GP lead for each home. Five of these had weekly GP clinics. The practice held an annual review of all patients in care homes in conjunction with the clinical commissioning group pharmacy team and the South Gloucestershire community active ageing service.
- The practice also supported the "interim beds pilot project" with South Gloucestershire Council in nursing and residential homes. These 20 beds were for patients who were medically fit for discharge from hospital, but who needed a further period of rehabilitation or recovery before they returned home. The care the practice offered as part of the pilot included a weekly review, responsive care if patients became acutely unwell, and the management of their medicines as well as advice and support to the home staff team.
- The practice offered proactive, personalised care to meet the needs of the older people in its population. The practice employed a paramedic practitioner who was able to visit patients in their own home. The practice also utilised the services of emergency care practitioners from the community healthcare services to undertake some home visits. This was initiated by the duty doctor who triaged all requests for home visits.
- The practice had employed a clinical pharmacist to work with older patients and those with long term conditions to promote medicines .
- The practice hosted the community nurses, the community matron and active ageing team on site and had an "open door" approach for discussing complex patients. The practice undertook the enhanced service for hospital admission avoidance, there was a fortnightly "virtual ward" meeting at the practice which included members of the community nursing team and community matron, the rehabilitation team, social workers and an Age UK support worker.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. The practice responded to chaotic circumstances of vulnerable individuals who arrived without an appointment by including them in the duty GP system and seeing unregistered patients as temporary residents to ensure they had access to health care. The practice

had engaged with the local research network on the HepCATT study, a trial designed to evaluate interventions to increase the diagnosis and treatment of vulnerable and at risk patients with Hepatitis C.

- The practice regularly worked with other health care professionals in the case management of vulnerable patients. The practice hosted a substance misuse service; they had a dedicated GP who had additional knowledge and skills, and offered shared care for patient who used the service. The practice also hosted an alcohol misuse worker who worked closely with them to support patients to undergo a community based alcohol detoxification programme.
- The nursing team ran an evening travel vaccination clinic and encouraged families to attend together to ensure appropriate vaccine coverage.
- The practice had a text service to remind patients of appointments which also gave patients the option to cancel appointments and respond to the Friends and Family test.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- There were accessible facilities and designated parking bays for blue badge holders, with lift access to all floors.

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday. Extended hours appointments were offered between 6.30pm and 7pm weekdays and for pre-booked appointments between 8.30am and 11am) for two Saturdays in every month. In addition to pre-bookable appointments that could be booked up to four weeks in advance, urgent appointments were also available for people that needed them. They offered a range of appointment types including urgent on the day, 24/48/72 hour release and one month appointments that balanced routine access with urgent care, for example, there were 13 early morning phlebotomy slots per week reserved for workers. The practice aimed to make available approximately 340 appointments each week, and had 18 unused appointments from the previous week.

They operated a "sit and wait clinic" to see any extra patients in the morning ensuring that patient had an appointment if their need was urgent. We saw only two of the available appointment had been used in the last week. The availability of appointments was kept under close review and staffing levels were planned to meet anticipated demand.

Results from the national GP patient survey published July 2016 showed that patient's satisfaction with how they could access care and treatment was comparable to local and national averages.

- 77% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group average of 75% and the national average of 78%.
- 66% of patients said they could get through easily to the practice by phone compared with the clinical commissioning group average of 68% and the national average of 73%.

The practice had identified the phone system as an area of development and had introduced a new system. We saw they monitored call waiting times closely so that if patient were waiting longer than the target time (10 minutes) more staff were deployed to answer calls.

Patients told us that they were able to get appointments when they needed them. We observed that on the day of the inspection there were unused appointments across the clinical team as well as the 'sit and wait' option.

The practice had a system in place to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

This was carried out by telephone triage when patients first contacted the practice. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits, wherever possible GPs visited their own patients.

Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns.

- Its complaint policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaint system on the website and a comprehensive practice leaflet.

We looked at a selection of the 11 complaints received in the last 12 months and found these were dealt with in a timely way to achieve a satisfactory outcome for the complainant. For example, complaints were responded to by the most appropriate person in the practice and wherever possible by face to face or telephone contact. The information from the practice indicated at what stage the complaint was in its resolution.

Lessons were learned from concerns and complaints and action was taken as a result to improve the quality of care. We found the learning points from each complaint had been recorded and communicated to the team or appropriate action taken.For example, a patient complained about the length of time it took us to answer their call. The action taken by the practice was to record a new telephone message so that they can make the live phone message to explain to patients if there are any delays in the service.

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 had a mission statement which was displayed in the waiting areas and staff knew and understood the values. This was:

"Kingswood Health centre strives to be a quality primary care provider that puts patient care at the heart of its activity, treating patients with dignity and respect at all times."

The practice stated their values as being:" Kingswood Heath centre aims to create a culture in which patients and staff treat each other with:

- Mutual respect
- Compassion
- Empathy
- Dignity
- Equality
- The practice had a strategy and supporting business plans which reflected the vision and values which were regularly monitored through the business meetings and strategic planning away day.
- **Governance arrangements**

  The practice had an overarching governance policy which outlined the framework which supported the delivery of the strategy and good quality care. This ensured structures and procedures were in place which meant that:

- There was a clear staffing structure and staff were aware of their own roles and responsibilities. All of the partners had lead roles in key areas such as diabetes or mental health and reported any practice development or treatment innovations at meetings.
- Practice specific policies were implemented and were available to all staff. These were updated and reviewed regularly.
- A comprehensive understanding of the performance of the practice was maintained.
- There was a formal schedule of meetings to plan and monitor the work of the practice, for example, the management met weekly to review the operational running of the practice.
- The practice had a programme of continuous clinical and internal audit in order to monitor quality and to make improvements. For example, the implementation of health and safety guidance in the building was audited to ensure the environment was safe for both patients and employees. We saw clinical audit used to monitor competence in cervical sampling, and effectiveness for procedures such as joint injections.
- There was a multidisciplinary skill mix for future proofing meeting the demands of the practice population. We saw the use of specific referral criteria for the paramedic, nurse practitioner and pharmacists, so patients were not put at risk or have care delayed due to being asked to see the wrong practitioner.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. For example, they monitored data on unplanned admissions to hospital as part of their involvement with the local Clinical Commissioning Group (CCG). They had a recall system for monitoring patients with long-term conditions outside of the QOF framework.
- There was a meetings structure that allowed for lessons to be learned and shared following significant events and complaints.

Leadership and culture

On the day of inspection the partners in the practice demonstrated they had the experience, capacity and capability to run the practice which ensured safe, high quality and compassionate care. Staff told us the partners were approachable and always took the time to listen to them.

- The clinical team met every day to discuss clinical queries, referrals and arrange home visits by the most appropriate person to provide the best care for the individual patient.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when

Are services well-led?

Good

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

things go wrong with care and treatment).This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment.

- The practice gave affected people reasonable support, truthful information and an apology
- The practice kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure in place and staff felt supported by management.

- The practice held and minuted a range of multi-disciplinary meetings including meetings with district nurses and social workers to monitor vulnerable patients. GPs, where required, met with health visitors to monitor vulnerable families and safeguarding concerns.
- Staff told us the practice held regular team meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. We noted team away days were held. Minutes were comprehensive and were available for practice staff to view.
- Staff said they felt respected, valued and supported. Staff were consulted about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. The PPG met regularly, carried out patient surveys and submitted proposals for improvements to the practice management team. For example, following feedback gathered from patients during the 2015 Survey the practice will be using the text messaging service to contact patients regarding their influenza vaccination. When we spoke to the PPG they identified they had been involved in changes to the practice such as arranging the waiting room to ensure patients could see the electronic message board, and requesting a variety of seating for patients who were less able.
- The practice had gathered feedback from staff through staff away days and generally through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.
- Staff told us they felt involved and engaged to improve how the practice was run. The practice used social media to inform those patients who may not use GP services frequently about upcoming events.
- The practice had a suggestion box and ran the family and friends test.
- The practice updated patients with a regular newsletter and a news section on the website.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. The practice was part of the One Care Consortium which aimed to improve access to treatment for patients through a number of pilot schemes such as same day physiotherapy assessment. They worked collaboratively with other providers to develop innovative services such as on-site "ophthalmology service" which gave patients rapid access to assessment and treatment for a range of eye conditions.

The practice had reviewed their staffing establishment and had employed a wide range of health care professionals to meet demands for services. This included a nurse practitioner, a clinical pharmacist and a primary care paramedic. They encouraged and supported personal professional development by funding courses and supporting staff with training and mentoring. There was a monthly clinical meeting at which clinical training and knowledge were shared; there was an expectation that staff could access a maximum of five paid study days per year.