Bradgate Surgery

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Bradgate Surgery on 3 March 2015. Overall the practice is rated as outstanding.

Specifically, we found the practice to be outstanding for providing safe, responsive , effective, well led and caring services and outstanding for well led. It was also outstanding for providing services for the all the population groups.

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- The practice used innovative and proactive methods to improve patient outcomes, working with other local providers to share best practice.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the Patient Participation Group (PPG).
- 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
- The practice had a clear vision which had quality and safety as its top priority. High standards were promoted and owned by all practice staff with evidence of team working across all roles.

We saw several areas of outstanding practice including:

- The practice had established integrated working with a regular morning meeting to which any attached healthcare professional could go and had established

Summary of findings

joint visits with community staff. There was a direct telephone line to the practice for healthcare professionals to access support and advice. The practice also hosted services such as drug and alcohol rehabilitation and mental health services so patients could receive treatment in their own locality; and held joint sessions with health visitors outside the practice for parents with young children to educate and promote awareness of child care and child health issues.

- The practice worked with other community groups for the health and well-being of the practice population and held open access meetings at community meetings. The practice contributed and were part of the community health plan.
- There was shared learning with other practices as the practice manager was seconded to another practice to establish systems of working which benefitted patients.
- The practice is involved in a pilot for email consultation which will increase access for patients to medical consultation. Also they currently access the tele-dermatology system to expedite dermatology consultation for patients.
- We found Bradgate Surgery was the first practice in Bristol to be given a young people friendly award. 'Young people friendly' is an NHS initiative that aims to encourage young people to feel more confident in using health services and to get the award, services needed to demonstrate that they were welcoming to all young people aged 11-19.
- The practice demonstrated a strong commitment to seeking and listening to patient views. Throughout the inspection they demonstrated how patient views had influenced improvements in patient care and service. They showed us a range of evidence (such as patient feedback and complaints) they had used to focus improvements on the needs and wishes of patients. This included celebrating what had gone well as well as identifying areas for improvement.
- The leadership, governance and culture within the practice were used to drive and improve the delivery of high-quality person-centred care. The practice performed consistently well against a number of key indicators, and were able to demonstrate year on year improvement.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

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?

Outstanding 

The practice is rated as outstanding for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. For example, we were shown the investigations and significant event analysis that had been carried out and the action taken. We found the practice used every opportunity to learn from internal and external incidents, to support improvement. Information about safety was highly valued and was used to promote learning and improvement across the staff team. Risk management was comprehensive, well embedded and recognised as the responsibility of all staff. Staffing levels and skill mix was planned and reviewed so that patients received safe care and treatment at all times. The arrangements in place to safeguard adults and children from abuse reflected relevant legislation and local requirements. The practice had robust arrangements in place to respond to emergencies and other unforeseen situations such as the loss of utilities.

Are services effective?

Outstanding 

The practice is rated as outstanding for providing effective services. Our findings at inspection showed systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence guidelines and other locally agreed guidelines. We also saw evidence to confirm that these guidelines were positively influencing and improving practice and outcomes for patients. Information about the outcomes of patients' care and treatment was routinely collected and monitored through auditing and data collection. For example, the practice undertook clinical audits to evaluate the effectiveness of prescribed treatment. We found staff had the skills, knowledge and experience to deliver care and treatment and had undertaken additional training to support this. Patient's consent to care and treatment was always sought in line with legislation and guidance, such as written consent for insertion of implants for subcutaneous medicines. The practice was using innovative and proactive methods to improve patient outcomes such as accessing the Prime Minister's Challenge Fund for improved appointment access and IT improvements. As well as sharing skills and experience with other local providers to promote best practice and service improvement.

Are services caring?

Outstanding 

The practice is rated as outstanding for providing caring services. We observed a strong patient-centred culture. Patients' feedback about

Summary of findings

the practice said they were treated with kindness, dignity, respect and compassion while they received care and treatment. We were given examples of how the practice had gone over and above what was expected of the service. For example, considering patients social circumstances as well as medical needs, and supporting patients with their families. Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieve this. We were told by all the patients we spoke with how much they valued the relationship they had with the nurses, GPs and practice. Patients told us they were treated as individuals and partners in their care. Several patients told us the GPs provided continuity of care and had contacted them outside of normal working hours to provide information and support. We were given examples of patient's making choices and being informed of the best care pathways for their treatment. We found the practice routinely identified patients with caring responsibilities and supported them in their role. Patients told us their appointment time was always as long as was needed, there was no time pressure, and patients were reassured that their emotional needs were listened to empathetically.

Are services responsive to people's needs?

Outstanding ☆

The practice is rated as outstanding for providing responsive services. The practice had initiated positive service improvements for its patients that were over and above its contractual obligations. It acted on suggestions for improvements and changed the way it delivered services in response to feedback from the patient participation group (PPG). It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found there was continuity of care, with urgent and routine appointments available the same day. The practice had excellent facilities and was equipped to treat patients and meet their needs. We found the practice was involved with providing integrated health services and embedded these with the local community services. The practice was responsive to changing risks including deteriorating health and wellbeing or medical emergencies. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Outstanding ☆

The practice is rated as outstanding 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

Summary of findings

and was regularly reviewed and discussed with staff. There was a clear leadership structure and staff felt supported by management. There were systems in place to monitor and improve quality and identify risk. 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. 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

Outstanding ☆

The practice is rated as outstanding for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. Patients over 75 had a named GP. We found integrated working arrangements with community teams and the community nurse for older people who completed frailty assessments which identified risk. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. The practice worked closely with carers and one GP took the lead responsibility for this and held specific clinics for carers. All older patients had a six monthly review of their prescribed medicines to ensure that prescribing was effective and met the latest guidance. The practice supported two large nursing homes for older people and worked with staff collaboratively to meet patient needs. The practice recognised the issues of social isolation for older patients and had several 'regular' patients who popped in for a chat and a cup of tea.

People with long term conditions

Outstanding ☆

The practice is rated as outstanding for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management. Patients diagnosed with long term conditions were supported through a range of clinics held for specific conditions such as, asthma, chronic obstructive pulmonary disease (COPD) and heart failure. Weekly nurse led clinics were available to patients diagnosed with diabetes. Patients at risk of hospital admission were identified as a priority for appointments. Longer appointments and home visits were available when needed. All of these patients had a structured annual review to check their health and medicines needs were being met. For those people with the most complex needs, a named GP worked collaboratively with relevant healthcare professionals to deliver a multidisciplinary package of care. Patients receiving palliative care, those with cancer diagnosis and patients likely to require unplanned admissions to hospital were added to the Out of Hours system to share information and patient choice with other service providers. The practice had reviewed staff availability and skill mix and had recruited an additional nurse practitioner to enhance the service provision.

Summary of findings

Families, children and young people

Outstanding

The practice is rated as outstanding 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 that 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. For example, compliance with the national child immunisation programme was checked regularly by the nursing team. The practice ensured parents were contacted if a child had not attended the practice for immunisations and there were systems to monitor and follow up children when they did not attend hospital appointments. We saw routine audits were carried out by the practice to highlight non-attenders for immunisations and other appointments. The practice participated in the 4YP scheme (for young people) and had a drop in clinic for sexual health; Bradgate Surgery was the first practice in Bristol to be given a young people friendly award. 'Young people friendly' is an NHS initiative that aims to encourage young people to feel more confident in using health services and to get the award, services need to demonstrate that they are welcoming to all young people aged 11-19. The practice had three staff who were champions of this scheme who also linked with the local youth centre to support young people to access services. The lead GP for children liaised closely with the community health visiting services and provided support with the education of young mothers in dealing with child health issues at local clinics. The practice worked closely with the local schools and youth forum to promote health education for young people including supporting young people to access mental health services such as the 'Off the Record" service.

Working age people (including those recently retired and students)

Outstanding

The practice is rated as outstanding 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. For example, specific treatments were available at any time such as intrauterine device insertion. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. The practice

Summary of findings

offered extended hours, weekend appointments and telephone consultations. They were also involved in developing a e-consultation service. Flu vaccination clinics were provided on two Saturdays in September to increase availability to patients who worked. The practice had a blocked appointment slot each morning for emergency intrauterine device fittings for patients who worked. The practice partners were involved in the community participation groups to formulate the local health and well-being plan. The business partner regularly attended community access sessions to develop relationships with the community. We heard how patients of working age had volunteered to be part of a research programme called CANDID (Cancer Diagnosis Decision rules) to contribute to earlier diagnosis of cancer.

People whose circumstances may make them vulnerable

Outstanding ☆

The practice is rated as outstanding 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, Roma travellers and those with a learning disability. It had carried out annual health checks for people with a learning disability; sometimes this took place at their homes. The practice had a high number of patients with a learning disability, some of whom had very complex needs, and had developed innovative ways of working to ensure health needs were met. For example, we heard of a patient who wished to come to the practice but was unable to enter the building, so non intimate consultation took place in a vehicle in the car park.

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. All of the practice staff had attended training about domestic violence and the practice had participated in two local schemes IRIS (Identification and Referral to Improve Safety) for women and HERMES (Health professionals responding to men for safety) for men.

The practice hosted a drug project worker two days a week and GPs worked with them to provide shared care for patients who abused substances. Any person of no fixed abode who required medical attention could access this through the open appointments system.

Summary of findings

People experiencing poor mental health (including people with dementia)

Outstanding

The practice is rated as outstanding for the care of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. Patients could access mental health support services at the practice. The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND and SANE. It 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 undertook an audit of patients with dementia to ensure services and support were appropriate. It carried out advance care planning for patients with dementia and worked with patients and families to ensure any DNAR (do not attempt resuscitation) decisions were appropriate and kept under review.

Summary of findings

What people who use the service say

We spoke with five patients visiting the practice and we received three comment cards from patients who visited the practice. We also looked at the practices 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 last Care Quality Commission inspection report about the practice.

The comments made or written by patients were very positive and praised the care and treatment they received. For example, patients had commented about seeing their preferred GP at most visits and about being involved in the care and treatment provided. Patients had rated the service they experienced at the practice as excellent.

We reviewed the results from the latest national GP Patient Survey and found the responses confirmed the experiences we heard from patients. The survey had found the proportion of patients who would recommend their GP surgery was 89.6% which was above the average for the Clinical Commissioning Group (CCG). 96% had confidence and trust in the last GP they saw or spoke to which was above the CCG average and 93.9% of respondents say their experience of the service was good or very good.

We found the practice had a patient participation group. The gender and ethnicity of the group was representative of the practice patient population Information was circulated through the group by meetings, emails or newsletters. We spoke with seven patients who were attending a planned meeting at the practice. All of the patients we spoke with gave very positive feedback about the practice. In particular patients told us how much they valued the relationship and mutual respect between them and the GPs and nurses. Patients told us they felt listened to and understood when they attended for consultations and treatment. We were told appointments took as long as was needed and no one felt rushed or hurried. Patients were very enthusiastic about the practice and overall interactions and experiences were described as excellent.

The practice had also commenced their current 'friends and family' survey we found they had collated the comments made by patients for January 2015 about what they appreciated about the practice. Comments included reference to pleasant, friendly and helpful staff and GPs; the ability to get an appointment when needed; courteous reception staff and feeling comfortable with staff who listen and offer advice which is helpful.

Outstanding practice

- The practice had established integrated working with a regular morning meeting to which any attached healthcare professional could go and had established joint visits with community staff. There was a direct telephone line to the practice for healthcare professionals to access support and advice. The practice also hosted services such as drug and alcohol rehabilitation and mental health services so patients could receive treatment in their own locality; and held joint sessions with health visitors outside the practice for parents with young children to educate and promote awareness of child care and child health issues.
- The practice worked with other community groups for the health and well-being of the practice population and held open access meetings at community meetings. The practice contributed and were part of the community health plan.
- There was shared learning with other practices as the practice manager was seconded to another practice to establish systems of working which benefitted patients.

Summary of findings

- The practice is involved in a pilot for email consultation which will increase access for patients to medical consultation. Also they currently access the tele-dermatology system to expedite dermatology consultation for patients.
- We found Bradgate Surgery was the first practice in Bristol to be given a young people friendly award. 'Young people friendly' is an NHS initiative that aims to encourage young people to feel more confident in using health services and to get the award, services need to demonstrate that they are welcoming to all young people aged 11-19.
- The practice demonstrated a strong commitment to seeking and listening to patient views. Throughout the inspection they demonstrated how patient views had influenced improvements in patient care and service. They showed us a range of evidence (such as patient feedback and complaints) they had used to focus improvements on the needs and wishes of patients. This included celebrating what had gone well as well as identifying areas for improvement.
- The leadership, governance and culture within the practice were used to drive and improve the delivery of high-quality person-centred care. The practice performed consistently well against a number of key indicators, and were able to demonstrate year on year improvement.

Bradgate 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 special advisor and a nurse special advisor.

Background to Bradgate Surgery

Bradgate Surgery is situated in a suburb of Bristol. It has approximately 9600 patients registered with a majority ethnicity of White British. .

The practice operates from one location:

Ardenton Walk, Brentry, Bristol BS10 6SP

The practice consists of six GPs and a business partner partnership, and employs one salaried GP. GP's of both genders are working alongside nurse practitioners, three qualified nurses and two health care assistants (all female). The practice has a primary medical service contract and a wide range of additional enhanced services such as extended hours for pre booked appointments and unplanned admission avoidance. The practice is open on Monday and Wednesday between 8am – 7pm, on Tuesday 7.30am – 7pm, 7.30am -6.30pm on Thursday, on Friday 8am – 6.30pm and pre-booked appointments are available on Saturday mornings from 8am – 9.30am. Patients can also sit and wait to be seen from 11am each morning. Online appointments are available with a GP for up to a 10 minute consultation. Nurse Practitioner appointments are also available online for daily minor illness.

The practice does not provide out of hour's services to its patients, This is provided by Bris Doc. Contact information for this service is available in the practice and on the website.

Patient Age Distribution

0-4 years 7.94 %

5-14 years 11.23 %

15-44 years 43.7 %

45-64 years 23.02 %

65-74 years 7.31 %

75-84 years 4.04 %

85 years + 2.76 %

Patient Gender Distribution

Male 49.14 %

Female 50.86 %

% of patients in residential care home 1.17 %

% of patients from BME populations 14.53 %

% of patients on Disability living allowance 6.41 %

With 1.17% of patients in a residential or nursing home (higher than the national average), the practice holds regular clinics at two large local nursing homes and several smaller care homes for people with learning disabilities.

The practice catchment area has pockets of high deprivation with a higher than average crime rate and low income, alongside areas of high income. People living in more deprived areas tend to have greater need for health services. The practice also has a higher than England average number of patients over 85 years. Information from

the Bristol Clinical Commissioning Group (CCG) showed that 55.7% of the patients in the area had long standing health conditions, which was higher than the national average of 54%.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

How we carried out this inspection

Before visiting, we reviewed a range of information we held about the practice and asked other organisations to share what they knew. This included the Bristol Clinical Commissioning Group (CCG), NHS England and Healthwatch.

We carried out an announced visit on 3 March 2015 between 8am - 5pm.

During our visit we met and spoke with six of the GPs, the nurse practitioners, two practice nurses and two health care assistants. We also talked with the practice manager and the reception and administration staff. We also took the opportunity to converse with the community nurse team leader, the community matron and the community nurse for older people when they visited the practice. We spoke with five patients in person and seven members of the Patient Participation Group during the day. We received information from the three comment cards where patients and members of the public had shared their views and experience of the service.

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

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)

Outstanding ☆

Are services safe?

Our findings

Safe track record.

The practice had robust systems in place for the safety of patients and staff who worked at the service. For example, we saw the health and safety issues for the practice were delegated to a trained member of staff who took responsibility to ensure safety audits were carried out. The practice ensured that all staff were trained to a level of competence which kept patients safe. We saw records of training which indicated staff had been updated to understand and implement the latest guidance for treatment such as how to deal with anaphylaxis. We spoke with five GPs and one GP in training, and reviewed information about both clinical and other incidents that had occurred at the practice. We were given information about 12 incidents which had occurred during the last 12 months. These had been reviewed under the practices significant events analysis process. These incidents included an unexpected death, needlestick injury and a prescribing error. We read each event was categorised and all were reviewed for any trends; where changes in practice had been highlighted we were able to confirm they had been implemented. When events needed to be raised externally, such as with other providers or other relevant bodies, this was done and appropriate steps were taken, such as providing information to the NHS England in response to a complaint. National patient safety alerts (NSPA) and other safety guidance was checked and circulated to the relevant staff.

The practice manager told us how the practice responded to comments and complaints received from patients . Staff we spoke to were aware of their responsibilities to raise concerns, and how to report incidents or events. We were told about the open culture in which staff felt they were listened to and responded to in a way which promoted learning rather than blame. We read minutes of meetings which evidenced that the above information was recorded and reviewed by the partners at the practice to prevent recurrence.

Learning and improvement from safety incidents.

There was a range of systems in place for recording incidents and taking appropriate action to improve systems and processes so that further incidents were prevented. For example, the practice had a system in place for reporting, recording and monitoring significant events. The records we reviewed showed that each clinical event or incident was analysed and discussed by the GPs, nursing staff and senior practice management. When we spoke with other staff we were told that the findings from these Significant Events Analysis (SEA) processes were disseminated to other practice staff if relevant to their role. We found the level and quality of incident reporting showed the level of harm and near misses, which ensured a robust picture of safety.

We saw from summaries of the analysis of these events and complaints which had been received that the practice put actions in place in order to minimise or prevent reoccurrence of events. For example, where an unexpected death had occurred, the GPs discussed what actions had been taken, and should the issue arise again what could be done differently. Another event recorded the theft of property which had later been found, but on analysis became a training issue for all staff.

Staff reiterated to us that promoting and improving the service for patients was their primary concern. We found staff were open and transparent and fully committed to reporting incidents and near misses. We were told how all staff were encouraged to participate in learning and to improve safety as much as possible and this meant they were confident to report concerns when things went wrong. For example, we found significant event and complaints were reported by both administrative and clinical staff.

We also looked at accident and complaint records and saw incidents had been recorded and if needed escalated to significant events which demonstrated the practice listened and had the intent to learn and make improvements. Safety alerts and information relating to patients was available on the electronic records for staff to readily access.

Reliable safety systems and processes including safeguarding

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

Are services safe?

CCG lead, and another GP led on safeguarding adults at the practice. All of the GPs had been trained to level three safeguarding children and we saw GPs had completed a range of modules to achieve this, for example, one GP had completed a module related to the safeguarding of immigrant children. This was significant as the catchment area for the practice had seen a steady increase in the immigrant population.

There are comprehensive systems to keep people safe, which took account of current best practice. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities. Staff knew how to share information, record information about safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible. All staff we spoke to were aware who the lead professionals were for safeguarding adults and children and who to speak to in the practice if they had a safeguarding concern. All of the practice staff had attended training in relation to domestic violence. The practice had participated in two local schemes IRIS (Identification and Referral to Improve Safety) for women and HERMES (Health professionals responding to men for safety) for men.

A proactive approach to anticipating and managing risks to patients was embedded and was recognised as the responsibility of all staff. There was a system to highlight vulnerable patients on the practice's electronic records. Staff were alerted with 'pop ups' when patients records were accessed. This included information to make staff aware of any relevant issues when patients attended appointments for example, children who were subject to child protection plans. We saw the practice produced a list each month of vulnerable adults and children and ensured they were correctly recorded on the electronic record system.

The lead safeguarding GP was aware of the patients who had been assessed as vulnerable children and adults. Information from the GPs demonstrated good liaison with partner agencies such as the police and social services and they participated in multi-agency working. Regular discussions took place with health visitors in regard to children identified as at risk. The community nurse for older people told us they had been invited to attend a meeting at the practice on a weekly basis when any 'at risk' adults could be discussed. We saw from the information discussed at the weekly meeting that the practice were proactively identifying patients who may be discharged into the community, for example, following a detention under the Mental Health Act 1983, so that they could put plans in place to mitigate any risks.

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

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 medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

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

The practice had a GP who was the prescribing lead and they were able to describe the processes in place for reviewing prescribing at the practice. We saw records which 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 administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses had received appropriate training to administer vaccines. A member of

the nursing staff was qualified as an independent prescriber and she received regular supervision and support in her role as well as updates in the specific clinical areas of expertise for which she prescribed.

There was a system in place for the management of high risk medicines, which included regular monitoring that followed the national guidance. We found appropriate action was taken based on the results. The lead GP worked closely with the CCG medicines optimisation pharmacist to ensure prescribing was appropriate and effective.

Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely. There was a protocol for repeat prescribing which followed the national guidance and was implemented in practice. The protocol complied with the legal framework and covered all required areas. For example, how staff who generated prescriptions were trained and how changes to patients' repeat medicines were managed. Staff told us this helped to ensure patients' repeat prescriptions were still appropriate and necessary. This was overseen by the patient's GP so that they would be aware of any discrepancies and changes to medicines. We were told when patients were discharged from hospital the scanned document was then sent to the appropriate GP for checking and authorisation of any medicine changes. No controlled drugs were kept on the premises..

Cleanliness and infection control

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

The practice had a nurse with lead responsibility for infection control who had undertaken further training to enable them to provide advice to the practice about the 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 the practice had carried out audits for the previous two years and that any improvements identified for action were completed on time. For example, cleaning all non-disposable privacy curtains.

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, the storage and use of personal protective equipment including disposable gloves, aprons and coverings. We also saw records were kept of staff training and updates, and immunisation status. The policies and protocols 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 guidance. For example, when carrying out intimate patient examinations or taking blood samples. There was also a policy for needle stick injury and staff we spoke with 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 wall mounted hand soap, hand gel and hand towel dispensers were available in treatment rooms. Taps were elbow operated and work surfaces had sealed and rolled edges to reduce the risk of cross infection accumulating. Waste bins were foot operated in clinical area to maintain hygiene standards.

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

The practice had 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 for the practice that confirmed regular checks were carried out according to the policy which reduced the risk of infection to staff and patients.

Equipment

The practice was suitably designed and adequately equipped. The building, its fixtures and fittings were owned by the practice who employed specialist contractors as needed. Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records 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.

Are services safe?

Other equipment such as fire extinguishers were also serviced and tested annually according to fire safety requirements. Fire alarms and emergency lighting were also regularly tested and serviced to meet the recommendations for fire safety. The security alarm was also tested annually.

There was a range of appropriate seating in the waiting areas such as lower chairs for children and chairs with arms to aid less mobile patients to stand; all appeared in safe condition. Adjustable examination couches were available in all treatment rooms which had appropriate privacy screening.

Staffing and recruitment

We were able to see personnel files 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 recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. We looked at employee files for the most recent recruits and confirmed this had been implemented. When looking at the staff files we saw there was an induction checklist appropriate to the role of the staff member. Staff we spoke confirmed these had been used.

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 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. The practice did not use locum GPs to ensure consistency of care was maintained as far as possible.

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. This was reflected in the comments made by patients about the staff at the surgery. The practice manager showed us records to demonstrate that actual staffing levels and skill mix met with planned staffing requirements.

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 was an identified health and safety representative. Cleaning materials were stored in way which met the Control of Substances Hazardous to Health (CoSHH) regulations.

We saw any identified risks were discussed within meetings. There were systems in place for monitoring higher risk patients such as those with long term conditions, in receipt of end of life care and patients being treated for cancer. Welfare, clinical risks and the risks to patient's wellbeing were discussed daily and weekly by the GPs and nursing staff. Patients who were identified as particularly vulnerable had a named GP and a care plan in place which specified potential problems and how the patient, in discussion with their GP, wished to be treated for them.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We were told there was always first aid equipment available on site when the practice was open. We looked at the accident recording log book and found when accidents had occurred at the practice, they were recorded and appropriate action taken to prevent recurrence.

The practice computer based records had an alert system in place which indicated which patients might be at risk of medical emergencies. This enabled practice staff to be alert to possible risks to patients. This information was shared with the reception team if patients were vulnerable. The staff we spoke with told us they knew which patients were vulnerable and how to support them in an emergency until a GP arrived.

Emergency medicines were also available in a secure area of the practice and were routinely audited to ensure all items were in date and fit for use. All staff had completed

Are services safe?

basic life support training and knew where emergency medicines and equipment were stored and how to use them, for example, for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia.

Emergency equipment available included oxygen and an automated external defibrillator. The equipment appeared to be in good working order and designated staff members routinely checked this equipment. Equipment was available in a range of sizes for adults and children.

Urgent appointments were available each day both within the practice and for home visits. We were told the practice prioritised requests for urgent appointments for children. Out of Hours emergency information was provided in the practice, on the practice's website and through their telephone system. The patients we spoke with told us they were able to access emergency treatment if it was required and had not ever been refused access to a GP.

The practice had an alarm system within the computerised patient record system to summon help if needed. A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to and who was responsible for what needed to be carried out. For example, contact details of the power supplier.

The building had a fire system and firefighting equipment, which was in accordance with the fire safety legislation. A fire risk assessment had been undertaken that included actions required to maintain fire safety. We saw records that showed the system had been maintained and tested.

Records showed staff were up to date with fire training and that they practised regular fire drills.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with told us about their approaches to providing care, treatment and support to their patients. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. 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. We found the safe use of innovative and pioneering approaches to care and how it is delivered were actively encouraged. New evidence-based techniques and technologies are used to support the delivery of high-quality care for example, tele-dermatology was offered to patients with dermatological conditions. The GPs photographed patients using high quality digital imaging equipment and then sent them electronically to a consultant dermatologist. For the patient this meant that an initial diagnosis was made within a few days and a follow up appointment if required, arranged. Using tele-dermatology provided rapid access to a specialist diagnosis for patients and was an efficient use of healthcare services.

The practice used an assessment tool aligned with professional knowledge of patients to identify high risk patients and it participated in joint working with other health and social care professionals and services to avoid any crisis in their health. 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 care plans. We saw the practice provided the emergency admission avoidance enhanced service. This enabled the service to follow up patients in this category who were recently discharged from hospital were reviewed within 48 hours. This was monitored by the staff on receipt of discharge summaries, who ensured they were followed up by the most appropriate staff member.

The patients we spoke with told us there was a holistic approach to assessing, planning and delivering care and treatment and we were given examples of how GPs and nurses involved them in their care and treatment. For example, patients told us they were always given treatment options and supported to make a decision about what would be most appropriate for them. We were told how the treatment they received helped them to get better or to maintain their health. 96% of patients involved in the most recent national GP patient survey said they had confidence and trust in the last GP they saw or spoke with and 100% had confidence and trust in the last nurse they saw or spoke with which demonstrated the good relationships the staff had established with patients.

The GPs told us they had lead responsibility for specialist clinical areas and internal referral between clinicians took place for a variety of conditions such as diabetes and heart disease. The practice nurses supported this work and held specialist training qualifications in order to hold nurse led clinics. The nurse practitioners also assessed and treated patient for minor illness. Clinical protocols were in place and had been adapted by the practice to add value to patient care. For example the Healthy Heart clinic protocol which ensured all patients received the treatment, reviews and advice about managing their condition according to the latest guidance and the asthma action plan given to all asthmatic patients and based on NICE guidance.

GPs and nursing staff we spoke with were open about asking for and providing colleagues with advice and support. We observed the discussions between GPs and nursing staff about specific patients' concerns during the daily meeting which utilised the electronic patient record system and allowed discussion and action to be taken to be recorded contemporaneously.

We saw from the information supplied by the practice during our visit that there was a programme in place which ensured the 71 patients who were registered as having a learning difficulty had an annual health check. Accessible information had been provided to support patient to understand about doctors and the practice. There was also a programme of medicines reviews specifically for patients taking multiple medicines (polypharmacy).

Outstanding ☆

Are services effective?

(for example, treatment is effective)

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

Management, monitoring and improving outcomes for people

We spoke with GPs about how they reviewed and assessed they were meeting patient's needs. We heard information from Quality Outcomes Framework (QOF), significant events and new guidance. 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. The practice had annually achieved a consistent QOF score of over 97% and was increasing performance, for example, the practice achieved 79.9% for cervical smears in 2013-14 and was on course to exceed 80% for the 2014-15 return. The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national) clinical targets.

The practice showed us clinical audits that had been undertaken in the last year. These were a range of completed audits from which the practice was able to demonstrate the changes resulting since the initial audit. For example, we saw there had been an initial audit in 2014 of patients living with dementia who were prescribed medicines which were not recommended for patients with a dementia diagnosis. The re-audit showed that there had been a significant reduction of 43% in patient taking the medicines and of those patients continuing with the medicine over 50% remained under the direct care of a consultant for prescribing.

The team was making use of clinical audit tools, clinical supervision and staff meetings to monitor the performance of the practice. The staff we spoke with discussed how they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice, their involvement and how they could contribute to improvements to the service.

There was a protocol for repeat prescribing which followed national guidance. Staff regularly checked that patients who received repeat prescriptions had been reviewed by the GP if necessary. They also checked that all routine health checks were completed for long-term conditions such as diabetes. The patient record system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. The gold standard framework guidance was implemented by the practice. When we spoke with the community nurses they told us that the practice was exceptionally good caring for patients at the end of their lives. We were told there were rarely any issues out of hours as the GPs had been effective in planning and implementing care which supported patients.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw most staff were up to date with attending mandatory courses such as annual basic life support. If there were gaps in training, particularly e learning, this was highlighted and planned for individual staff. We noted a good skill mix among the GPs with specialist interest and training in gynaecology, paediatrics, substance misuse , research and palliative care. One GP had a special interest in drug rehabilitation, another led on medical ethics. 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).

The practice had an established pattern of meetings to ensure staff understood the demands of the service. There was a weekly huddle at the start of the week at which a member of staff from each area attended. This meeting allowed staff to be informed and plan for any events in the

forthcoming week. On a daily basis, the GPs and nurses had a daily meeting in order to plan the most effective way in which to provide a service to patients. This allowed for planning for joint visit and sharing of information.

The nurse practitioner/prescriber and practice nurses had defined duties and were able to demonstrate they were trained to fulfil these duties. For example, insulin initiation, administration of vaccines, cervical cytology and family planning. We were told by all levels of staff that they were provided with the time and the opportunity to undertake training and personal development. Staff told us annual appraisal identified learning needs from which action plans were developed and documented.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and to work in a coordinated way to manage the needs of patients with complex needs. The practice had attached staff such as health visitors, midwife's and the community nursing team.

There was multidisciplinary team working for patients identified as at risk through age, social circumstances and multiple healthcare needs. The practice had patients in the community who were included in the 'virtual ward'. Regular meetings with other professionals such as the community matron, community nursing teams, health visitors, palliative care team took place. Staff felt this system worked well and there was a team approach to supporting their patients. We obtained positive feedback from the health care professionals who came in contact with the service. We were told that the staff were committed to working collaboratively, people who have complex needs were supported to receive coordinated care and there were innovative and efficient ways to deliver more joined-up care to patients who used services. We heard how the practice worked with other health care providers in the area such as nursing homes to promote good health and well-being for patients. For example, working with the palliative care teams and nursing home teams to implement good practice for end of life care, through training and advice. We were told they were a very friendly and open staff team who never failed to provide support to other professionals.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. The practice also used the Choose and Book for secondary care appointments, patient to patient electronic transfer of medical records and summary care records. The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained to use the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. The practice also had an internal system to share documents and records relating to the running of the service, clinical protocols, policies and procedures were all available to staff electronically.

Information was shared with other health care professionals in an appropriate way, for example, we heard from community teams that they were able to link into the practice patient electronic records to add information. The community teams also attended meetings at the practice to share information as well as undertake joint visits with practice staff to patients. Health care professionals also had a telephone direct line to contact the practice.

Consent to care and treatment

We found staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. We were told that patients were supported to make their own decisions and documented this in the medical notes. Patients with a learning disability and those with a diagnosis of dementia were supported to make decisions through the use of care plans, in which they were involved. These care plans were reviewed three monthly or more frequently if changes in clinical circumstances dictated it. The practice had a policy, procedure and information in regard to best interests' decision making processes for those people who lack capacity. We were given the example of patients who lived in residential care for whom 'best interest' decision making meetings were held. The practice confirmed that the GPs involved patients and families in 'Do Not Attempt Resuscitation' decisions. We also read this information was recorded on the care plans of vulnerable patients.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

All clinical staff demonstrated a clear understanding of Gillick competencies and Fraser guidelines. (These are used to help assess whether a child had the maturity to make their own decisions and to understand the implications of those decisions).

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

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

Health promotion and prevention

The practice had met with the local authority and the clinical commissioning group in respect of public health and health promotion, to identify and share information about the needs of the practice population. The practice website had information about healthy lifestyles as well as practical guidance about self-treatment for minor illness. We noted the culture of the practice was to use their contact with patients to help maintain or improve mental, physical health and well-being. This was reflected by the information available to patients in the waiting room which had dedicated notice boards for specific topics. We were told that the practice had delegated to a member of staff responsibility to keep noticeboards up-to-date. We heard about the joint project the practice had with the local community schools which identified the best way to communicate information to younger patients.

It was practice policy to offer a health check with the health care assistant or practice nurse to all new patients registering with the practice. New patients' health concerns were identified and arrangements made to add them into any long term health monitoring processes such as the diabetes, asthma or heart conditions clinics or reviews. The practice provided information and signposted patients to services which help maintain or improve their mental, physical health and wellbeing. For example, by offering smoking cessation advice to patients who smoke. The practice told us they had a higher population of patients who smoked than the CCG average. They had three trained smoking cessation advisors and had 61 patients involved.

The practice offered NHS Health Checks to all its patients aged 40 to 75 years and had signposted patients on to other services when needed. We saw patients had been referred to services such as weight management and physical activity. The practice also participated in outreach clinics for NHS health checks.

The practice identified patients who needed additional support. For example, the practice kept a register of all patients with a learning disability, all of whom were offered an annual physical health check. Similar mechanisms of identifying "at risk" groups were used for patients such as those receiving end of life care, and these patients were offered service support according to their needs. We saw evidence that these lists were reviewed every month.

The practice participated in the national screening programs such as those for cervical cancer, and bowel cancer. There was a process to follow up patients if they had not attended. The practice offered a full range of immunisations for children, travel vaccines and flu vaccines. We were told that flu vaccination clinics were held at weekends to encourage children and families to receive the vaccination.

The practice participated in the 4YP scheme (for young people) and had a drop in clinic for sexual health. Bradgate Surgery was the first practice in Bristol to be given a young people friendly award. 'Young people friendly' is an NHS initiative that aims to encourage young people to feel more confident in using health services and to get the award, services need to demonstrate that they are welcoming to all young people aged 11-19. The practice had three staff who were champions of this scheme who also linked with the local youth centre to support young people to access services. The lead GP for children liaised closely with the community health visiting services and provided support with the education of young mothers in dealing with child health issues at local clinics. The practice worked closely with the local schools and youth forum to promote health education for young people including supporting young people to access mental health services such as the 'Off the Record" service.

Advice and information was readily available in the practice about a wide range of topics from health promotion to support and advice. Information was also available on the practice website or patients were directed to links to other providers for specific advice.

Outstanding ☆

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 latest national patient survey information for 2014, a survey of 337 patients with a return rate of 32%. The evidence from all this 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 94% of patients felt that their overall experience was good or very good and 100% had confidence and trust in the last nurse they saw or with whom they spoke .

Patients completed CQC comment cards to tell us what they thought about the practice. We received 3 completed cards which 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. We also spoke with the patient participation group on the day of our inspection. All told us they were satisfied with the care provided by the practice. Patients stated they felt GPs took an interest in them as a person and overall impression was one of wanting to help patients. We were given many examples of the GPs taking additional time to ensure patients received the care they needed such as making contact with patients outside of normal working hours and contacting secondary medical services to ensure referrals were received. All the patients we spoke with said they would recommend the practice.

Feedback from people who use the service, those who are close to them and stakeholders was consistently positive about the way staff treated people. Patients told us that staff go the extra mile and the care they received exceeded their expectations. For example, patients shared their experiences of receiving treatment at the practice, one patient explained their long term condition had been addressed so well since registering with the practice, that they were healthier than they had been for several years. Both patients and staff expressed the service had a holistic approach and a culture which put patients first. This was echoed by the comments received from health care professionals attached to the practice, who rated the practice highly for their professional and caring approach.

Patients also spoke highly of the relationships between them and the staff at the practice. We heard staff recognised and respected patients' needs taking personal and social needs into account. For example, the practice worked in partnership with numerous organisations within the Bristol area which supported patients with different needs such as the Bristol Dementia Partnership with dementia navigators and the Bristol Drug Project whose project workers are based at the practice for easier access for people who found attendance at other venues difficult to achieve.

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

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 switchboard was located away from the reception desk to keep patient information private. The reception desk was also separated from the waiting room. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour.

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 showed 96% of respondents had confidence and

trust in the last GP they saw or spoke to, and 96% felt the nurse was good at explaining treatment and results which was above average compared to Clinical Commissioning Group 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 that telephone translation services were available for patients who did not have English as a first language. We saw the website had a facility for translation of information.

We found that more than the required 2% of the patient population identified as vulnerable had their own care plan. We were told that the GPs acted as the care coordinator for a number of patients, all the plans had been reviewed. We found this provided a continuity of care and support for the patient because GPs could recall their patients and the particular circumstances, for example, if there was any local support or care. The care plans included information about end of life planning and choices made by the patient. Similar evidence was seen in regard of patients diagnosed with long-term conditions. Older patients, over 75, had their own named GP. Children and young people attending appointments told us they were treated in an age-appropriate way, and how GPs and nurses involved them in the consultation and acted on their preferences.

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, 91% said the last nurse they saw or spoke with was good at treating them with care and concern. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this patient information. For example, these highlighted that staff responded compassionately towards carers and family members when they needed help and provided support when required.

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. We were told how access to appointments was flexible to patients who were carers, or had difficulty attending the practice because of their mental health needs. We were told how the GPs and health care staff were flexible in providing home visits to reduce the difficulties carers of patients had attending the practice. An example of this being home visits to patients and their carer for influenza immunisations.

One of the GPs acted as a carer's champion for the practice and the practice's computer system alerted GPs if a patient was also a carer. This meant that all carers were identified and sent relevant information about the monthly drop in clinic run by the local carer's organisation. A monthly carers clinic is held at Bradgate Surgery by a representative from the Bristol and South Gloucestershire Carer Support Centre. These are pre-booked appointments offering an hour of specialist help, advice, and support to carers. Staff (clinical and non-clinical) suggested these appointments whenever they become aware someone is a carer so as to ensure that carer access a full range of services. This may be benefits advice, carer breaks/holiday, and emergency card scheme, introduction to voluntary agencies and social services, as well as general support.

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

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

Outstanding ☆

Are services caring?

answered their questions well and were patient with them when they needed reassurance. The practice had also been proactive in identification of social isolation amongst patients and had worked to ensure that services wherever possible were based at the practice, such as mental health services, and there was access to facilities such as a volunteer driver service. The practice also sponsored a 'good neighbour' award which could be given to people nominated in the community.

The patients and staff we spoke with on the day of our inspection and the comment cards we received gave examples of how the practice was caring towards its patients. We were given examples by staff how the practice went over and above to ensure patients were safe and their needs met. For example, the staff arranged for a patient's car to be driven to their home after they had been admitted to hospital directly from the surgery.

Outstanding ☆

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 that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised.

Patients and staff told us that all patients who requested urgent attention were always seen on the day of their request this included patients requiring home visits. There was also triage service so that urgent requests were assessed and requests were prioritised according to need. The practice had provided a responsive service by holding clinics, such as the diabetes ulcer clinic, on a regular day each week for patients who found it difficult to attend variable appointment times. The practice had a blocked appointment slot each morning for emergency intrauterine device fittings for patients who worked.

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

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. The practice had a Patient Participation Group (PPG) and patients were able to provide feedback about the quality of services at the practice through the PPG. The PPG carried out regular patient surveys and there was evidence that information from these was used to develop services provided by the practice. Representatives from the PPG said the practice listened to them about the comments patients made about the service. For example, PPG members agreed with the practice that the priority for 2014-15 was to look at alternatives to patients using the telephone as their first choice for contact and so the practice promoted online services, which met the practice strategy of 'click first' rather than 'call first' for prescription ordering and appointment booking.

The practice had identified that they could support patients by reducing the need to attend hospital for minor operations. A GP with specialist interest provided minor operations in the practice and joint injections as required.

Tackling inequity and promoting equality

The practice had access to online and telephone translation services. The practice had their equality and diversity statement on their intranet. The practice provided equality and diversity training for all staff. We also saw that the information on the website could be translated and that the self-booking in system was available in alternate languages.

The premises and services had been designed to meet the needs of patients with disabilities. We saw wheelchair access at the entrance to the practice, an accessible toilet and sufficient space in the waiting room to accommodate patients with wheelchairs and pushchairs which allowed for easy access to the treatment and consultation rooms. The services for patients were on the ground and first floor; however there was lift access to the first floor. We noted that the practice was a dementia friendly environment with good lighting, clear signage and use of colour contrast to assist patients around the premises.

The practice had recognised the needs of different groups in the planning of its services. The practice provided home visits to patients who were unable to attend the practice and to those living in residential or nursing home. Each morning the practice had a meeting where any requests for home visits of vulnerable patients were discussed, and a suitable plan of action agreed amongst the team. This promoted team discussion, innovative solutions and team learning. On the day of our visit we observed this meeting and found that a vulnerable patient had been identified who was due to be discharged from hospital. The team had planned how and when they would make contact to ensure they had sufficient support to remain well in the community. We also found that the practice was involved in co-commissioning of specialist services with other practices. They had co-commissioned an over 75's nurse specifically to visit the patients at home to carry out routine

health checks and care planning. We also found that he practice had accessed a talking glucometer for a patient with visual impairment which supported them to be independent in their disease management.

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

The practice was open on Monday and Wednesday between 8am – 7pm, on Tuesday 7.30am – 7pm, 7.30am -6.30pm on Thursday, on Friday 8am – 6.30pm and pre-booked appointments were available on Saturday mornings from 8am – 9.30am. Patients could also sit and wait to be seen from 11am each morning, this clinic was also book-able online. Online appointments are available with a GP for up to a 10 minute consultation. Nurse Practitioner appointments are also available online for daily minor illness. The practice also offered a GP telephone consultation service. The practice operated a traffic light system for appointments which guided the receptionist to allocate patients to the correct clinician for the appropriate length of appointment time based on information from patients and on the record system. This had been reviewed and found to be very effective.

The practice does not provide out of hours services to its patients, this is provided by Bris Doc and information about the out-of-hours service was provided to patients. Appointments were available outside of school hours for children and young people. Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed.

The practice was also flexible with appointments taking place which met patient need such as inside a vehicle in the car park when a patient was unable to come into the surgery.

Patients told us they were aware that appointment times were not limited to ten minutes but lasted for however long was needed. This system was valued by patients although it meant that they may have had to wait beyond the time they expected. Patients were made aware when they arrived for appointments if appointment times were late, and that if a child or baby arrived and needed to be seen urgently, then they would be seen by the next available GP. The patients were aware that they could request to see a specific GP otherwise we were told they were happy to see any of the GPs at the practice. For pre-booked appointments patients could choose which GP they saw so there was continuity in their care. The feedback we received from patients was that they were very happy with their access to appointments. The practice also had an online booking system for planned appointments.

Longer appointments were also available for patients who requested them, for example, those who may have more than one medical condition. This also included appointments with a named GP or nurse. The patient record system had an alert which to indicate patients who required longer appointments. Home visits were made to a local care homes by named GPs.

The practice was looking at how they could meet the demand for appointments at the practice. For example, they had carried out an audit of nurse practitioner appointments for May 2014 and found from the 564 appointment available only 41 remained unused, and a low patient return rate. This was discussed further at the practice away day where it was decided to move 'nurse' appointments from one of the nurse practitioners to free up more appointment time.

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 looked at all the complaints received in the last 12 months and found these were satisfactorily handle and dealt with in a timely way. An acknowledgement had been sent out, the issues investigated and a response sent to the complainant. The practice took account of complaints and comments to improve the service, for example, complaints were discussed by the team so staff could contribute and learn.

We saw that information was available to help patients understand the complaints system. Information was on display in the patient areas and included on the practice website. There were leaflets provided for patients to take

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

away if they wished to with details of how the complaints process worked and how they could complain outside of the practice if they felt their complaints were not handled appropriately. None of the patients we spoke with had ever needed to make a complaint about the practice but told us they felt the practice would listen and respond to their concerns. The practice also attended the local neighbourhood forum to meet members of the community and receive feedback about services.

The complaints ranged from a variety of issues, some were in regard to staff attitude at the first point of contact at the reception desk. Others were in regard to patient expectation for treatment or referral to other healthcare providers. We saw from all complaints the practice had looked at how it could improve and avoid patients raising similar complaints in the future.

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

Are services well-led?

Outstanding ☆

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

Our findings

Vision and strategy

Leaders within the practice had an inspiring shared purpose; they strove to deliver and motivate staff to succeed. The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We heard from all the staff we spoke with that there was a 'patient first' ethos within the practice. This was corroborated by the patients with whom we spoke. We found that there was strong leadership and strategic vision within the practice. We found the partners in the practice understood their role in leading the organisation and enabling staff to provide good quality care. The practice had a strategic approach to future planning and had put in place succession arrangements to identify and address future risks to personnel leaving or retiring. We found details of the vision and practice values were part of the practice's strategy and business planning. The practice vision and values included, providing the highest quality care which meets the identified needs of patients whilst supporting patients to make decisions to improve and maintain their health. Staff told us that they treated patients with courtesy, dignity and respect at all times by putting patients at the centre of everything the practice does. The practice also participated and engaged with colleagues as part of the North & West Bristol CCG locality.

We looked at minutes of the practice away days held over the last year and saw that staff had discussed the vision and values. The patients we spoke with about the practices values told us they felt these were being achieved. There was a whole team approach to change and innovation which involved the staff and the patient participation group and related agencies such as the CCG. We found examples of involvement in pilot schemes and working collaboratively with other practice to access funding for innovation, such as the e-consultation pilot scheme which would allow patients to access a consultation from home or work. The practice culture was innovative, forward looking and adaptable.

Governance arrangements

Staff were able to demonstrate their understanding and commitment to providing high quality patient centred care. The leadership, governance and culture were used to drive and improve the delivery of high-quality person-centred care. The practice had a number of policies and procedures in place to govern activity and these were available on a shared drive which staff could access from any computer in the practice. We looked at a number of these policies and procedures and found that they had been reviewed regularly and were up to date. GPs and nursing staff were provided with clinical protocols and pathways to follow for some of the aspects of their work. For example, the handling of vaccines and medicines or ensuring a consistent approach was made for patient referrals. Information on the practice website also informed patients about policies such as confidentiality and how patients could access their own records. The practice also had a policy to follow for patients who made freedom of information requests. Staff we spoke to confirmed these they understood these topics and would be able to support patients.

There was a clear leadership structure with named members of staff in lead roles. The practice provided us with a list of the areas for which each partner GP took the professional lead in the practice. We found that for each of the lead roles there was an expectation that the lead GP would undertake and provide evidence annually of how their work had improved outcomes for patients. For example the lead GP for dementia care had audited the number of patients according to demography of the patients group and found patients had not been correctly coded and therefore may not benefit from the additional support for their condition, for example, a regular review. The safeguarding lead had introduced a new approach to recording information about patient risk and was implementing recommendations from the local CCG and NHS England Area Team in relation to safeguarding training. We saw that buddy arrangements between doctors were clearly documented and staff told us this worked very well in practice and provided a safety network for patients.

We spoke with 11 members of staff and they were all clear about their roles and responsibilities. They told us they felt valued, well supported and knew who to go to in the practice with any concerns. We found that the responsibility for improving outcomes for patients was shared by all staff. The practice gave us examples where both non–clinical and clinical staff had worked together for example message taking which was an ongoing issue for all staff and general principles for clinical and non-clinical teams were agreed. A working party was formed with every

Are services well-led?

Outstanding ☆

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

team represented; the aim of the working party was to ensure that changes to message taking and the practice rules for booking telephone consultations did not unfairly impact on one team.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice was equitable with national standards and was above average for the local Clinical Commissioning Group (CCG) and England average in a number of clinical indicators.

The practice had systems in place to monitor and improve quality. The practice had a continuous programme of clinical audit which it used to monitor quality and systems to identify where action should be taken. For example, prevalence and diagnosis of dementia.

The practice held weekly governance meetings to discuss quality audits, serious and significant events, complaints, patient feedback, performance data and other information relating to the quality of the service. We saw meeting minutes and reports that demonstrated the practice routinely reviewed data and information to improve quality of service and outcomes for patients. We found the practice approached governance and improvement in a supportive and collaborative way. There was evidence that the practice took the welfare of its staff seriously for example, performance was reviewed in to enable staff to develop and improve.

The practice ensured risks to the delivery of care were identified and mitigated before they became issues. We found risk assessments had been carried out where risks were identified and action plans had been produced and implemented, for example within the business continuity plan. We discussed how the practice monitored 'at risk' patients to meet the requirements of the enhanced services. For example, the 'Avoiding Unplanned Admissions' enhanced service meant the practice needed to be proactive in identifying vulnerable patients. and ensuring the care plans were in place and were reviewed. We found the practice had systems in place for monitoring, for example, audits, procedures, reviews, monitoring mechanisms, questionnaires and meetings. These individual aspects of governance provided evidence of how the practice functioned and the level of service quality delivered to patients. The practice periodically looked at these as a whole using other indicators such as survey results, other forms of patient feedback, sudden deaths, diagnosis of new cancers and staff appraisals to provide an in depth review of service provision and shape their ongoing business plan.

Leadership, openness and transparency

There was a well-established management structure with clear allocation of responsibilities. We spoke with a number of staff, both clinical and non-clinical, and they were all clear about their own roles and responsibilities. They were able to tell us what was expected of them in their role and how they kept up to date. Staff told us there was an open culture in the practice and they could report any incidents or concerns about the practice. This ensured honesty and transparency was at a high level. We saw evidence of incidents that had been reported by staff, and these had been investigated and actions identified to prevent a recurrence. Staff told us they felt confident about raising any issues and felt that if incidents did occur these would be investigated and dealt with in a proportionate manner. The staff we spoke with were clear about how to report incidents. Staff told us they felt supported by the business partner and the clinical staff and they worked well together as a team.

The practice had invited a number of key stakeholders to speak with us during the inspection. All spoke highly of the practice and how well the practice worked jointly with their organisation. This demonstrated the practice had an open approach and recognised the value of other organisations in providing quality improvement. The practice invited us to sit in on the planned patient participation group meeting where the members expressed their views and involvement with the practice. This confirmed an open and transparent approach by the practice and demonstrated their commitment to patient involvement.

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

The practice employed a business partner to enable the business and administration of the service. Their

Are services well-led?

Outstanding ☆

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

responsibilities included the development and implementation of practice policies and procedures. The practice manager provided us with a number of policies, for example the recruitment policy and induction programmes which were in place to support staff. We were shown the online staff information that was available to all staff. Those we spoke with knew where to find these policies if required.

The practice was proactive in planning for future needs; GPs and nurses were being provided the opportunities and access to additional training to develop new services and enhance their skills. For example, we were told about the future planning that had taken place to review and expand the minor illness clinics.

The management team also had a yearly away day which was intended to review, consolidate and plan for the service. The away day was divided into three areas of discussion; the concerns of the partners (a partner only session), review of the previous year -what had been the successes and what could have been done better/ differently, and looking forward t and this section was about where the practice was going. This demonstrated the practice took an innovative approach to team productivity and improvement.

A GP partner held lead responsibility within the practice as the Caldicott Guardian and was clear about their role. A Caldicott Guardian is a senior person responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing. Each NHS organisation is required to have a Caldicott Guardian; this was mandated for the NHS by Health Service Circular: HSC 1999/012. The practice had protocols in place for confidentiality, data protection and information sharing.

Seeking and acting on feedback from patients, public and staff

The practice demonstrated a strong commitment to seeking and listening to patient views. They welcomed rigorous and constructive challenge from people who used the service, the public and stakeholders. Throughout the inspection they demonstrated how patient views had influenced improvements in patient care and service. They showed us a range of evidence, such as patient feedback, compliments and complaints they had used to focus improvements on the needs and wishes of patients. This included celebrating what had gone well as well as identifying areas for improvement. For example, The practice had gathered feedback from patients through patient surveys, complaints received and the recently implemented friends and family questionnaire. The results from January and February 2015 indicated 84.3% of respondents would be extremely likely to recommend the practice and 13.7% likely to recommend the practice. Patients responsive were received online, in the surgery and from home visits.

The patient participation group (PPG) included representatives from various population groups; patients of working age and recently retired and older patients groups. The PPG had carried out annual surveys and met quarterly. 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 also had a virtual PPG of approximately 40 members who were consulted about surveys and changes within the practice such as the decision to stop telephone prescription requests.

The practice had gathered feedback from staff through staff away days and generally through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. One member of staff told us that they had asked for specific training 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. There were high levels of staff satisfaction. Staff told us they were proud to work for the practice.

Management lead through learning and improvement

There was a strong focus on improvement and learning shared by all staff. The staff we spoke with demonstrated an understanding of their area of responsibility and each took an active role in ensuring a high level of service was provided on a daily basis. The GPs and nurses we spoke with told us how they conducted routine condition and medicines reviews. GPs and nurses routinely updated their knowledge and skills, for example by attending learning events provided by the Bristol Clinical Commissioning Group (CCG), completing online learning courses and

Are services well-led?

Outstanding ☆

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

reading journal articles. Learning also came from clinical audits and complaints. We heard from the GPs that sharing information and cascading learning through the team was an established process and one which kept the staff informed and up to date. The learning was recorded on 'Evernote' a system that was accessible for staff. The practice had completed reviews of significant events, complaints and other incidents. Significant events were a standing item on the practice meeting agenda and were attended by the GPs, the practice manager and practice nurses. Recent significant events were discussed and we were told by GPs they also reviewed actions from past significant events and complaints. There was evidence the practice had learned from these events and that the findings were shared.

The practice was a GP training practice with two partners taking lead responsibility for GP training who are members of the deanery Advanced Trainers group and provide placements of GPs who may need some retraining, and four GPs in total acting as trainers. Bradgate Surgery had trained GPs for 20 years and had been awarded a top "A" grade for the quality of its GP training. This is one of only two "A" grades awarded this year in the Severn region of Gloucestershire, Avon, Bath and Somerset. The ethos of the practice was that GPs in training brought new ideas and ways of working to the practice, and were able to challenge established practice. It also provided practical experience for medical and nursing students. The practice offered training placements for medical students, doctors undertaking training to be GPs and student nurse placements. The surgery had also participated in the Introduction to Medicine course for sixth formers run by North Bristol Trust. The practice hosted four pupils from local schools to give them a 'taster' of medicine before they applied to university. We spoke with the GP currently training at the practice who was appreciative of the support and understanding provided by the practice. We also receive comments from GPs who had completed their training at the practice which praised the quality of the training and support from the staff team as a whole.

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. In the staff files we looked at we saw regular appraisal took place which included a personal development plan. Staff told us that the practice was very supportive of training.

The surgery took part in research and had approximately 15 trials to which they were recruiting patients such as the CANDID study for cancer diagnosis. Some of these trials were offered via the CRN: West of England (Clinical Research Network) and some were industry studies. In the majority of the research is observational monitoring of patients however they had also been involved with phase III drug trials. This contributed to the practice remaining up to date with latest developments in clinical care.

The practice participated in joint working for local service developments such as the Prime Ministers Challenge Fund. The practice are part of a care consortium who successfully bid for some of the fund and are actively involved in development of an IT strategy to introduce a CCG wide intranet to all practices which would allow access to updated guidance, templates and policies from NHS England and the CCG. This meant that any changes, such as in referral templates, would automatically be updated and linked to the practice's electronic records system.

Bradgate Surgery was part of the One Care Consortium (OCC) and was actively engaged in two of the modules. These were working towards, and developing, referral to secondary care pathways, and reviewing the work-stream around the "Back-Office" function. Their plan was to develop the productive general practice methodology and pilot it in a small number of practices. This would then be shared more widely to the whole of OCC using the EMISweb in an innovative way to communicate and embed these changes. The practice collaborated with other practices in the area, and the practice manager is currently seconded to neighbouring practice in order to share different ways of working and expertise. An outcome from this had been shared training. This was of benefit to both practices as they learnt from each other and developed a joint understanding of the patient need in the area.