St George Health Centre

Quality Report

St George Health Centre
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St George
Bristol
Avon
BS5 7PH
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Website: www.stgeorgehealthcentre.nhs.uk

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at St George Health Centre on 9 December 2014. Overall the practice is rated as good.

Specifically we found it good for safe, effective, caring, responsive and well led 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. Staff were trained and knew how to recognise signs of abuse in older people, vulnerable adults and children. Staff were aware of their responsibilities to share information and properly record documentation of safeguarding concerns.
- 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 that they felt involved in their care and decisions about their treatment.
- Information about the services provided and how to complain was available and easy to understand. Complaints were managed well.
- 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.

In addition the provider should:

Summary of findings

- There should be an overall health and safety risk assessment for the building.
- There should be a planned cycle of clinical audits that evidenced continued quality of care and treatment provided to patients was monitored and maintained good health outcomes.

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 we spoke to understood and fulfilled their responsibilities to raise concerns, report incidents and near misses. Records showed lessons were learned from incidents or complaints and communicated to staff with actions put in place in order to prevent reoccurrence. Information about safety measures were recorded, monitored, appropriately reviewed and addressed. Individual areas of risks to patients were assessed and well managed. There was no overall health and safety risk assessment for the building. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Information and data from NHS England and the practice showed that patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence (NICE) 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. 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.

Accessible notices in the patient waiting room and practice website signposted patients to support groups and organisations external to the practice. The practice's electronic patient record system alerted GPs and other staff if a patient was also a carer.

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. Patients told us 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 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 and responded appropriately.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice 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 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 virtual patient participation group was active. The practice provided practical experience for medical and nursing students. There was a focus on the development of individuals. 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. Information and data received from NHS England showed us that above 7% of practice population were over 65 years old. Around 3.7% of the practice patients were 75-84 years old and just over 1.5% 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 over the age of 75 was provided with a named GP. There was multidisciplinary team working to support patients to remain in their own homes and prevent hospital admissions. The practice staff were responsive to the needs of older people and provided home visits for patients who required regular reviews, health screening and immunisations.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Information and data from NHS England showed that 52% of the patients had long term health conditions, which was similar to the national average. Nursing staff had lead roles in chronic disease management. Patients who had been deemed at risk were provided with support from multidisciplinary team. Care plans were in place to prevent hospital admissions. Longer appointments and home visits were available when needed. These patients had an annual review to check that their health and medication needs were being met.

There had been investment in new equipment to improve patient's experience. The practice had purchased hand held spirometry equipment (to help diagnose lung conditions.

Families, children and young people

Good

The practice is rate as good for families, and young people. There were systems in place to identify and follow up children who were at risk. There was good multidisciplinary team working with health visitors to provider continuity of care. Immunisation rates were around equal for all standard childhood immunisations in comparison to the national average. Appointment were available outside of school hours and joint clinics were in place for post natal and six week baby checks. The premises were suitable for children and babies. A sexual health service was provided for young people.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rate as good for the care of working age people (including those recently retired and students). Over 40% of the patients registered with the practice were aged from 15 to 44 years, 24.5% were aged from 45 to 64 years old. Of the working age population 5.2% were unemployed. For the working age population, those who could not attend the practice during working hours were offered access through extended hours and on Saturday mornings. The practice offered online services as well as a full range of health promotion and screening that reflects the needs of this age group.

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, such as the community matron in the case management of vulnerable people or people seen as at risk. The practice provided patients access to and gave information about various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and knew how to contact relevant agencies. The percentage of patients who had caring responsibilities was just over 12.5% 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. All of these patients had a care plan in place. Patients also had access to substance misuse service held in the practice.

Summary of findings

What people who use the service say

We spoke with eight patients during the day. We received information from the 47 comment cards left by patients at the practice premises. Three patients contacted us either by email or telephone.

Patients were generally satisfied with the appointments system. Three patients (of the 55 who commented) told us they had experienced difficulty getting through to the practice to book an appointment or had to wait a longer for their appointment. However, they also told us they appreciated the practice was busy and were willing to wait. 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 either speak to a GP or attend appointments on the same day of contacting the practice.

Patient were very positive about the emotional support provided by the practice staff. For example, we were told by one patient how they and their family were supported during a life threatening event and their now on-going long term care. They told us their treatment and care was explained to them, their options discussed and decisions supported. They had found they were able to speak to the GPs and nursing staff who answered their questions well, were supportive of their family's needs and provided the reassurance they needed.

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. In addition comments included many positive personal reflections about the valued care and treatment they had from individual GPs at the practice. It was also clear from comments that if patients decided to decline treatment or a care plan this was listened to and acted upon.

Patients we spoke with and who wrote in the comment cards said they had found the practice clean, tidy and comfortable. Patients had commented they had found the practice environment hygienic and had no concerns about infection control.

Areas for improvement

Action the service SHOULD take to improve

In addition the provider should:

- There should be an overall health and safety risk assessment for the building.
- There should be a planned cycle of clinical audits that evidenced continued quality of care and treatment provided to patients was monitored and maintained good health outcomes.

St George 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 two specialist advisors: a GP and Practice Manager.

Background to St George Health Centre

St George Health Centre is situated in a residential area of the city of Bristol. The practice had approximately 10391 registered patients from the St George, Speedwell, Kingswood, Hanham, Crew's Hole and part of Fishponds areas. The practice provides care and support to a low number of patients residing in nursing and care homes in the area. Based on information from NHS England, we found that 0.8% (September 2013) of patients registered at the practice lived in residential homes.

The practice is located in purpose built premises over two levels. There is a central patient waiting and reception on the ground floor with consulting and treatment rooms accessible from this area. Patients also had access to consulting rooms on the first floor which were accessible by stairs or lift. The practice is on a primary medical service contract with Bristol Clinical Commissioning Group.

St George Health Centre is only provided from one location:

St George's

Bellevue Road

St George

Bristol

Avon

BS5 7PH

The practice supported patients from all of the population groups such as 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 44% of patients registered with the practice were working aged from 15 to 44 years, 24.5% were aged from 45 to 64 years old. Just above 7% were over 65 years old. Around 3.7% of the practice patients were 75-84 years old and just over 1.5% of patients were over 85 years old. Just above 18% of patients were less than 14 years of age. Information from NHS England showed that 52% of the patients had long standing health conditions, which was similar to the national average. The percentage of patients who had caring responsibilities was just over 12.5% which is below the national average of 18.5%. Of the working population 5.2% were unemployed which is below the national average of 6.3%.

The practice consisted of four GP partners who employed three salaried GPs. Of these seven GPs there were three male and four female GPs. There were four practice nurses, three health care assistants and a phlebotomist (blood testing) all of whom provided health screening and treatment five days a week. There were additional clinics implemented when required to meet patient's needs such as the undertaking of influenza vaccinations. The practice telephone was open to patients from 8am to 6:30pm.The practice provided extended hours opening (appointments booked in advance only): Monday 7.30-8am (GP/blood test appointments), some weekdays 6.30pm-7pm and some

Detailed findings

Saturday mornings (GP/nurse appointments). The practice referred patients to another provider Brisdoc for an 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.

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 information 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 spoke with six of the GPs, three practice nurses, and the phlebotomist (blood testing). We also spoke with the practice manager and the reception and administration staff on duty. We spoke with eight patients in person during the day. We received information from the 47 comment cards left at the practice and three email and telephone conversations. We received additional feedback about the practice from four health care professionals and representatives of other health care providers. Two locum GPs and another member of staff who had worked at the practice contacted us and provided comments about the service. Three patients also provided additional information prior to the inspection visit.

On the day of our inspection we observed how the practice was run, such as the interactions between patients, carers and staff and the overall patient experience.

Good

Are services safe?

Our findings

Safe track record

We spoke with six GPs and reviewed information about both clinical and other incidents that had occurred at the practice. We were given information about 17 incidents which had occurred during the last 12 months. These had been reviewed under the practices significant events analysis process. These incidents included gaps in clinical coding when patient medical records were received by the practice and overdose of an immunisation because records were not clear. The response times and actions taken when a patient presented with respiratory problems at the practice, were also reviewed under this process.

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 district nurses about immunisation errors.

National patient safety alerts (NSPA) and other safety guidance was checked and circulated to the relevant staff. There was a system of meetings where new information was discussed and plans put in place to ensure changes were made to the service where required. The practice manager told us how comments, complaints and compliment 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 members of the practice management. A monthly significant event review meeting took place, dedicated to reviewing previous and new significant events that had occurred. The practice had recently implemented a computer spread sheet to improve recording and monitoring of significant events. When we spoke with other staff we were told that the findings from these Significant Events Analysis processes were disseminated to other practice staff.

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, raising awareness to other members of the practice about the risk factors for patients with poor mental health and the option of providing the patient with mental health crisis team telephone numbers. The practice changed how home visits were organised to prevent delays in patients being visited during the day or handed over to the on call service.

Safety alerts and information was available on the electronic records for staff to readily access.

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. Practice training records showed 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 adults, level three, at the practice. Other GPs had received training for safeguarding vulnerable adults and been trained to level two/three for safeguarding children.

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 lead was 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' of flags when patients records were accessed. There was also a dedicated member of administration staff with responsibility to identify communication received into the practice about safeguarding concern. The information was promptly assessed and passed onto the relevant GP.

There was a list of children with safeguarding issues kept by the practice which ensured that staff were aware of patients there were concerns about. The GPs demonstrated good liaison with partner agencies and they participated in multi-agency working. Monthly discussions took place with health visitors in regard to children

identified as at risk. Information from the health visitor team showed that this worked well and there was a shared approach to caring for children at risk. In November 2014 meeting of the GP safeguarding lead and the health visiting team noted nine children under five on a child protection plan or classed as child in need. Through discussion with staff it was evidenced 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 at risk.

The practice had a chaperone policy, which was visible on the waiting room and in consulting rooms. Additional training had been provided to some of the administration and reception staff, with disclosure and barring checks carried, to provide chaperone support to patients. Not all of the seven patients we spoke with told us they were aware of the availability of chaperones if they required it. Two people told us about how the GPs and nursing staff had responded quickly to ensure a chaperone was available when they needed it. They also told us they found it a comfortable and not intrusive experience.

Medicines management

We looked at the systems for medication used at the practice and the safe keeping of prescription pads and paper.

Staff told us about the practices for safe medication administration and storage at the practice. Medicines stored in the treatment rooms and medicine refrigerators were stored securely. There was a policy for ensuring that medicines, such as vaccines, were kept at the required temperatures. The policy 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. Expired and unwanted medicines were disposed of in line with waste regulations. Records were kept of medicines used at the practice including ordering, stock levels and disposal or use. No controlled medicines were kept in the practice. The practice had a GP who was the medicines management lead. GPs took responsibility for checking their medicines used in their doctors bags.

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.

There were systems in place for monitoring patients with polypharmacy (multiple medications prescribed). Annual reviews of 94% of these patients had been undertaken at the time of this inspection to check safe medicines had been prescribed. The practice employed a pharmacist (20 hours per week) to check appropriate prescribing was in place for these patients.

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. The practice had a GP who was clinical lead for the enhanced service for drug misuse. Safe systems and monitoring were in place for these specific prescriptions.

Patients said the prescription service was quick and managed well, staff friendly and helpful. Patients could drop a prescription request off at the practice or use the on line request service.

Cleanliness and infection control

We observed the premises to be clean and tidy. There were cleaning schedules in place and there were recognised approved systems for equipment. For example colour coded mops and cloths. We were informed cleaning audits were carried out by the practice manager. A 'walk round' building check in October 2014 showed gaps in cleaning standard were identified. There was information that actions were taken and a follow up check confirmed these concerns were rectified. The practice manager maintained a cleaning defect log where staff could report concerns identified. However, there was no planned programme for this.

Patients we spoke with and who wrote in the comment cards said they had found the practice clean, tidy and comfortable. Patients had commented they had found the practice environment hygienic and had no concerns about infection control.

We were told there was a nurse lead 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. Staff were able to access this electronically and in hard copy in the practice. We were told that e learning was included in new staff's induction training and that e learning was available to all staff.

We spoke with the practice nurses on duty about infection control audits. They were able to show us documentary evidence of infection control audits carried out at the practice. We were also told about what visual checks they carried out daily in clinical and treatment areas. This included hand wash facilities, work surfaces and clinical waste. 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.

There were systems in place for managing clinical waste; appropriate waste bins were available in consulting rooms and treatment areas. An external contractor was engaged to remove and dispose of clinical waste at the practice. There was a system and instruction given to staff for the receiving and handling of specimens brought to the practice and sent from the practice to the local laboratory.

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.

Safe systems and guidance was available for staff in regard to chemicals and cleaning fluids that should be kept in accordance to the Control of Substances Hazardous to Health Regulations 2002. Items were stored safely away from patient areas.

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. We were told about the investment in new equipment to improve patient's experience. The practice had purchased hand held spirometry equipment (to help diagnose lung conditions).

Staffing and recruitment

We looked at documents relating to the recruitment and employment of two new staff. The records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, the right to work, references, and qualifications. Registration checks were carried out with the appropriate professional body and criminal records checks through the Disclosure and Barring Service.

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 such as a job description and details about the practice. Records of the interview and selection process were kept. There was a formal induction process with a checklist to ensure that staff had been provided with the necessary information about their role and the service. New staff were provided with a three month probationary period.

There were arrangements for planning and ensuring the number of staff and mix of staff needed to meet patients' needs was met. There were designated roles for staff. Some 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. Three patients (of the 55 who commented) told us they at times had difficulty obtaining telephone contact to book an appointment or had to wait a longer for their appointment. However, they also told us they appreciated the practice was busy and were patient to wait.

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

Good

Are services safe?

to the practice. These included regular checks of the building and the environment. For example fire, water and the chemicals used at the practice. Each risk was assessed and actions recorded to reduce and manage the risk, such as the fire safety. There was no overall health and safety risk assessment and risks of slips, trips or falls not carried out. The practice also had a health and safety policy which was included in the staff handbook. Health and safety information was displayed for staff to see. Health and safety training was incorporated in new staffs induction training.

We saw that any risks were discussed within team meetings. This included the welfare, clinical risks and the risks to patient's wellbeing which were discussed as they occurred by the GPs and nursing staff. There were systems for monitoring patients with long term conditions, end of life care and patients and families who were identified as at risk in regard to safeguarding and abuse.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that staff had received training in basic life support. There was a training programme for this to be repeated every three years. 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. These included those for the treatment of cardiac arrest, anaphylaxis and low blood sugar. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. There was also a system to check that equipment such as defibrillator electrode pads did not expire and were renewed regularly.

A business continuity plan, the disaster recovery policy, was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Such as power failure, adverse weather, and unplanned sickness. Staff were also provided with guidance on dealing with other aspects of responding to incidents. For example, where to find water stopcocks in the building, panic alarms and fire evacuation procedures. 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. Partners, salaried GPs and nursing staff had access to the on line St Georges Health Centre Clinical System handbook, which defined the expectations of the clinicians working at the practice. There were practice meetings where the implications of changes to best practice and the practice's performance discussed and actions agreed.

The practice staff assessed and identified high risk patients, such as those with long term conditions, substance misuse, and patient requiring palliative care. The practice staff participated in partnership working with other health and social care professionals and services such as 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 chronic heart disease, kidney disease and dementia. The practice nurses supported the GP with this work for patients with on-going long term conditions. We heard about GPs other interests; such as one GP led with the care for patients with Chronic Obstructive Pulmonary Disease (COPD). The GP had undertaken further training and provided up to date guidance for the other GPs and nursing staff to follow.

One GP led on involving the practice in clinical research.

The intelligent monitoring information was made available from the practice and NHS Quality and Outcomes Framework (QOF) information. 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 maintaining patient health. This information from March 2014 showed the practice was in line or above with expected national levels of achievement. For example, of the 237 (2% of the patient population) patients on the register for chronic heart disease 97% had received checks on their blood pressure which was maintained below the expected levels of 150/90 mmls. We were informed there were 444 (4% of the patient population) patients of which 378 (95%) who had an annual foot examination during the previous 12 months. We saw that 57 patients identified with a diagnosed mental health had a care plan agreed.

The practice gave information that they had 37 patients who were registered as having a learning difficulty and 59 patients on their epilepsy register. There was also a programme of medication reviews and annual health checks in place for these patients.

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 named GP with responsibility for patients over 75 years of age; obesity and asthma. One GP worked in conjunction with the local drug service, Bristol Drug Partnership, supporting and caring for patients with drug and alcohol problems.

We spoke with GPs 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 audits. For example, audits in relation to palliative care. The two audits six months apart during 2013/2014 looked at the care provided to patients identified as requiring end of life care during that period. The outcome from these audits identified that improved discussions and actions needed to be in place in regard to advanced decisions about patients care and ensuring record keeping is fully completed.

The practice showed us other examples of other clinical audits that had been undertaken in the last year which was in regard to Rhino sinusitis/Nasal Polyps Management. There was no information provided by the practice that there was a planned strategy or programme of clinical audits.

Good

Are services effective?

(for example, treatment is effective)

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 such as seasonal influenza vaccinations. The practice's achievement was either 99% or 100% for patients with long term conditions such as diabetes and chronic heart disease. The practice provided cervical smear tests, 90 %(80% target) of patients who fell in this category had had this undertaken during the last 5 year period. The practice participated in other screening not included in QOF, such as chlamydia testing.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. There was a dementia screening programme involving support from the external dementia nurse.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that staff were up to date with attending mandatory courses such as basic life support and fire safety. GPs had an interest in a variety of different areas such as cardiology, mental health and child health. 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 a system of in house learning; joint training with other members of staff took place such as Mental Health Awareness training in April 2014. Lead GPs had obtained the specific training they required such as updates with safeguarding children training.

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

We were told by all levels of staff that they were provided with the time and the opportunity to undertake training and personal development. We saw information and staff told us annual appraisals which 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 other health care provider's services such as those from Bristol Drug Project. Patients could also access a podiatry service; Health Visitor led clinics for mums and babies, midwifery services and speech and language therapies on site.

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. This system worked well and there was a team approach to supporting their patients. This was evidenced by the positive feedback from the four health care professionals who came in contact with the service. These health care professionals were very positive about the working relationships they had with staff at the practice. They had found GPs had an 'open door' policy and were always willing to discuss and work with them to achieve a positive outcome for patients. They also added staff responded to queries and feedback promptly.

We heard how the practice worked with other health care providers in the area such as a local care home and community services.

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

Good

Are services effective?

(for example, treatment is effective)

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 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. Staff had access to key policies and procedures in regard to mental capacity, assessment and obtaining consent. This included best interests' decision making processes for those people who lack capacity. 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 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. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

Patients 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

The practice offered a health check with the health care assistant or practice nurse to all new patients registering with the practice. Through this process patients' health concerns were identified and arrangements made to add them into any long term health monitoring processes such as the 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 enabling access to a stop smoking group and by offering smoking cessation advice to patients who smoke. They had recently sent out invites in Polish to encourage patients from this population group to attend. The practice offered a weight management service and provided a sexual health service for young people know as 4YP.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was either above average or slightly below for the CCG. There was a clear policy for following up non-attenders. The practice implemented combined six week baby and post natal check to ensure that patient's needs were met in one appointment.

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 or support.

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) for March 2014. Patients participating in this survey gave positive comments about the staff and the level of care received.

There were 47 patients who completed CQC comment cards to tell us what they thought about the practice. We had feedback from three patients though emails and telephone contact. We also spoke with eight patients on the day of our inspection. Patients said they had very positive experiences of care and support from the practice and the staff. Patients said staff were treaty with dignity and respect and empathy. Patients had found the staff helpful and caring.

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. 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 away from the main reception and waiting room areas 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. This was reflected in the 47 comment cards in addition to the many personal reflections patients had made about the valued care and treatment they had from individual GPs at the practice. It was clear from comments that if patients decided to decline treatment or a care plan this was listened to and acted upon.

Translation services were available for patients who did not have English as a first language. We saw notices in the reception areas, leaflets and on the practice website informing patents this service was available.

Patient/carer support to cope emotionally with care and treatment

Patients we spoke with were very positive about the emotional support provided by the practice staff. For example, we were told by one patient how they and their family were supported during a life threatening event and their now on-going long term care. They told us their treatment and care was explained to them their options discussed and decisions supported. They had found they were able to speak to the GPs and nursing staff who answered their questions well, were supportive of their family's needs and provided the reassurance they needed.

There were notices in the patient waiting room and patient website also told patients how to access a number of support groups and organisations external to the practice. The practice's electronic patient record system alerted GPs and other staff if a patient was also a carer. There was a carer's register so that all staff were aware of those patients who were also carers. The practice provided carers information packs and obtained support from carer's advice services to direct carers to additional help.

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 the needs of the practice population were understood and systems were in place to address their identified needs. For example, one GP provided support to patients with drug and alcohol problems and worked with external services to ensure their needs were met. The practice had adapted their telephone system so that anyone requiring palliative care had a direct line to reception.

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 prioritised according to need. The practice had implemented combined appointment systems for new mothers which ensured their babies first health check was carried out with their post natal check. The practice staff had looked at how they supported members of the student population in the area and had put systems in place for ease of registering and receiving treatment at the same time.

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, such as the development of the on line booking system for appointments and the implementation of two open surgery sessions per day for patients with urgent needs.

Tackling inequity and promoting equality

The practice had recognised they needed to support people of different groups in the planning and delivery of its services. Information from the virtual PPG showed they had identified the under representation of three main groups of patients: those under 34; ethnic minority groups and male patients. The practice had actively supported the PPG to advertise and approached patients who visited the practice or who had been in contact through a complaint or comment to the service to be involved in the group.

Patient areas were all on ground floor level and some of the first floor were 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. There was a lift to the first floor. The practice was able offer facilities to a local pharmacy to provide a service on-site.

There was a main waiting area on the ground floor which was large enough to accommodate patients with wheelchairs and prams and allowed generally for easy access to the treatment and consultation rooms. There was a small waiting area on the first floor for the visiting practitioner's services such as the midwife clinics. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Access to the service

The practice was open to patients from 8am to 6:30pm.The practice provided extended hours opening for appointments booked in advance only: Monday 7.30-8am (GP/blood test appointments), some weekdays 6.30pm-7pm and some Saturday mornings (GP/nurse appointments).The practice referred patients to NHS 111 and Brisdoc for an out of hour's service to deal with any urgent patient needs when the practice was closed.

The practice offered special clinics for influenza vaccinations for children which included Saturday mornings, lunchtime and after school hours from mid-October to mid-January. A similar service was in place for adults. The practice provided extended hours surgery's appointments to enable the working population to access appointments several days per week. To ensure that housebound patients received their care and support they needed the practice nurse staff provided chronic disease checks, immunisations for influenza, shingles and pneumonia.

Information was available to patients about the opening times and 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. 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 either speak to a GP or attend appointments on the same day of contacting 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, the practice manager, who handled all complaints in the practice.

Information was available to help patients understand the complaints system. It was included in the practice information leaflet, on display in the patient areas and the practice website. The information contained 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. The 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 23 complaints the practice had received in the 12 months 2013/2014, and found they were dealt with in a timely way. The complaints ranged from a variety of issues, some were in regard to telephone access, cleanliness of the building and the sharing of information. We saw that from the complaints we reviewed the detail of, the complainant had been kept informed and the practice had looked at how it could improve and avoid patients raising similar complaints in the future. Patients had the opportunity to make comments; a comments box was available in the practice reception. Comments made in this way were managed in a similar way to complaints, investigated, assessed and feedback provided to the person making the comment. Equally compliments were reviewed by the practice and patients were responded to and thanked for their feedback.

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. Their vision included promoting a culture of collaboration, openness and on-going learning. The practice told us their ethos was 'to keep patient needs at the forefront.' This was in the information provided to patients on their website and practice information leaflets.

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. There was a focus of providing a community service for the local people.

Governance arrangements

The practice had policies and procedures in place to govern how services were provided. These policies and procedures were available electronically, and in hard copy for easy access. Partners, salaried GPs and nursing staff had access to the on line St Georges Health Centre Clinical System handbook, which defined the expectations of the clinicians working at the practice. 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 different the aspects of their work. For example, caring for patients with Chronic Obstructive Pulmonary Disease (COPD) and safe management of medicines and vaccines.

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 they were supported well and valued for the work they undertook at the practice. Staff knew who to go to in the practice with any concerns or suggestions and were involved in the development of the service.

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 the QOF data was regularly discussed at monthly team meetings and plans were put in place to maintain or improve outcomes.

The practice had carried out a small number of clinical audits which it used to monitor quality and systems to identify where action should be taken. However, there was not a planned programme of audits in place.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us the risk assessments relating to the environment and safe delivery of the service. Risk assessments had been carried out and where risks were identified action plans had been produced and implemented. There was no overall health and safety risk assessment process for the practice.

The practice held either two weekly or 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 within the practice meeting system or otherwise, they had the opportunity to and felt comfortable raising issues. Salaried and trainee GPs were included in meetings and this was reflected in the conversations and feedback from past and current locums, where they felt included and valued in the running and development of the service.

The practice employed a practice manager to enable the business and administration of the service to be run effectively. Their responsibilities included the recruitment and management of staff and complaints management. We reviewed a number of policies, such as those for employing and supporting new staff and found they were up to date and contained the required information. The complaints process was detailed and comprehensive. 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, compliments 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.

Are services well-led?

Good

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

Concerns about accessing appointments was identified as one the key worries patients had and from this the practice had introduced a triage service and open access surgeries to ensure that all urgent patients' needs were attended to.

The practice had a number of people involved in their patient participation group or as they called themselves the Patient Reference Group. This virtual group, of around 47 patients were supported by the practice staff, highlighted in their last annual report they were working on increasing the diversity of the group to reflect the population of patients the practice supports. They had identified hard to reach groups such as those under the age of 34 years or those from ethnic minority groups and had worked with the practice to increase interest and awareness through leaflets and personal invites to participate.

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. We looked at examples of induction training, mentoring and support provided to new staff at the practice. We saw these were detailed programmes with the opportunity for regular feedback and discussion with the new member of staff and their line manager. 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. We heard from occasional sessional locum GPs how the practice remain in contact, even when they are not working at the practice about any guideline or practice procedure changes so that they could keep up to date.

The practice provided practical experience for medical and nursing students and a member of the practice partnership was the designated lead for these students and for the locum and salaried GPs. Another took the lead for clinical supervision and appraisal of all clinical staff.

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. We heard from associated health care professionals that they were invited to be involved with projects and targets. There was shared learning and their professional opinion was listened to and acted upon.