Air Balloon Surgery

Quality Report

Air Balloon Surgery
Kenn Road
St George
Bristol
BS5 7PD
Tel: 0117 9099912
Website: www.airballoonsurgery.co.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

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Air Balloon Surgery on 12 March 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, well-led, effective, caring and responsive services. It was also good for providing services for patients 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 and people experiencing poor mental health (including people with dementia). Some services for older patients were outstanding.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and 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.

Summary of findings

- 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.

We saw areas of outstanding practice, these included:

- The practice is a member of the Prime Ministers challenge fund "One Care" pilot project which aims to use technology to improve access to primary care, manage demand effectively and improve the quality and consistency of care delivered both in hours and out of hours. One care is already providing pre bookable weekend appointments to patients who might otherwise be admitted to hospital. E-consultations are also provided to improve the possible access routes for patients for practice consultations.
- The nominated GPs made three times a week ward round visits to patients in an adjacent nursing home. They carried out routine monitoring and to use information gathered to update care plans for the most vulnerable patients although the care plans for people with a diagnosis of dementia had not always been updated. Twice weekly ward rounds were carried out at two other residential homes for older patients as well as a home for people with a learning disability.
- GPs from the practice were involved in a pilot study in the use of the Edmonton Frailty Scale to inform decisions where patients lacked capacity to make decisions about future care needs. This assessment tool is a brief, valid, reliable tool which can be used by clinicians without special training in geriatric medicine to assess the frailty of the older patient. It assesses 10 domains including cognitive impairment, balance and mobility.
- Practice staff recognised the needs of vulnerable patients and made additional efforts to support them. They spent over two hours helping a non-English speaking patient to complete a registration form and providing additional support; adapting a treatment room to accommodate a vulnerable patient so they could receive a minor injuries procedure without the need for a hospital admission.
- All patients diagnosed with diabetes were offered and provided with a personal care plan to manage their diabetes where it was their choice to have one. The care plan enabled the patients to record test results, maintain a foot risk status with help from the nursing team and develop a plan for their diabetes reviews and establish a personal action plan. These care plans were seen as helpful and motivating by the patients with whom we spoke.

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

Importantly the provider should;

- Review its processes for recalibrating equipment to include equipment held in individual GPs bags.
- Review care plans for patients with a diagnosis of a dementia to ensure they are all up to date.
- Review the confidentiality of conversations taking place in the top floor consultation rooms.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

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

Are services effective?

Good

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

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for almost all aspects of care. Feedback from patients about their care and treatment was consistent and strongly positive. We observed a patient-centred culture. Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles in achieving this. We found many positive examples to demonstrate how patient's choice and preferences were valued and acted upon. Views of external stakeholders were very positive and aligned with our findings.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice had initiated positive service improvements for its patients that were over and above its contractual obligations. It acted upon suggestions for improvements and changed the way it delivered services in response to feedback from the patient participation group (PPG). The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these had been identified.

Summary of findings

Patients told us it was easy to get an appointment with a named GP or a GP of choice the majority of the time, with continuity of care and urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had a clear vision with quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff. High standards were promoted and owned by all practice staff and teams worked together across all roles. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. The practice carried out proactive succession planning. There was a high level of constructive engagement with staff and a high level of staff satisfaction and retention. The practice gathered feedback from patients using new technology, and it had a very active patient participation group (PPG).

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 supporting people with a diagnosis of 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 nominated GPs made three times a week ward round visits to patients in the adjacent nursing home to carry out routine monitoring and to use information gathered to update care plans for the most vulnerable patients. Twice weekly ward rounds were carried out at two other residential homes for older patients as well as a home for people with a learning disability.

One of the staff had a lead responsibility for carers. The practices carers strategy and processes were reviewed every six months with the local Carers Forum to review services provided for carers. The forum gave very positive feedback about the work the practice did.

Monitoring was in place for A&E attendances by older patients, in addition calls to the out of hours service and admissions rates to hospital were monitored. The practice used a full range of community services to support these patients such as community nurse visits and had low A&E admissions rates for older patients.

The practice had clear links to the local hospice and other end of life support services. The wider end of life services network attended the practices palliative care meetings to ensure older patients received appropriate care and treatment. This work was also supported through a close working relationship with a psychiatric consultant.

People with long term conditions

Good

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

structured annual review to check their health and medicine needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Staff knowledge, skills and competence to respond to the needs of this population group had been reviewed. A clinical Practice Pharmacist was employed in-house by the practice. The nursing staff skill mix was shaped to meet the clinical needs of patients, with a high level of qualifications such as diploma's in the majority of common long term conditions. This was supported by regular refresher training.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

The practice had a positive performance for children's immunisation due to a closely monitored programme. They consistently achieved 90% immunisation take up rates including for measles, mumps and rubella (MMR). The practice had amalgamated their post natal check with the child's first immunisations and baby check. A patient focussed approach had resulted in high attendance rates.

Families, children and young patients had access to a range of services within the practice. These included, ante natal services, baby clinics, family planning and sexual health clinics, access to specialist children's dental services and speech therapy.

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 which reflects the needs for this age group.

Data from Public Health England showed the practice had a higher than average number of patients working very long hours and away from home. The practice responded by providing 'commuter' extended hours sessions between 8:00 am and 8:00 pm four days a week, 8.00 am to18.30 pm on a Friday and bookable appointments every Saturday morning. A wide choice of appointment times across the day and week were also provided for many clinics such as blood tests, long term conditions and health checks. A telephone consultation service was also available where clinically indicated.

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 the majority of these patients had received a follow-up. It offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

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

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND and local mental health services. It

Summary of findings

had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training about how to care for people with mental health needs and dementia.

The practice carried out joint patient consultations with local mental health teams to ensure greater continuity of treatment for the patient and improved information sharing for the professionals involved. For example, in the types and choices of treatment available to the patients.

The GPs and practice nurses had received training in learning disabilities, mental health and dementia. The practice was able to evidence a positive dementia detection rate. In keeping with many practices, mental health is a high priority.

Summary of findings

What people who use the service say

We spoke with six patients visiting the practice and three members of the patient participation group during our inspection. We received 24 comment cards from patients who visited the practice and saw the results of the most recent patient participation group survey. We looked at the practice's NHS Choices website to look at comments made by patients (NHS Choices is a website which provides information about NHS services and allows patients to make comments about the services they received). We also looked at data provided in the most recent NHS GP patient survey and the Care Quality Commission's information management report about the practice. 87% of patients described their overall experience of this surgery as good during the 2014 GP patient survey.

All of the comments made or written by patients were positive and praised the GPs and nurses who provided their treatment. For example; about receiving exceptional care and treatment, about seeing a GP or nurse of their choice and about being treated with respect and consideration by all staff. Comments from carers also explained about the informative support they received with regard to their caring role and the support of the main GP partner and carers lead. Comments about the reception team were equally positive.

We heard and saw the majority of patients found access to the practice and appointments easy and how telephones were answered after a period of waiting. The most recent 2014 GP survey showed 56% of patients found it easy to get through to the practice but that 94% of patients found the appointment they were offered was convenient for them. Patients also told us they used the practices online booking systems to make appointments, 62% describe their experience of making an appointment as good. The practice was aware of these issues and were working on ways to improve access for example, by providing online consultations with the duty doctor.

Patients told us their privacy and dignity was respected at all times both during consultations and in the reception and waiting areas. They told us they found the reception area was generally private enough for most discussions they needed to make. The most recent 2014 GP survey showed 91% of patients said they found the receptionists at this practice helpful. Patients told us about GPs providing extra support to themselves and carers at times of difficulty and bereavement. Many patients had been attending the practice for over 25 years and told us about how the practice had evolved, how they were always treated well and how the most recent premises had improved access to treatments. The GP survey showed 87% of patients said the last GP they saw or spoke with was good at giving them enough time and 95% stated they had confidence and trust in the last GP they saw or with whom they spoke.

Patients told us the practice always appeared clean and tidy and the practice had appropriate security measures at all times. Online repeat prescription facilities had been added to help patients access their medicines in a timely way. They told us during intimate examinations GPs and nurses wore protective clothing such as gloves and aprons and that examination couches were covered with disposable protective sheets.

The practice had an active and fully engaged patient participation group (PPG) who communicated with practice staff regularly and helped make suggestions about improvements to the services offered by the practice. The last PPG report for 2013/2014 had made several recommendations which they told us had been actioned. The groups representatives we spoke with also told us about the professionalism and responsiveness of the practice and the value they gained from the regular involvement of a GP and the practice manager in their communications. All PPG members we spoke with told us about the high quality of patient care provided by the practice and about the dignity and respect shown by staff.

Areas for improvement

Summary of findings

Action the service SHOULD take to improve
The provider should;

Review its processes for recalibrating equipment to include equipment held in individual GPs bags.

Review care plans for patients with dementia to ensure they are all up to date.

Review the confidentiality of conversations taking place in the top floor consultation rooms.

Outstanding practice

- The practice is a member of the Prime Ministers challenge fund "One Care" pilot project which aims to use technology to improve access to primary care, manage demand effectively and improve the quality and consistency of care delivered both in hours and out of hours. One care is already providing pre bookable weekend appointments to patients who might otherwise be admitted to hospital. E-consultations are also provided to improve the possible access routes for patients for practice consultations.
- The nominated GPs made three times a week ward round visits to patients in an adjacent nursing home. They carried out routine monitoring and to use information gathered to update care plans for the most vulnerable patients although the care plans for people with a diagnosis of dementia had not always been updated. Twice weekly ward rounds were carried out at two other residential homes for older patients as well as a home for people with a learning disability.
- GPs from the practice were involved in a pilot study in the use of the Edmonton Frailty Scale to inform decisions where patients lacked capacity to make decisions about future care needs. This assessment tool is a brief, valid, reliable tool which can be used by clinicians without special training in geriatric medicine to assess the frailty of the older patient. It assesses 10 domains including cognitive impairment, balance and mobility.
- Practice staff recognised the needs of vulnerable patients and made additional efforts to support them. They spent over two hours helping a non-English speaking patient to complete a registration form and providing additional support; adapting a treatment room to accommodate a vulnerable patient so they could receive a minor injuries procedure without the need for a hospital admission.
- All patients diagnosed with diabetes were offered and provided with a personal care plan to manage their diabetes where it was their choice to have one. The care plan enabled the patients to record test results, maintain a foot risk status with help from the nursing team and develop a plan for their diabetes reviews and establish a personal action plan. These care plans were seen as helpful and motivating by the patients with whom we spoke.

Air Balloon Surgery

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 and other specialists including, a practice manager and a practice nurse.

Background to Air Balloon Surgery

Air Balloon Surgery, Kenn Road, St George, Bristol BS5 7PD is located about 3 miles from the centre of Bristol. The premises are purpose built and are shared with a privately run pharmacy.

Air Balloon Surgery has approximately 13,500 patients registered with the practice with a catchment area which includes St George, Speedwell, Redfield, Whitehall, Kingswood, Hanham, Fishponds (south of Fishponds Road) and Staple Hill (south of Staple Hill Road, High Street, Tewell Street and Station Road). There is a boundary outside of these areas of which the practice cannot accept patients.

There are five partners who are complimented by three associate GPs and a large team of clinical staff including practice nurses, a clinical practice pharmacist, phlebotomist, health care assistant, and smoking cessation counsellors. Two partners are female and three are male, the hours contracted by GPs are equal to 3.38 whole time equivalent employees. The three associate GPs are female and equal to 2.75 whole time equivalent employees. Additionally there are six nurses and a nurse manager employed equal to 5.37 whole time equivalent employees, a practice pharmacist and four health care assistants/ phlebotomists equal to 3.48 whole time equivalent employees employed. Non-clinical staff included secretaries, IT staff, finance staff, support staff and a small management team including a practice manager.

The practice population is predominantly White British with an age distribution of male and female patients predominantly in the working age population group. About 5% of patients who have stated their ethnicity come from non-white ethnic groups. The average male and female life expectancy for the practice is 78 and 83 years respectively, male life expectancy is slightly below the national average. The patients come from a range of income categories with an average for the practice being in the fifth most deprived category. One being the most deprived and ten being the least deprived. The practice has the highest number of patients over the age of 65 years in Bristol and about 10% of patients are over the age of 75 years with about 16.5% under the age of 15 years. Over 81% of patients said they would recommend the practice in the most recent National GP patient survey 2013/14.

The practice has a Personal Medical Services (PMS) contract to deliver health care services; the contract includes enhanced services such as extended opening hours, online access and diabetes services. This contract acts as the basis for arrangements between the NHS Commissioning Board and providers of general medical services in England. Approximately 6255 of the practices patients are registered for online services and provide over 7000 contacts with the practice via their website.

Approximately 33,000 GP consultations are provided each year, these are supplemented by 17,000 GP phone calls annually. The practice staff make about 3,400 home visits each year. The nursing team provide almost 33,700 nurse face to face and telephone consultations each year and about ¼ million prescribed items are provided to patients.

Detailed findings

The practice is a member of the Prime Ministers challenge fund "One Care" pilot project which aims to use technology to improve access to primary care, manage demand effectively and improve the quality and consistency of care delivered. These services include the use of online platforms to manage appointments, repeat prescriptions and consultations and integrated patient records with read and write access to patient records across the area.

The practice has opted out of providing out-of-hours services to their own patients. This service is provided by BrisDoc and patients are directed to this service by the practice during out of hours.

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.

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

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)

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations such as the Bristol Clinical Commissioning Group and Healthwatch to share what they knew. We asked the provider to send us information about their practice and to tell us about the things they did well. We reviewed the information for patients on the practices website and carried out an announced visit on 12 March 2015.

We talked with the majority of staff employed in the practice who were working on the day of our inspection. This included four GPs, three practice nurses, three health care assistants, the nurse manager, the practice pharmacist, the practice manager and four administrative and reception staff. We also spoke with the pharmacist from the adjacent pharmacy, a nurse in the adjacent nursing home and a community nurse located in the practice. We spoke with 10 patients visiting the practice during our inspection, three members of the patient participation group and received comment cards from a further 24 patients.

Good

Are services safe?

Our findings

Safe track record

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

We reviewed safety records, incident reports and minutes of monthly meetings where these were discussed for the last 18 months. These showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term. The minutes of the meetings we saw demonstrated these events were communicated across the staff team and that patient and staff safety was a priority within the practice.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last 18 months and we were able to review these. Significant events was a standing item on the practice meeting agenda and a dedicated meeting was held monthly to review actions from past significant events and complaints. Significant events were also a standing item on the practices weekly meeting agenda for any issues needing a quick review. Regular Lamb report review meetings were held with practice safeguarding lead and health visitor safeguarding lead and actions were recorded and followed up. (The Lamb report is the government's final response to the events at Winterbourne View).

There was evidence the practice had learned from these investigations and meetings and the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they told us they felt encouraged to do so if needed.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. She showed us the system used to manage and monitor incidents. We tracked six incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result of investigations for example, longer appointment times with a nurse for a set period of time to allow for a skills reassessment to take place. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated by lead partners, the practice's pharmacist and the practice manager to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care for which they were responsible. They also told us alerts were discussed at practice clinical meetings to ensure staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

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

The practice had appointed a dedicated GP with lead responsibility for safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who the lead professional was and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans or elderly patients diagnosed with dementia. The practice had also identified children, young

people and families living in disadvantaged circumstances and monitored their needs, placing them on the vulnerable patients list where required. The practice followed up children who persistently fail to attend appointments for example, for childhood immunisations. Immunisation rates were amongst the highest in the Clinical Commissioning Group (CCG) area. The lead safeguarding GP was aware of vulnerable children and adults and practice records demonstrated clear liaison with partner agencies such as the police and social services.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, and described the action to take in the event of a potential failure. The practice staff followed the policy. Temperature log books were kept with each fridge and all were seen to be completed appropriately. A backup medicines fridge was available for use in emergency situations.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. A practice pharmacist was employed by the practice; they provided an oversight of all aspects of medicines management. Along with the practice nurse they took responsibility for ensuring stocks of medicines were rotated and ordered to ensure cost effective use of medicines. They also carried out a range of audits for nurses and GPs with regard to the use of medicines for example, medicines used in the treatment of osteoporosis, treatment-induced bone loss.

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example, patterns of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice. We saw the practice was following guidance about managing common infections such as respiratory tract and urine infections. This had led to a more targeted use of antibiotic prescribing to reduce resistance to antibiotic treatments.

The nurses and the health care assistants administered vaccines using patient group and patient specific directions that had been produced in line with legal requirements and national guidance. We saw that nurses and the health care assistants had received appropriate training to administer vaccines and received regular skills updates in this area.

There was practice pharmacist who ensured a system was in place for the management of high risk medicines, which included regular monitoring in line with national guidance. Appropriate action was taken based on the results. We checked a small sample of four anonymised patient records which confirmed that the procedure was being followed.

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; these were tracked through the practice and kept securely at all times.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a specifically designed controlled drugs cupboard in a locked room and access to them was restricted. The keys were held securely. There were arrangements in place for the destruction of controlled drugs.

Practice staff undertook regular audits of controlled drug prescribing to look for unusual products, quantities, dose, formulations and strength. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

Cleanliness and infection control

We observed the premises to be clean, tidy and well maintained. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

Good

Are services safe?

The nurse manager who had lead responsibility for infection control had undertaken further training to enable them to provide advice about the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead professional had carried out annual audits and any improvements identified for action were completed on time. Minutes of practice meetings showed that the findings of the audits were discussed.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. For example, during minor surgery or intimate patient examinations. There was also a clearly displayed policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

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

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.

Cleaning materials were managed in accordance with control of substances hazardous to health (CoSHH) guidance. Information leaflets for the products were available to staff. Materials were stored securely. Clinical waste was stored securely in line with Environment Agency guidance.

Equipment

Staff we spoke with told us they had sufficient 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 such as certificates that confirmed this.

All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer. However we saw a sphygmomanometer (equipment used to monitor blood pressure) and pulse oximeter (used to monitor the oxygen saturation of a patient's blood) in a GPs bag had not been calibrated when other similar equipment had been done recently. Storage areas for gasses such as oxygen were clearly marked.

Other equipment for example fire extinguishers were also serviced and tested annually in line with fire safety requirements. The last test had been carried out in August 2014. Fire alarms and emergency lighting were also routinely tested and serviced in line with the practices fire policy. The security alarm was tested annually.

Staffing and recruitment

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

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

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

The practice also had safe practices for the employment of locum GPs to ensure patients received safe and informed

treatment. The practice showed us documents which demonstrated continuity of patient care was maintained by the use of named locum GPs whose professional status was checked by the practice manger.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there were clearly identified health and safety representatives.

Identified risks were included on a risk log. Each risk was assessed, rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at GP partners' meetings and within team meetings. For example, the practice manager had shared the recent findings from an infection control audit with the team.

We saw staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example: there were emergency processes in place for patients with long-term conditions. Staff gave us examples of referrals made for patients whose health deteriorated suddenly. The nominated GPs made three times a week ward round visits to patients in the adjacent nursing home to carry out routine monitoring and to use information gathered to update care plans for the most vulnerable patients. Twice weekly ward rounds were carried out at two other residential homes for older patients as well as a home for people with a learning disability. In conjunction with the health visitor and midwife emergency processes were in place for acute pregnancy complications.

Staff gave examples of how they responded to patients experiencing a mental health crisis or lapses in behaviour due to substance misuse. We saw there were referral mechanisms in place to support these patients as well as services provided on site such as a weekly drug and substance misuse service.

A system was in place to ensure staff safety. The practice had a system which alerted other staff in the practice to a potential problem and who was involved.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. The notes of the practice's significant event meetings showed that staff had discussed a medical emergency concerning a patient. The practice had learned from this appropriately for example, by adding protective blankets to the emergency equipment packs for incidents outside the practice.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. We were assured that a full risk assessment had been undertaken of the medicines required and a protocol was in place to manage other emergency risks. For example, dialling 999 and calling an ambulance or police. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details to whom staff could refer. For example, contact details of a heating company to contact if the heating system failed.

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

Risks associated with service and staffing changes (both planned and unplanned) were required to be included on the practice risk log. We saw an example of this for example, succession planning for GPs and older nursing staff and the mitigating actions that had been put in place to manage this.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed these actions were designed 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, dementia, cancer, drug and alcohol misuse and clinical governance and the practice nurses supported this work through their own skill areas. This allowed the practice to focus on specific conditions through clinics as well as individual patient care. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of respiratory disorders. Our review of the clinical meeting minutes confirmed this happened.

All patients diagnosed with diabetes were offered and provided with a personal diabetes care plan where it was their choice to have one. This was an NHS Bristol initiative which the practice proactively supported. The care plan mirrored the information on the patient record and enabled the patients to record test results, maintain a foot risk status with help from the nursing team. Develop a plan for their diabetes reviews and establish a personal action plan with the nursing team. The care plan also provided information which explained test results and the ranges which results provided. These care plans were seen as helpful and motivating by the patients who we spoke with.

The senior GP partner and practice manager showed us data from the local CCG of the practice's performance for antibiotic prescribing, which was comparable to similar practices locally and nationally. The practice had also completed a review of case notes for patients with high blood pressure which showed all were receiving appropriate treatment and regular review. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital, which required patients to be reviewed immediately or within two days by their GP according to the patients' needs.

National data showed the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of patients with suspected cancers referred and seen within two weeks. We saw minutes from meetings where regular reviews of elective and urgent referrals were made, and that improvements to practice were shared with all clinical staff.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed the culture in the practice was that patients were cared for and treated based on need and 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 day to day operations, staff management, premises management, financial management, data input, scheduling clinical reviews, managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to carry out clinical and other audits.

The practice showed us 17 clinical audits that had been undertaken in the last two years. All of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, in 2013/13 near patient blood testing audits had resulted in reminders being added to patient notes to indicate blood tests had been missed, written reminders were also sent to patients. In 2014/15 a repeated audit showed improvements in near patient blood testing and how the appointment of the practice pharmacist was improving patients missing blood test appointments and

Good

Are services effective?

(for example, treatment is effective)

blood pressure monitoring. Other examples included audits to confirm that patients partaking in 24 hour ambulatory blood pressure monitoring were doing so in line with National Institute for Health and Care Excellence guidance.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, we saw an audit regarding the prescribing of antibiotic drugs for two consecutive periods. Following the second audit, the practice pharmacist identified improvements in line with the guidelines but also commented on how the small number of patients covered by the audit resulted in one non-adherence causing a big impact on overall results. We saw these results were communicated to all prescribers and were told a subsequent audit was planned.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 100% of patients with diabetes had an influenza vaccination, and the practice met all the minimum standards for QOF in diabetes, asthma, chronic obstructive pulmonary disease (lung disease) and palliative care. The practice had regularly scored over 98% for QOF except for the year 2013/14. The reasons for this had been examined by the practice and changes put in place to reinstate the practices high performance back to 98% or higher.

The practice was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement. This was enhanced by routine mentoring of the associate GPs by the partners which helped maintain and improve quality standards. For example, through supporting the associate GP during a complaint from a patient to deescalate the situation and provide the patient with their preferred outcome. This was regarded by the associate GPs as very supportive and was provided in addition to routine appraisal and clinical supervision.

There was a protocol for repeat prescribing which was in line with national guidance. In accordance with this, staff regularly checked patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice was working towards the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. As a consequence of staff training and better understanding of the needs of patients, the practice had increased the number of patients on the register.

The practice also participated in local benchmarking run by the Bristol Clinical Commissioning Group (CCG). This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to or above other services in the area. For example, the number of health checks carried out by the practice .

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 with most having additional diplomas in subjects such as sexual and reproductive medicine, minor surgery, children's health, homeopathy and obstetrics. 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).

All staff undertook an annual appraisal that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant

courses. For example a nurse was currently undertaking a diploma course about diabetes to enable the practice to maintain sufficient staffing levels in the event that there were unexpected staff absences. The practice was a teaching practice for medical students; these students had access to a senior GP or nurse throughout the day for support.

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

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 upon any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

The practice was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw the policy for actioning hospital communications was working well in this respect. The practice undertook routine audits of follow-ups to ensure inappropriate follow-ups were documented and that no follow-ups were missed.

The practice held multidisciplinary team meetings every three months to discuss the needs of complex patients, for example those with end of life care needs or children on the 'at risk' register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information. However we noted three care plans did not contain the latest information about patients. For example, the extent their dementia had deteriorated. The GP showing us this information recognised it was out of date and ensured a more up to date version was produced.

The practice worked with a number of external organisations and services including, the Bristol Clinical Commissioning Group, local universities as part of their research programmes, nursing and care homes and other practices. The practice manager was providing support one day a week to another practice who had employed a new practice manager. The practice also had positive working relationships with community nurses, a local hospital, midwife services and the adjacent pharmacy. We spoke with staff from these services who told us about the effectiveness of the GPs and nurses and the quality of care and treatment provided. This was reflected in the patient comments we received.

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. Electronic systems were also in place for making referrals, and the practice made the majority of referrals last year through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported this system was easy to use.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. We saw how straight forward this task was using the electronic patient record system, and staff highlighted the importance of this communication with A&E. The practice has also signed up to the electronic Summary Care Record and planned to have this fully operational by 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

Good

Are services effective?

(for example, treatment is effective)

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record EmisWeb to coordinate, document and manage patients' care. All staff were fully trained to use the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. One of the GPs had a lead responsibility as the Caldicott Guardian within the practice. 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. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff, for example with making do not attempt resuscitation orders in which the GPs piloted the Edmonton Frailty Scale to inform such decisions. This assessment tool is a brief, valid, reliable tool which can be used by clinicians without special training in geriatric medicine to assess the frailty of the older patient. It assesses 10 domains including cognitive impairment and balance and mobility. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed quarterly and had a section stating the patient's preferences for treatment and decisions. However some of the care plans had not been updated to reflect the current status of elderly patients for example, where dementia was now diagnosed. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. 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).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure. Written records of consent were also gained and scanned to the patient's record.

The practice had not needed to use restraint, but staff were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

The practice had met with the Public Health team from the local authority and the CCG to discuss the implications and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the local area. This information was used to help focus health promotion activity.

It was practice policy to offer a resource pack and detailed health questionnaire to all new patients registering with the practice. The GP was informed of all health concerns stated 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 chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Data provided to us showed the practice had amongst the highest scores for offering health checks to patients in the Bristol inner city and East area for the last three quarters of 2014/15. A GP showed us how patients were followed up within two weeks if they had risk factors for disease identified at the health check and how they scheduled further investigations.

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 and all were offered an annual physical health check through visits to the homes in which they lived. Practice records showed all had received a check up in the last 12 months. The practice had also identified the smoking status of patients over the age of 16 and actively offered nurse-led smoking cessation

clinics to these patients. There was evidence these were having some success as the number of patients who had stopped smoking in the last six months was 41%, which was approximately average compared to neighbouring practices. 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's performance for cervical smear testing uptake was 89%, which was better than most others in the CCG area. There was a policy to offer reminders for patients who did not attend for cervical smear testing and the practice audited patients who do not attend. There was also a named member of staff responsible for following up patients who did not attend screening.

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 above average for the CCG, and again there was a clear policy for following up non-attenders by the named practice nurse.

Services for older patients were a key focus of the practice due to it's larger than average elderly population. One of the partners was the Bristol Clinical Commissioning Group (CCG) lead for older frail people's services. This provided the practice with strong additional insights into the whole local health services functioning and a high level of influence on whole local health economy direction. For example, providing a local hospital's comprehensive geriatric and frailty clinic. They were also a Trustee at a local Hospice.

The practice had developed and implemented care plan systems to support all older patients. They were engaged with the unplanned admissions directed enhanced services (DES) and had 220 vulnerable patients on the register with care plans.

The district nursing team, community matron and community nurse for older patients were all based in the practice. The practice had a close working relationship with them and the proximity enhanced communications. The close proximity and clear communications provided positive patient outcomes through shared knowledge and inter agency referrals for example, identifying carers who were becoming stressed by their role or bringing deteriorating health to the practices attention. One of the staff had lead responsibility for carers. The practices carers strategy and processes were reviewed every six months with the local Carers Forum to review services provided for carers. The forum gave very positive feedback about the work the practice did.

The practice had a well-established process of providing a named GP for each older patient; this had been in place for a considerable period before it was a contractual obligation. Named GPs had lead responsibilities for local nursing and care homes and provided a three times weekly "ward rounds" at the adjacent nursing home. Additionally a twice weekly ward round took place at another home and a weekly round was also provided at East Bristol Intermediate Care Centre. These ward rounds built relationships and systems and aided the practices understanding of individual patient's needs. Regular review meetings were held for patients in the four care homes looked after by the practice.

Ensuring patients and carers were receiving appropriate coordinated, multi-disciplinary care was achieved through enhanced communications through the use of Adastra notes. Additional communications were enhanced through 'Connecting Care', a local initiative where numerous health organisations can look at parts of patient records. For example, the out of hours service could see parts of the practices Emis records and plans were in hand to further develop read/write medical notes with the out of hours service.

The practice had clear links to local hospice and other end of life support services. The wider end of life services network attend the practices palliative care meetings to ensure older patients received appropriate care and treatment. This work was also supported through a close working relationship with a psychiatric consultant.

The practices clinical practice pharmacist (CPP) leads evidence based medicines management work for example, embedding National Institute for Health and Care Excellence (NICE) guidelines and ensuring safe prescribing. An example of this was the disease-modifying antirheumatic drugs (DMARDs) processes and reviews. A medicines review was undertaken by our CPP for all frail elderly patients discharged from hospital including them doing home visits. The CPP also worked directly with patients from other population groups to help ensure patient compliance with medicines and treatments was maintained.

Good

Are services effective?

(for example, treatment is effective)

Monitoring was in place for A&E attendances by older patients, in addition calls to the out of hours service and admissions rates to hospital were monitored. The practice used a full range of community services and had low A&E admissions rates for older patients and those from other population groups.

Staff knowledge, skills and competence to respond to the needs of this population group were a priority for the practice. Staff were provided with specialist training which included dementia awareness for support staff as well as clinical staff. Regular meetings took place with the specialist community memory nurse to help practice staff support these patients.

A range of enhanced services for older people was provided in the practice including audiology and nail cutting services. The practice was about to pilot an in practice welfare and benefits service in partnership with Bristol City Council to help support older patients and their carers. Plans were also in hand for a volunteer befriending service working with the 'Retired and Senior Volunteer' programme.

For patients with long term conditions regular 'patient care reviews', involving patients and carers was in place. A call up system was in place and the practice were currently reviewing the system following a change to patient record systems. The plan was to move towards everyone a 'Due Diary' date. A policy was in place for reviewing non-attenders at the point each patient's prescription was due for renewal and issue.

Staff knowledge, skills and competence to respond to the needs of this population group had been reviewed. A clinical Practice Pharmacist was employed in-house by the practice. The nursing staff skill mix was shaped to meet the clinical needs of patients, with a high level of qualifications such as diploma's in the majority of common long term conditions. This was supported by regular refresher training.

The practice was a member of the local diabetic network. Recent audits to identify possible diabetic patients resulted in proactive blood results system being put in place. Health promotion advice and information related to long term conditions including advice on self-management was provided in the practice and on their website as part of the Clinical Commissioning Group (CCG) pathway.

The practice offered a wide choice of appointment times across the week and day with 12 hour opening four days a week. Pre-bookable One Care appointments were available at the weekend if required and phone consultations where these were clinically possible were also provided. The practice pharmacist saw patients with asthma on the day if attending for another reason and they were recorded as having poor compliance with review call ups. The practice organised single visit appointments for regular review of some patients with multiple conditions such as diabetes and cardio vascular disease.

Mothers, babies, children and young people were supported by robust safeguarding policies and processes where they may be on 'at risk' registers. In addition regular safeguarding meetings were held with health visitors and issues identified were communicated back to the wider team. The minutes of meetings we saw confirmed this. Staff had received training in safeguarding vulnerable adults and children. Minor injuries nurses do not see pregnant women or children under one year old, these appointments are managed by a GP to help monitor patient safety.

A local drug project worker held weekly clinics in the practice and saw children and parents to ensure safe management of medicines and potential risks. They liaised with the lead GPs in the practice where concerns were identified in regard of the drug user or the child.

The practice had a positive performance for children's immunisation due to a closely monitored programme. They consistently achieved 90% immunisation take up rates including for measles, mumps and rubella (MMR). The practice had amalgamated their post natal check with the child's first immunisations and baby check. A patient focussed approach had resulted in high attendance rates.

Families, children and young patients had access to a range of services within the practice. These included, ante natal services, baby clinics, family planning and sexual health clinics, access to specialist children's dental services and speech therapy.

We saw information was available for young patients visiting the practice about sexual health and the clinics and services available to them, for example, contraception advice.

Data from Public Health England showed the practice had a higher than average number of working patients working very long hours and away from home. The practice

Good

Are services effective?

(for example, treatment is effective)

responded by providing 'commuter' extended hours sessions between 8:00 am and 8:00 pm four days a week, 8.00 am to18.30 pm on a Friday and bookable appointments every Saturday morning. There were over 6000 patients registered with the practice for online services. A wide choice of appointment times across the day and week were also provided for many clinics such as blood tests, long term conditions and health checks. A telephone consultation service was also available where clinically indicated.

The practice monitored their appointments system and improvements were made where a lack of appointments for working patients was identified. Twice a week evening appointments for health checks were available which the practice staff said were well attended. These were implemented following a surveying of patients. Targets for health checks and smoking cessation services were exceeded. The practice had started to lead a pan locality project to look at working differently in federations or collaboratively to improve access to services for working patients across the city. Additional resources were provided over the winter with two extra GP sessions per week to help meet additional predicted demand. The practice routinely used the 'Choose and Book' system for these patients and was planning to use the 'Bristol Referral Service' which will expand patient choice.

A range of additional in-house services including, phlebotomy (blood tests), spirometry (a test that can help diagnose various lung conditions), international normalized ratio (INR) blood tests monitoring, NHS health checks and minor surgery were provided. When referrals were required we heard from patients that choice was offered via the Choose and Book system. On-line prescribing and appointments had been introduced.

Patients whose circumstances may make them vulnerable were identified on a register in the practice. The list included those patients from various vulnerable groups for example, patients with learning disabilities, patients who had drug or alcohol problems and children on the 'at risk' register. All patients with learning disabilities received annual follow-up appointments and medicines reviews.

The practice operated a 'no barriers' approach to accessing GP services. Staff told us they did not discriminate against any groups of patients and went out of their way to be accessible and work with our patients. Language line was used where a patient's first language was not English. The GPs provided clinical support to a local residential unit for homeless people. The practice address was used where patients had no fixed abode and they kept patients on the register who move in and out of area or who were 'sofa surfing' but needed continuity of care. The practice worked closely with patients whose behaviour is challenging or chaotic by providing appointments at times suitable to them to enable them to continue to receive treatment and support.

Patients who experienced poor mental health were provided with a range of services through referrals to locally based services, for example, Child & Adolescent Mental Health Services (CAMHS) and Adult mental health services. The practice carried out joint patient consultations with local mental health teams to ensure greater continuity of treatment for the patient and improved information sharing for the professionals involved. For example, in the types and choices of treatment available to the patients.

The GPs and practice nurses had received training about learning disabilities, mental health and dementia. The practice was able to evidence a positive dementia detection rate. In keeping with many inner-city practices mental health is a high priority. We saw evidence of early diagnosis of dementia for elderly patients from the care plans the practice produced. For those patients with a diagnosis of dementia, we saw they had advanced care plans in place; however some of these required updating. We saw referrals to speech and language therapists and psychological services were also made. Carers of these patients were identified and referrals were made to a local carer's organisation to enable them to receive support if they required it, as well as the Carer's National Association.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice about patient satisfaction. This included information from the national patient survey 2014/14 and a survey of 132 patients undertaken by the practice's patient participation group (PPG). The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'among the best' for patients who rated the practice as good or very good. The practice was also above average for its satisfaction scores on consultations with doctors and nurses with 83% of practice respondents saying the GP was good at listening to them and 87% saying the GP gave them enough time.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 24 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Four comments were less positive with a common theme to these of accessing appointments. We also spoke with ten patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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 the consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard with the exception of the small waiting area on the top floor.

We saw staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice main switchboard was located away from the reception desk which helped keep patient information private. In response to patient and staff suggestions, a system had been introduced to allow only one patient at a time to approach the reception desk. This reduced the opportunity of patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that at most times it enabled confidentiality to be maintained.

Staff told us if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected; they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff. We were shown an example of a report about a recent incident that showed appropriate actions had been taken. There was also evidence of learning taking place as staff meeting minutes showed this has been discussed.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Staff told us that referring to this had helped them diffuse potentially difficult situations.

In support of treating patients with compassion and empathy the practice had implemented a whole team training programme for working with patients with mental health problems, personality disorder and dementia. This was supplemented by the practice identifying individual patients who might require extra care or time. Certain patients would automatically be provided with double appointments for example, a patient diagnosed with an autistic spectrum disorder. Additionally one of the GPs undertook research about patients with autistic spectrum disorders and their experiences in primary care. Subsequently they provided a training session for all staff about how the world is for these patients and how the practice could best meet their needs.

Examples of how the practice staff supported patients with compassion and empathy included a member of reception staff spending over two hours supporting a patient for whom English was not their first language to complete the practice registration form. They also drew a map to where the health visitor was holding a clinic and ensured they took the right route to get to the appointment. For a patient with learning disabilities whose family raised concerns about the support offered by secondary care services, the practice provided a venue for the family to meet with the services involved. A member of the practice team supported the patient and family throughout the meeting

and acted as an advocate for the patient. For another patient with learning disabilities, we saw feedback from the service that supported them about their treatment. The patient needed a minor injuries appointment but had a water fixation; the practice adapted the treatment room to enable the patient to remain calm and to receive their required treatment with a positive outcome.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey 2013/14 showed 75% of practice respondents said the GP involved them in care decisions and 85% felt the GP was good at explaining treatment and results. Both these results were average when compared with other practices in the Clinical Commissioning Group (CCG) area.

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

Staff told us translation services were available for patients who did not have English as a first language. We saw notices in the practice and on the practices website informing patents this service was available.

The GP partners were actively involved in the care planning of population groups such as older people, and people living with complex and long term conditions for example, a learning disability. We received positive feedback from the lead nurse of a local nursing home about the GPs visits. The nurse told us the practice offered excellent care to the elderly residents and how end of life care plans included the patients chosen place to die. Other comments included praise for continuity of care by the same GPs, professional support in developing and reviewing residents' care plans including end of life care.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, two patients and a carer we spoke with told us they had received help to access support services to assist them in managing their treatment and care when it had been needed. The comment cards we received were also consistent with this information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required. One of the GP partners was particularly highlighted in this regard.

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Staff told us if families had suffered a bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice about how to find a support service. The nursing home staff told us how their GP provided them with their personal telephone number so the home could contact them for advice over the weekend or out of hours for advice. Patients we spoke with who had experienced a bereavement confirmed they had received this type of support and said they had found it helpful.

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 NHS England Area Team and Clinical Commissioning Group (CCG) told us the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. For example, improving health awareness – what can help us feel well, preventing illness, helping people manage their own care effectively, reducing hospital admissions and providing more community support to help people remain at home.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). These included comments about appointment availability, increasing the number of receptionists, improving information about health checks, offering evening appointments and organising healthy lifestyle leaflets for patients. We saw evidence during our inspection of responses to all these action points.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, patients with no fixed abode, patients with learning disabilities and patients with mental health problems. The practice had access to online and telephone translation services.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed they had completed the equality and diversity training since being employed and that equality and diversity was regularly discussed at staff appraisals and team events.

The premises and services had been adapted to meet the needs of patient with disabilities There were parking spaces for patients with disabilities and level access into the practice. Automatic opening doors assisted access into the building and there was sufficient space for wheelchair users and parents with pushchairs to manoeuvre safely. A lift was available to each floor in the building. There were accessible toilets and baby changing facilities. All consulting and treatment rooms had level access and were only a short distance from the waiting areas. A privately run pharmacy was located adjacent to the practice and enabled patients to access prescribed medicines easily.

The practice actively supported patients who had been on long-term sick leave to return to work by referring them to other services such as physiotherapists, counselling services and by providing 'fit notes' for a phased or adapted return to work.

Access to the service

Appointments were available from 8:00 am and 8:00 pm four days a week, 8.00 am to18.30 pm on a Friday and bookable appointments were available every Saturday morning. There were over 6000 patients registered with the practice for online services. A wide choice of appointment times across the day and week were also provided for many clinics such as blood tests, long term conditions and health checks. A telephone consultation service was also available where clinically indicated. The practice had also started providing online GP consultations to help provide wider access to appointments.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and 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 the telephone number they should ring depending on the circumstances. Information about the out-of-hours service was provided to patients.

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse where indicated or requested. Home visits were made to three local care homes on up to three days each week, by a named GP and to those patients who needed one.

Patients were generally satisfied with the appointments system. They confirmed they could see a doctor on the same day if needed. They also said they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in

Good

Are services responsive to people's needs?

(for example, to feedback?)

urgent need of treatment had often been able to make appointments on the same day of contacting the practice. For example, one patient we spoke with told us how they needed an urgent appointment for their unwell daughter and were seen by a GP within two hours of calling the practice.

The practice's extended opening hours were particularly useful to patients with work commitments. This was confirmed by patients we spoke with when arriving for the inspection and by patients who were shift workers who had appointments that day.

Listening and learning from concerns and complaints

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

We saw information was available to help patients understand the complaints system. Simple complaints leaflets were available in the practice and detailed information was available on the practice website. Comments and suggestions were also encouraged through forms provided in the waiting areas. 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 six complaints received since the start of the year which had been provided in person, in writing or by email. We found all had been managed in line with the practices complaints policy. The complaints had been dealt with in a timely way and the practice had been open and transparent when dealing with the complaint. We saw staff had spoken with the patient involved, had sent an apology or had been invited into the practice to discuss the events leading to the complaint.

The practice reviewed complaints regularly to detect themes or trends. The outcomes of these reviews were discussed at monthly meetings and lessons learned from individual complaints had been acted upon. We saw and heard about shared learning from complaints with staff and other stakeholders such as health centre staff to help improve facilities. Minutes of team meetings showed complaints were discussed which ensured all staff were able to learn and contribute to determining any improvement action that might be required.

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. We found details of the vision and practice values were part of the practice's strategy and business plan. These values were clearly displayed in the waiting areas and in the staff room. The practice vision and values included personalised, effective and high quality General Practice services; working in partnership with patients, their families and carers and involving them in decision making about their treatment and care; treating and communicating with all patients with dignity and respect and observing the need to safeguard confidentiality; preventing disease and ill health by promoting health and wellbeing and offering care and advice to patients; operating and maintaining robust and safe systems and practises relating to staff recruitment; supporting staff in their work and in their personal development through operating safe systems and promoting a culture and systems which supports a learning organisation which actively seeks out opportunities for feedback, review and improvement.

We spoke with nine members of staff about the vision and values and they all knew and understood these including what their responsibilities were in relation to them. We looked at minutes of a range of staff meetings and saw the vision and values formed an integral part of discussions. The values were also embedded in the discussions held during a review of priority development areas which was updated in February 2015.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at a small sample (12) of these policies and procedures and all staff we spoke with told us they had read the policies and could explain the detail of the policies we discussed. All 12 policies and procedures we looked at had been reviewed annually and were up to date.

There was a clear and extensive leadership structure with named members of staff in lead roles. For example, there was a nurse manager with lead responsibility for infection control, the HR manager was responsible for carers, an IT manager responsible for performance data and a GP partner had lead responsibility for safeguarding. The practice manager had oversight of these roles and co-ordinated overall performance within the practice to ensure quality standards were maintained. 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), Calculating Quality Reporting Service (CQRS) and research outcomes to measure its performance. The QOF data for this practice showed it was performing in line with or better than national standards in most areas. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice nurse told us about a local peer review system they took part in with neighbouring GP practices. We looked at notes from the last peer review, which showed the practice had the opportunity to measure its service against others and identify areas for improvement. For example, around children's immunisations.

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, providing education sessions to help improve community management of nasal polyps and ensuring blood testing was carried out for patients with erectile dysfunction to see if diabetes was indicated. The latter audit was now in its third cycle and indicated improvements in testing.

The practice had robust arrangements for identifying, recording and managing risks. The practice manager showed us the risk log, which addressed a wide range of potential issues, such as health and safety, infection control and maintaining business continuity. We saw the risk log was regularly discussed at team meetings and updated in a timely way. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. For example, in enhancing staff and premises security and providing better integration of IT systems across multiple agencies. The practice was piloting systems for Bristol Clinical Commissioning Group in IT systems by providing online access to GP consultations. This last point brought benefits to patients such as those from the working population and those isolated at home to access GP advice.

Are services well-led?

Good

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

The practice held regular governance meetings. We looked at minutes from the last three meetings and found that performance, quality and risks had been discussed. We saw improvements had been made to performance; particularly Quality and Outcomes Framework (QOF) over the previous period and were reflected in the overall performance of the practice.

Leadership, openness and transparency

The practice had a strong clinical and managerial leadership structure in place. This included five GP partners and three associate GPs, a clinical practice pharmacist an experienced practice manager, nurse manager, HR manager, finance manager and IT manager The practice leadership recognised the link between positive leadership and high levels of performance. As a result, GP partners and practice management were actively encouraged to undertake leadership courses and other forms of personal development. Each held lead roles linked with patient outcomes and patient experiences of accessing the service. These covered areas such as clinical governance, contract management, the care and treatment of elderly patients, safeguarding, infection control and audits.

The staff with lead roles were accountable for their role in service improvement and produced audits and management reports for discussion at monthly team meetings. We were invited to join the nursing and staff teams during their "coffee morning break" and staff we spoke with felt this was an effective forum for peer discussion and support. Non-clinical staff told us there was an open culture within the practice and they had the opportunity to raise issues at team meetings and informally with lead staff.

We saw from minutes that management team meetings were held regularly, at least monthly. These meetings involved GP partners, the nurse manager, reception manager and practice manager. Staff who attended these meetings told us there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. GPs held continuous professional development meetings and ensured that associate GPs were included in these meetings to ensure they were informed of the most up to date clinical information. Similar meetings were held for the nursing staff.

The practice partners routinely mentored the associate GPs to help maintain and improve quality standards across the clinical team. This was regarded by the associate GPs as very supportive and was provided in addition to routine appraisal and clinical supervision.

Administrative and reception team meetings were also held regularly to plan and deliver the practices services and to reflect on the positive work done by this team of staff. For example, at a meeting in January 2015 staff were thanked for their commitment in and around the reception area of the practice. Other subjects discussed included, health and safety, updating the appointments system, staff changes and E-learning. The minutes showed these meetings were well attended and staff signed a form to say they read the minutes.

The practice manager was responsible for policies and procedures. We reviewed a number of policies, for example, recruitment policy, induction policy for different staff roles and management of sickness which were in place to support staff. We were shown the computer based information that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

Overall the staff we met spoke positively about the leadership within the practice and how they were accessible, open and transparent in the way they supported all employees in the practice. We saw that staff with lead responsibility within the practice took their roles seriously and ensured other members of staff were kept informed of improvements in the way they worked. We observed the office functions within the practice were well led by a particularly dynamic management team who communicated effectively with staff at all levels.

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

The practice had gathered feedback from patients through their patient participation group, patient surveys, comment cards and complaints received. We looked at the results of the 2014 annual patient survey and 17% of patients agreed changes to the service which would result in attendance of health checks. We saw as a result of this the practice had introduced changes to the invitation. We reviewed a report about comments from 106 patients in the 2014 survey,

Are services well-led?

Good

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

which had a common theme of accessing appointments. The practice manager showed us improvements that had been made to the reception staff rota and online services which had improved appointment access for patients.

The practice had an active patient participation group (PPG) which had steadily increased in size. The PPG included representatives from various population groups including, older patients, the working population and patients with long term illnesses. The PPG had carried out annual surveys and met regularly. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys are available on the practice website.

The practice had gathered feedback from staff through staff away days and generally through staff meetings, appraisals and general discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. One member of staff told us they had asked for specific training around diabetes at a staff event and this had happened. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning and improvement

Staff told us the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five staff files and saw regular appraisal took place which included a personal development plan. Staff told us the practice was very supportive of training and that they had staff away days where guest speakers and trainers attended.

The practice had a learning and development programme in place. This was informed by information collated by the practice such as the health care needs of patients, skills and knowledge required by staff to carry out their roles and best practice guidance requirements for clinical staff. Records we looked at showed this programme was regularly reviewed with staff as part of their supervision and appraisal. Staff told us this promoted their professional and personal development.

We saw evidence which showed the practice had actively been involved in pilot projects over time; and as a result they had been quick to implement innovative changes to improve services for patients. For example, promoting online GP consultations and other online services. The practice reviewed significant events and other incidents that occurred within the practice and shared the learning with staff to ensure the practice improved outcomes for patients.

Staff told us the practice was very supportive of their individual training needs and they were allowed protected time for team development. This included away days to focus on the service provision and future planning. Staff were supported to acquire further qualifications that were relevant to the work they performed and patient health needs. These included diplomas related to diabetes and minor illnesses for the practice nurses and leadership courses to develop staff management skills. This was in line with the practice's aim of "supporting staff in their work and in their personal development".