Southmead and Henbury Family Practice

Quality Report

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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?	Requires improvement
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 Southmead and Henbury Family practice on 18 March 2015. Overall the practice is rated as good.

The practice comprises of two surgeries, one at Southmead Health Centre and the other in nearby Henbury at the Willow Tree Surgery. These are registered separately with the Care Quality Commission. As part of the inspection we visited both locations. This report reflects our findings for the Southmead Health Centre. Our findings for the Willow Tree Surgery are reported separately.

Specifically we found the practice to be rated as good for providing safe, effective, caring, responsive and well led services.

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses that were recorded and reviewed.
- Risks to patients were assessed and well managed except in relation to some aspects of infection control and fire safety.
- Patients' needs were assessed and care was planned and delivered following national guidance. Staff received training appropriate to their roles.
- Patients said they were treated with compassion, dignity and respect and were involved in decisions about their care and treatment.
- Information about services and how to complain was available in the practice and on the practice website. Complaints were treated seriously and learning was shared with the staff team.
- Patients said it was easy to make an appointment and there was continuity of care.
- The practice was well equipped to meet patients' needs.
- There was a clear leadership structure and staff felt supported by management.
- The practice actively sought feedback from patients, which it acted upon.

Summary of findings

However, there were also areas of practice where the provider needs to make improvements.

Importantly the provider must:

To ensure all aspects of infection control are maintained the provider must ensure there are suitable arrangements in place for the management of clinical waste and ensure all areas of the practice are maintained in a way to reduce the risk of cross infection. In addition they must ensure there are suitable arrangements for the safe handling of and management of bodily fluids taken as specimens.

The provider should:

- Carry out a patient specific fire safety risk assessment.

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?

Requires improvement

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

Some improvements must be made to infection control arrangements and the practice should devise a surgery patient specific fire safety risk assessment.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were similar to the England average. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. Staff worked with multidisciplinary teams.

Are services caring?

Good

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

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment and there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat

Summary of findings

patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. There was learning from complaints with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and 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. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

The practice provided a service for two care homes close by that provided nursing care for older people. One of the GPs was linked with the homes and visited weekly. All of the patients in the homes had care plans and we saw the template used to record the plan. Where people expressed a wish to not be resuscitated (DNAR) the appropriate forms were completed. A copy of the patient's care plan and DNAR was kept in the care home and a summary of the care plan was communicated to the Out of Hours service.

The practice maintained a register of all patients in need of palliative care. There were regular multidisciplinary case review meetings where all patients on the palliative care register were discussed.

For the last four years the practice had hosted a weekly knitting group to help alleviate social isolation.

People with long term conditions

Good

The practice is rated as good for the care of patients with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and offered a structured annual review to check that their health and medication 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.

The practice monitored patients with long term conditions through the Quality and Outcomes Framework (QOF) and told us it was proactive in identifying chronic disease.

Through links with the Public Health Improvement Neighbourhood Team one of the receptionists had become a community health champion and was able to signpost patients to community health resources.

Summary of findings

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. 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 good examples of joint working with midwives, health visitors and school nurses.

There was a sexual health clinic at the Southmead surgery. Staff were refreshing the 4YP training practice (Wherever the 4YP logo is displayed patients can be sure that the services on offer are young people friendly) and had achieved standards to ensure it met the needs of young patients.

The practice had initiated teenage health checks learning from the success of other local practices.

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. 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.

Each week staff from the North Bristol Advice Centre were available at Southmead surgery to give patients advice on benefits enabling patients to obtain information locally.

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 homeless people, travellers and those with a learning disability. It had carried out annual health checks for people with a learning disability and 95% of these patients had received a follow-up. It offered longer appointments for people with a learning disability.

The practice care coordinator had a role in the prevention of hospital admissions and facilitating discharge from hospital. They provided support to the practices clinical staff to ensure that frail

Summary of findings

and older patients obtained the support and care necessary to reduce the risk of unplanned hospital admission, Following discharge they contacted the patient to ensure they had all the support they needed.

There was a weekly coffee morning and the practice was registered to issue foodbank vouchers for people who benefitted from these services.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of patients experiencing poor mental health (including patients with dementia). 96% of patients experiencing poor mental health had an agreed care plan documented in their record in the preceding 12 months. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

One of the GPs was the identified lead GP for mental health and dementia. They told us they had booked refresher training for April 2015. They met with the community dementia care nurse monthly. There were an increasing number of patients with dementia for whom assessments had been carried out. None of the practice nurses had undertaken training in dementia awareness.

The practice was committed to reducing social isolation through the 'Well Aware' information for well-being website and the practice community health champion signposted patients to community health resources. It issued prescriptions for exercise and self-help books.

Summary of findings

What people who use the service say

We spoke with four patients at Southmead Health Centre. Patients told us they felt safe at the practice. They said they felt the practice was clean and there were good security arrangements. When asked, they told us treatment had been effective and when referred for secondary healthcare this was done speedily. Patients said they were involved in decisions about their care and treatment and their privacy and dignity was respected. Patients thought the practice was organised and well run. One of the patients spoke about the practice response to the health care needs of their child explaining it was efficient.

We received positive comments from a health visitor who felt the health visitor team had a good relationship with the practice with mutual respect for each other's roles.

We looked in the comments book patients used to record their wishes for a GP who retired from the practice. It contained many positive comments and good wishes indicating patients held them in high esteem and considered them to be a caring GP.

Areas for improvement

Action the service MUST take to improve

To ensure all aspects of infection control are maintained the provider must ensure there are suitable arrangements in place for the management of clinical waste and ensure all areas of the practice are maintained in a way to reduce the risk of cross infection. In addition they must ensure there are suitable arrangements for the safe handling of and management of bodily fluids taken as specimens.

Action the service SHOULD take to improve

Carry out a patient specific fire safety risk assessment.

Southmead and Henbury Family Practice

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 advisor, two other CQC inspectors and other specialist advisors including a practice manager and practice nurse. We were accompanied by another member of CQC staff who specifically spoke with patients.

Background to Southmead and Henbury Family Practice

The Southmead and Henbury Family Practice provides services across two sites. The main surgery is in Ullswater Road in Southmead and the other surgery known as the Willow Tree Surgery is in Trevelyan Walk in Henbury.

The practice register lists in excess of 11,300 patients with a higher than average number of children registered. Over 8,000 patients are registered at the Southmead surgery.

There are eight partners and two salaried GPs comprising of six females and two males. There is a practice business manager and assistance practice business manager. The nursing team are managed by a senior nurse manager and there is a business support team.

Information from Public Health England indicates the practice provides services in areas of high deprivation with higher than national rates for child poverty, older people living in poverty and long term unemployment. The practice told us the average life expectancy is 9.4 years less than neighbouring Henleaze.

The practice provides services under the standard personal medical services contract. These being essential, additional and enhanced services. The core (essential) services include GP consultations, asthma clinics, coronary heart disease clinics and diabetes clinics. Additional services include contraceptive services, maternity services and child health surveillance.

Enhanced services include dementia identification and management, diabetes management and learning disability management. The practice also provides a range of other services including minor surgery.

District nurses, health visitors the community matron, podiatry, speech therapy, community midwife and the community nurse for older people were all based within the Southmead health centre.

The practice shared the building with a dental practice.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Detailed findings

How we carried out this inspection

We reviewed all of the information we held about this provider, contacted the NHS England area team, Bristol Clinical Commissioning Group and local Healthwatch. We spent time at each of the practice surgeries on Wednesday 18 March 2015 and we spoke with staff including GPs, nurses, the practice manager and administrative staff. We spoke with patients and received feedback form the health visitor team.

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 are provided for specific groups of people and what good care looks like for them. The population groups are:

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

People experiencing poor mental health (including people with dementia)

Requires improvement

Are services safe?

Our findings

Safe track record

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

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last year. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had developed a pro-forma for the recording of significant events. We saw analysis of significant events showed there had been 35 events reported during the last year. Of these 13 related to delayed diagnosis and related to pathway issues however, only seven of the 13 reported events were related to the actions of the practice and the others were the fault of other service providers. Five were in connection with delayed treatment and five were related to administrative errors. Four were concerned with medicines errors.

Reports of significant events were circulated to staff by email. The practice manager told us there was an electronic system, to record when staff had read the incident report.

Meetings were held to discuss significant events every two months. Some staff told us they could attend the meetings if appropriate and said they could report issues that constituted significant events.

The practice had devised a 'Being open' policy in December 2014. It referred to when something went wrong relating to a patient. It outlined the support for staff involved and how the practice would respond to the patient or their family.

Reliable safety systems and processes including safeguarding

One of the GPs was identified as the lead for safeguarding children and vulnerable adults and another was identified as deputy. There were meetings held monthly at Southmead and Henbury Family Practice and the Willow Tree surgery to discuss patients on the respective registers. The GP we spoke with was knowledgeable and showed a good understanding of issues relating to the protection of children and safeguarding vulnerable adults.

We looked at the practice protocols for child protection and safeguarding vulnerable adults. In addition to a statement of intent the practice arrangements were recorded and information about the Independent Safeguarding Authority (ISA) was included. The child protection and safeguarding vulnerable adults policies were based on the General Medical Council document 'Raising and acting on concerns about patient safety'. The protocols included the contact details of agencies to whom concerns should be reported and a flow chart to show the practice reporting process.

There were 99 young people on the vulnerable children register. There were monthly meetings with the health visitors to discuss these patients.

An example of good practice we were told about related to the persistence of the practice to follow up a vulnerable child after concerns were expressed by a social worker.

We saw all children in need, those considered vulnerable and those who were looked after were coded on the patient's record. Vulnerable adults' records were also marked with a code.

All of the GPs had attended child protection training at level three, nurses at level two and all other staff at level one. The GP with lead responsibility for safeguarding had completed an update on 15 March 2015. They showed us the presentation slides and told us they would be sharing the additional information at a clinical meeting.

We noted the chaperone policy was displayed and we saw policies relating to whistle-blowing and for responding to violent and aggressive patients. Some of the administrative staff been checked using the Disclosure and Barring Service (DBS) and had received training so that they could act as chaperone. The lead nurse told us they were identifying further training to make chaperone training available for more staff.

Requires improvement

Are services safe?

Medicines management

We saw the practice medicines review protocol explained that all prescribers within the practice were responsible for annual review of their patients. It gave staff full details of the medicines review procedures and actions to be taken to ensure consistency of recording.

The practice aimed to improve the safety and efficacy of prescribing for patients over 75 years, particularly those with long term conditions or at risk of acute hospital admission. To achieve this, the practice recruited a practice based pharmacist and developed a service level agreement to ensure the objectives and output measures were clear.

The practice was piloting a repeat prescription system with 200 of its patients. The request for a repeat prescription was made electronically and checked by the dispensing pharmacist. The practice manager told us this would be audited to ensure patients were not ordering too much of their medicines.

The nurse manager was undertaking training in prescribing at the University of the West of England. The pharmacist was working on a 'Stop Start' tool for medicines related to the prevention of unplanned hospital admissions.

The practice completed a controlled drugs self-assessment and declaration for NHS England in 2014/15 and no controlled medicines were held in the practice.

We looked at the security of blank prescriptions. The practice had recently begun to log batches of blank prescriptions as they were received. There was no system for recording which printer they were allocated to and printers were not lockable although consulting rooms were. Staff told us there were times when the surgery was accessed by the cleaner when no other staff were around and this could present a security risk to the audit and safekeeping of prescription paper. When GPs took prescription pads on visits with them they were booked in and out.

We saw there were Patient Group Directions for when nurses carried out ear syringing and immunisations.

Cleanliness and infection control

An infection control audit was conducted in December 2014. It identified some shortfalls and actions were agreed and these had been completed. There were also additional actions to maintain good practice.

There was a practice policy for hand hygiene and audits were carried out to ensure guidelines were being followed. Staff received specific training in relation to good hand hygiene.

The practice clinical waste protocol was updated in December 2014. It outlined the arrangements for the disposal of clinical waste and actions in response to any needle stick injuries obtained from clinical waste.

Cleaning audits were conducted monthly.

We carried out an audit of infection control arrangements using a recognised infection prevention and control audit tool. Whilst most of the arrangements for hand hygiene were in place we noted hand hygiene did not feature as an integral part of staff induction and there were some hand washing facilities where there was no liquid soap. All of the arrangements for the safe handling of sharp instruments were in place.

We found areas of the practice were not maintained in a way to reduce the risk of cross infection. In the sluice room laminate shelving was damaged and there were areas around the building where paint had chipped. In one of the GPs consulting rooms there was damaged laminate on the desk and the bottom of the storage drawers and trollies needed replacing as they were old and there was flaking of the outer surface of the coating around the edges leading to an infection control risk. We saw reusable equipment was decontaminated appropriately although the curtains in one of the treatment rooms needed replacing. In an examination room we saw dirty paper roll on the examination couch and a used glove left on the floor. We saw the skirting board around the sink in one of the consulting rooms was loose.

We looked at the arrangements for the disposal of clinical waste and found bins were dirty and were not of the foot pedal opening type. There were arrangements for the safe handling of specimens however there were no records to show staff had been trained in the safe use of equipment used for handling specimens and there was no hand washing facility in the sluice room. Records showed staff had appropriate immunisations.

The landlord carried out checks for Legionella.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments

and treatments. They told us all equipment was tested and maintained regularly and we saw equipment maintenance logs to confirm this. We saw evidence of calibration of relevant equipment such as weighing scales, and blood pressure monitoring devices.

The doors inside Southmead and Henbury Family Practice were not suitable for wheelchair users, people with limited mobility or parents with prams. The practice manager acknowledged this and that they were planning to install electronically operated systems during this year.

We felt the storage of pedestal weighing scales in a corridor outside of an examination room could present a trip hazard.

Staffing and recruitment

We discussed recruitment with a newly appointed member of staff. They described their experience of the process where they were required to submit a written application and were interviewed by three people. They were given a job offer letter and job description.

The practice had a policy relating to criminal records checks for staff. All of the staff had criminal records checks with the Disclosure and Barring Service (DBS). All GPs had DBS checks at level three, Nurses and other healthcare staff DBS checks were at level two and the practice was in the process of renewing these at level three. Some non-clinical staff had DBS checks at level one.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff to keep patients safe.

Monitoring safety and responding to risk

There were practice policies relating to health and safety and fire safety.

The premises were owned by NHS Property Services. Its guide for customers and tenants outlined how facilities management functions would be provided directly by the company or by a third party, including compliance with statutory functions such as fire and legionella prevention.

The practice manager showed us a contractors risk assessment carried out on behalf of the landlord however this was not specifically in relation to the provision of healthcare services to patients.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed staff had received training in basic life support. Emergency equipment was available. We checked the emergency medicines and found they were in place as required. Processes were in place to check whether emergency medicines were within their expiry date and suitable for use. We saw there were guidelines for staff for dealing with anaphylaxis and cardio-pulmonary resuscitation.

The practice manager felt there was a low risk to business continuity because of the location of the practice.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

The staff we spoke with and the evidence we reviewed confirmed that the practice aimed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions.

Information from Public Health England for 2013/14 showed the practice had a higher than England average of patients with a health related problem which affected their daily life. However, there was a lower than average number of patients with a long standing health condition.

The practice provided a service for two care homes close by that provided nursing care for older people. One of the GPs was linked with the homes and visited weekly. All of the patients in the homes had care plans and we saw the template used to record the plan. Where people expressed a wish to not be resuscitated (DNAR) the appropriate form was completed. A copy of the patient's care plan and DNAR was kept in the care home and a summary of the care plan was communicated to the Out of Hours service.

One of the GPs was the identified lead GP for mental health and dementia. They told us they had booked refresher training for April 2015. The practice lead for dementia met with the community dementia care nurse monthly. There were an increasing number of patients with dementia for whom assessments had been carried out. The practice nurses told us they had not undertaken any specific dementia training.

The practice maintained a register of all patients in need of palliative care. There were regular multidisciplinary case review meetings where all patients on the palliative care register were discussed.

All referrals for other healthcare services were sent on behalf of the practice by the medical secretaries. The practice manager told us there were plans to commence using the referral management system.

The practice linked with two NHS Trusts each having its own discharger processes. One sent discharge summaries direct to the practice computer system and there was a good system for ensuring they were all responded to. The other Trust sent paper summaries to the practice.

The GPs operated a buddy system to ensure discharge summaries and test results were responded to when a GP was absent.

Community midwives were based at Southmead Health Centre and provided services for patients at both surgeries. Any communication received from midwives in written form was scanned into patient records. Patients did not see their own GP to confirm pregnancy. If they had a positive home test they were asked to collect a midwife booking pack from reception. The practice aimed for the patient's own named GP and community midwife to take care of them during pregnancy. Relaxation classes and parenting classes were held in the surgery. Post natal and baby checks were carried out during routine appointments.

Health visitors and district nurses were also based in the Southmead health centre. GPs could directly contact district nurses by computer to allocate tasks to them.

Management, monitoring and improving outcomes for people

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

The practice showed us clinical audits that had been undertaken in the last year. One of these related to an audit of patients with coeliac disease (gluten intolerance). There had been some progress in response to the audit over time,

Good

Are services effective?

(for example, treatment is effective)

and the practice admitted it had not been pro-active to achieve better results. An action plan was now agreed and we saw prompts had been added to patient records. The action plan was shared with all GPs.

An audit of the practice prescribing of non-steroidal anti-inflammatory drugs (NSAIDS) was carried out following the 2012 European Medicines Agency review of the cardiovascular safety of different classes of NSAIDS. The audit considered the monitoring of patients and contraindications. It was carried out in 2013 and again in 2015 and showed good progress. For example in 2013 there were 51 patients taking a particular medicine and in 2015 the number had reduced to seven. Similarly in 2013 of the 51 patients taking the medicine only 44 had a clear indication for taking the NSAID recorded however in 2015 all of the seven patients had this information in their record. We saw there was evidence of improvement for other aspects of the audit.

The practice used a schedule for the monitoring of patients prescribed high risk medicines to ensure patient safety. It recorded the types of tests to be carried out along with the frequency of the testing. The staff pointed out the list was not exhaustive and some more intensive monitoring may be indicated by a patient's clinical condition.

The practice monitored patients with long term conditions through the Quality and Outcomes Framework (QOF) and told us it was proactive in identifying chronic disease. For example the ratio of expected to reported prevalence of coronary heart disease was 0.78 compared to the England ratio of 0.72. The practice operated a 'usual GP' system to enhance continuity and consistency of care.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the doctors each having special interests such as children's health, chronic disease management, learning disabilities and mental 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).

A newly appointed member of staff recalled their induction which included a tour of each of the practice surgeries and followed a checklist to ensure all areas were covered. We saw induction was role specific for all staff. They told us they shadowed other experienced staff for the first few weeks and their probationary period had included several meetings with their manager.

Staff told us about the training opportunities provided by the practice including the mandatory on-line learning. This included Mental Capacity Act 2005, child protection and safeguarding vulnerable adults. One of the receptionists had completed training in medical terminology and was to attend a course in phlebotomy to enable them to extend their role within the practice. Another member of staff told us about their role specific training including coding and summarising for medical records.

The lead nurse told us about the training they had completed in the past. They had identified training needed to be completed by the nurses in the team including working with children, dementia care, older people and vulnerable adults. They said they would be organising in-house training.

A member of staff told us how their potential had been recognised and they had progressed to a new role. They said they felt valued and had a mentor within the practice who they met with regularly to support them in their role.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post.

The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The practice contracted it's Out of Hours arrangements to Brisdoc. If a patient was seen by an Out of Hours GP and a follow up

Good

Are services effective?

(for example, treatment is effective)

was needed a communication from the service was sent to the Patient's GPs electronic mail service for them to review. The GPs operated a 'buddy' system and covered each other during absences.

All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

There were meetings held every two months for the GPs and nurses to discuss admission to hospital avoidance where patients whose condition made them vulnerable to hospital admission were reviewed to ensure the best care was provided for them.

End of life care meetings were held to discuss those on the palliative care register so the GPs and nurses were knowledgeable about these patients and their particular needs.

Information sharing

The practice Caldicott policy was updated in November 2014. It identified one of the GP partners as the Caldicott Guardian to ensure that if patient identifiable information was shared with other NHS organisations it was necessary for the safe treatment of patients.

We saw a code of practice related to the confidentiality of patient information.

The lead nurse told us all staff had completed on-line training in information governance.

The practice newsletter was available in the practice and we saw the Patient Reference Group suggested it should also be distributed to local churches and libraries. The winter 2014 edition outlined changes to practice staff, seasonal immunisations and information regarding the summary care record.

The newsletter advised how information about a patient's medicines, allergies and adverse reaction to medicines would be shared with other healthcare staff. It also advised what a patient should do if they did not want this information shared.

Consent to care and treatment

The consent policy was reviewed in December 2014. It included guidance on 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.

The practice obtained written consent for some treatments including the use of intra-uterine devises for contraceptive purposes.

Where patients wished for test results or correspondence to be collected they were required to give consent to this by signing a dedicated form.

We saw information provided by the NHS England area team that provided a framework for making decisions in respect of advance directives to not resuscitate. There was a form for staff to use and guidance on who the patient's decision should be shared with.

Staff we spoke with demonstrated an understanding of mental capacity and the need for informed consent. They were able to describe what to do if a patient lacked capacity.

One of the patients we spoke with told us they were involved in decisions about their treatment but that sometimes when they are examined the GP does not always ask them directly if they are happy with this.

Health promotion and prevention

Clinics for the management of asthma and diabetes were held in the surgery and appointments could be made with a health promotion nurse for lifestyle and diet advice, well person checks, coronary heart disease checks, cervical smears, menopause advice and smoking cessation.

It was practice policy to offer a health check with the health care assistant / practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability. The

Good

Are services effective?

(for example, treatment is effective)

practice had also identified the smoking status patients with physical or mental health conditions. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice provided services for patients with drug and alcohol dependence. One of the GPs led in this area There were patients on supported opiate prescribing and the practice maintained a close relationship with the Bristol Drug Project. The practice had signed up to provide an enhanced service for those with alcohol dependence and was able to assist with detoxification. Alcohol detoxification medicine programmes were prescribed by several of the GPs.

The practice had a service level agreement (SLA) with Public Health Bristol to provide a pilot community GP alcohol detoxification service. The SLA linked the practice with Bristol 'ROADS' for patients to receive assessment and psycho-social support and support for family and carers.

The practice's performance for cervical smear uptake was 82.9% which was higher than the England average.

We looked at information provided by the Bristol North and West Clinical Commissioning Group (CCG) related to the take up of seasonal influenza vaccination. It showed the practice uptake rate was above average compared to other practices in the area for the immunisation of children aged two to four years, pregnant women, under 65 years olds with clinical risk and patients aged over 65 years.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance.

The practice maintained a register of patients at high risk of unplanned admission to hospital and those at end of life care. There were multidisciplinary team meetings to discuss their support needs. The care coordinator contacted patients after discharge form hospital to ensure their support needs were met.

Patients with long term conditions such as diabetes had structured annual reviews. In the last year 94% of patients had a foot examination and risk classification, 96.8% had influenza immunisation.

The practice attained good rates for childhood immunisation and there were good working relationships with midwives and health visitors.

The number of patients with schizophrenia, bipolar affective disorder and other psychoses who had a documented, comprehensive care plan was higher than the England average of 86% at almost 97%. More than 92% of patients in this group had alcohol consumption recorded within the last 12 months.

Similarly the number of patients with dementia whose care had been reviewed in a face to face consultation in the preceding 12 months was higher than the England average at 85% compared to 83%

A practice leaflet entitled 'Champion your health' provided information for patients and their children. It outlined when patients should seek medical help in respect of various conditions. These included sprains and strains, the common cold, cough and acute sinusitis in adults, sore throat, fever in children, headache and ear infection. In addition it contained guidance in relation to eczema, acne and constipation. The leaflet directed patients to the appropriate course for their condition including A&E, NHS Walk-in centres, pharmacy, NHS Direct and GP surgery along with relevant telephone contact details.

Through links with the Public Health Improvement Neighbourhood Team one of the receptionists had become a community health champion and was able to signpost patients to community health resources. Each week staff from the North Bristol Advice Centre were available at Southmead Health Centre to give patients advice on benefits. This enabled patients to obtain information locally.

The practice was committed to reducing social isolation through the 'Well Aware' initiative and the practice community health champion. It issued prescriptions for exercise and self-help books.

There was a sexual health clinic at the Southmead Health Centre. Staff were refreshing the 4YP training (Wherever the 4YP logo is displayed patients can be sure that the services on offer are young people friendly) and had achieved standards to ensure it met the needs of young patients. The practice had initiated teenage health checks learning from the success of other local practices.

Good

Are services effective?

(for example, treatment is effective)

There was a television monitor in the waiting room showing health related information. This included information about antibiotic treatments and smoking cessation advice. In addition there were a range of health related leaflets available for patients to take away with them.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

The practice dignity and respect policy included the arrangements for offering a chaperone. The lead nurse told us all staff had completed on-line training in equalities and diversity

We looked at the results of the NHS England national GP patient survey for 2013/14. It showed 83% of respondents described their overall experience of the practice as 'fairly good' or 'very good'. The results showed 82% of patients said their GP was 'good' or 'very good' at involving them in decisions about their care and 84% said the GP was 'good' or 'very good' at treating them with care and concern. There were similar results to questions about patients' experience of being treated by a nurse and all of the results were close to the England average.

We noted the reception area did not allow for confidential conversations between receptionists and patients and there was no sign indicating a private space was available if needed. There was a sign asking patients to respect the privacy of others by standing back from the reception desk until it was their turn to be seen however, conversations could still be heard.

The practice confidentiality agreement was displayed in the waiting area.

We overheard telephone calls and conversations between staff and patients at the reception desk. Patients were spoken to politely and respectfully.

One of the patients we spoke with told us their privacy was maintained. They said conversations were kept private and the GPs and nurses always locked treatment room doors prior to carrying out examinations.

Care planning and involvement in decisions about care and treatment

The practice employed a care co-ordinator, as part of the Bristol Primary Care Agreement, whose remit was to provide support to GPs and nurses to ensure the practice's frail and elderly patients obtained the support and care necessary to reduce the risk of unplanned hospital admissions.

They told us how they were responsible for ensuring care plans were in place for vulnerable patients. They said if a patient was admitted to hospital as an emergency or attended the accident and emergency department at hospital they telephoned them within 72 hours of their discharge to check they were alright, were feeling supported and had the care that met their needs.

Patient/carer support to cope emotionally with care and treatment

One of the GPs was identified as the lead person for working with carers and told us the practice was actively seeking to identify carers. There was a care co-ordinator and one of the receptionists was a key link between carers and the practice.

There was a statement in the practice for carers. It said that the practice wanted to ensure carers received the support they needed. It suggested carers asked the receptionist for a carer's identification and referral form, completed it and posted it in the carer's referrals box in reception or hand it to the receptionist. The identification and referral form asked for the person's details and details of the person they looked after. In addition there was space for carers to indicate whether they wanted their details passed to the carer's service or wished for referral to Adult Care Services for a carer's needs assessment. The practice maintained a carer's register with approximately 210 carers listed.

Volunteers held a carers meeting every two weeks at the Southmead Health Centre and there were weekly one to one appointments available there.

When the practice received notification of the death of a patient the information was circulated to all staff. Contact was made with the patient's family and information about support organisations was highlighted.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

The practice had an active appointment management policy. It outlined how on any day each GP would offer 12 routine appointments in the morning along with six same day, urgent appointments and six telephone consultations. In the evening they offered 10 routine appointments, three telephone consultations and five same day, urgent appointments. The policy explained contingencies for how the practice would respond to demand in various circumstances.

We looked at the appointments system in the early afternoon on the day of our visit. There were 13 remaining appointments available for the day. The next available appointments with a named GP varied from between the same day to 10 days.

The practice held an enhanced service contract with the NHS England local area team for extended hours. It provided extended opening on Friday mornings from 7.30 am with a GP and nurse and with GPs on Monday and Tuesday until 6.45 pm and with a GP on Wednesday evening until 7.00 pm. There were also pre-bookable appointments with a GP on Saturday mornings from 8.15 am until 9.45 am.

Patients were referred to other services as appropriate. One of the GPs was linked to the care homes the practice supported. They told us they were aware of the high number of referrals they made to the speech and language therapy service and attributed this to patients having swallowing difficulties.

One of the patients we spoke with told us how their referral to an external healthcare provider had been actioned speedily. Another patient told us their referral had not been made and they did not see a specialist as discussed with the GP.

Tackling inequity and promoting equality

The practice provided equality and diversity training through e-learning.

The practice manager told us, in order to meet the changing demographics in the area and respond to the increasing number of patients from Eastern Europe, the practice found it was using the telephone interpreting service more frequently.

We noted the doors within Southmead Health Centre had signs in braille to enable patients with the ability to interpret the communication to 'read' the signs.

Access to the service

We looked at the results of the NHS England national GP patient survey for 2013/14. It showed 74% of patients gave a positive answer to a question about accessing the practice by telephone and 82% of patients were 'fairly satisfied' or 'very satisfied' with the practice opening hours.

Patients could register with a GP of their choice and the practice endeavoured for patients to have routine appointments with the GP they were registered with. Patients were seen at the surgery they were registered at and patients could request appointments in person or by telephone. Some telephone consultations were available.

There were extended hours appointments available to meet the needs of the working age population, those recently retired and students. These included early morning, evening and Saturday morning appointments in addition to telephone consultations. NHS health checks were offered and patients could order repeat prescriptions on line. The practice told us it actively promoted NHS health checks for patients in the 40 to 75 years age group.

Pre-bookable appointments were available up to four weeks in advance and same day 'urgent appointments were available. The Southmead Health Centre opened at 8.00 am and the Willow Tree Surgery opened at 8.30 am. Patients requiring urgent afternoon appointments were asked to call after midday. Telephone consultations were available.

The treatment room was open during surgery hours for dressings, investigations, injections, and removal of stitches. There were urgent, same day, minor illness appointments available with a nurse at Southmead Health Centre. Minor surgical procedures and treatment with liquid nitrogen were provided by some of the GPs.

Good

Are services responsive to people's needs?

(for example, to feedback?)

We were told patients could make appointments at either Southmead Health Centre or the Willow Tree surgery. However, reception staff at Willow Tree indicated this did not happen except in the case of patients receiving support with addictions.

Prescriptions for repeat medicines could be requested by post, in person or through the on line service.

Listening and learning from concerns and complaints

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

The complaints procedure was summarised within the practice leaflet. It advised patients that if they were not happy about any aspect of their care or treatment they should speak with the GP or a member of staff in the first instance. The policy outlined timescales for investigating complaints, the investigation process and how complaints would be responded to. It explained if a patient remained unhappy the complaint would be investigated by a senior member of staff.

We saw the complaints log book recorded complaints received in respect of both the Willow Tree Surgery and Southmead Health Centre and noted that many of the complaints made by patients were not related to action by the practice but by other agencies. We saw a complaint had been raised as a significant event and was discussed at a significant event meeting. The learning outcome was recorded and shared amongst the GPs. Other complaints we looked at related to cultural differences and treatment concerns.

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 statement of purpose for Southmead and Henbury Family Practice outlined the mission of the practice to improve the health, well-being and lives of its patients. Its vision was to work in partnership with patients and staff to provide the best primary care services possible working within local and national governance, guidance e and regulations. The statement of purpose also described how this would be achieved and listed the range of services available.

We saw the practice had a six month management plan that recorded practice objectives for improvement, priorities, how achievement would be measured and target dates. We saw some of the objectives within the current plan had been achieved.

Governance arrangements

The practice had a number of policies, procedures and protocols in place to govern activity and these were available to staff on the desktop on any computer within the practice. The practice used Intradoc an administration and compliance software to store policies, procedures and protocols along with complaints, significant events, audits and other administrative tools. Intradoc allowed the practice to monitor who read what policy and when. All 12 policies, procedures and protocols we looked at had been reviewed annually and were up to date.

We saw the NHS Constitution document 'Rights and responsibilities of patients and staff' had been interpreted by the practice to form two separate documents relating to these.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead GP for safeguarding and identified lead nurse for infection control. We saw a table showing which staff specialised in clinical roles and non-clinical roles

We spoke with eight members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

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

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. We looked at the audits of patients with gluten intolerance and the prescribing of non-steroidal anti-inflammatory drugs (NSAIDS) and saw improvements had been made. Where the improvements were low the practice implemented an action plan to secure greater improvement.

Leadership, openness and transparency

Practice staff had a break each morning that staff told us was a good opportunity to discuss any issues. There were team talks every Friday at the Southmead Health Centre. The talks were communicated to the Willow Tree surgery staff through the Intradoc computer system. The meetings were used to disseminate information to staff.

Reception staff met every two months and there were a range of other meetings and occasional away days.

We spoke with a range of staff about their perception of the practice. One staff member described an 'inclusive team' and told us it was a good team to be a part of. They said there was good coordination between the two surgeries that enabled the practice to work well. Staff told us they felt supported, spoke about team work and enjoying their job within the practice.

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

We met with three members of the patient participation group (PPG). They told us about the meetings they held every three months and how the PPG for each of the surgeries within the practice had merged and held a successful first meeting. The PPG was led by one of the GPs and provided a forum for open discussions.

The terms of reference for the group listed its purpose as being a forum for patients to share their views and experiences, to help shape and develop services and to express views on wide health care matters pertinent to the North and West Bristol Clinical Commissioning Group.

Are services well-led?

Good

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

The PPG members told us about the achievements of the group to improve the service, including the provision of a suggestion box, newsletter and influencing the decision to install electronically operated doors at the Southmead health centre in the forthcoming year.

During February and March 2014 the PPG carried out a patient survey using an external agency to collate and disseminate results to the practice. The survey questionnaire comprised of 28 questions related to patient's experiences. Patients were asked to rate each question as 'excellent', 'very good', 'good', fair' or 'poor'. For most questions patients rated the practice as 'good', 'very good' or 'excellent'. There were some exceptions such as 79 respondents' rated 'being able to see a GP within 48 hours' as 'poor' with 106 respondents rating the statement as 'fair'.

The results were analysed and areas for improvement were identified including comfort of the waiting room, satisfaction with opening hours, telephone access and seeing a GP within 48 hours. In addition there were other priorities including ensuring the practice and PPG worked together to reach under-represented groups on the PPG.

We looked at the results for the Friends and Family Test. There were 101 responses from 374 patients surveyed. The report summary for January 2015 showed 92% of patients would recommend the practice, 7% would not recommend and 1% would nether recommend or not recommend the practice.

Management lead through learning and improvement

One of the GPs was the lead for education and training. They organised educational sessions for the GPs and nurses and managed the training of GP registrars. Educational sessions included patient self-care and alcohol management.

Southmead and Henbury Family Practice had provided training for GPs for over 25 years. All of the GPs were involved in the training of GP registrars. We saw there were information packs given to trainees. We looked at the updated 'guide for GP registrars' and found it informative and useful.

We spoke with a GP registrar who had been at the practice for three months. They told us about their initial induction where they sat with clinical and non-clinical staff to help them understand the working of the practice and gain knowledge of practice protocols such as those relating to the computer system and fire safety. They had an identified supervisor and spoke about the support they received from them and the other GPs. They said they attended all meetings and told us they felt able to contribute to discussions.

We saw written feedback from a past GP registrar. It read positively about the general support, supervision, resources and opportunities provided by the practice. They rated the practice very highly for the training they received.

The practice was part of the Bristol Primary Care Research and Development Consortium and hosted research in collaboration with various NHS organisations. It had been actively involved in research programmes including the management of depression, children with fever, sexually transmitted disease, antibiotic resistance and anxiety disorders.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **The provider did not ensure there are suitable arrangements in place for the management of clinical waste and ensure all areas of the practice are maintained in a way to reduce the risk of cross infection. In addition they did not ensure there are suitable arrangements for the safe handling of and management of bodily fluids taken as specimens.**