Care Quality Commission

Walnut Tree Practice

Quality Report

May Lane Surgery
Dursley
Gloucestershire
GL11 4JN
Tel: 01453 540555
Website: www.walnuttreepractice.co.uk

Date of inspection visit: 7 November 2017
Date of publication: 27/12/2017

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	
Are services safe?	
Are services effective?	
Are services caring?	
Are services responsive to people's needs?	
Are services well-led?	

Summary of findings

Contents

Summary of this inspection
Page

Overall summary 2

The six population groups and what we found 4

Detailed findings from this inspection

Our inspection team 5

Background to Walnut Tree Practice 5

Detailed findings 6

Overall summary

Letter from the Chief Inspector of General Practice

This practice is rated as Outstanding overall. (Previous inspection 18/05/2015 – Good)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Outstanding

Are services well-led? - Outstanding

As part of our inspection process, we also look at the quality of care for specific population groups. The population groups are rated as:

Older People – Good

People with long-term conditions – Outstanding

Families, children and young people – Outstanding

Working age people (including those recently retired and students – Good

People whose circumstances may make them vulnerable – Good

People experiencing poor mental health (including people with dementia) - Outstanding

We carried out an announced comprehensive inspection at Walnut Tree Practice on 7 November as part of our inspection programme.

At this inspection we found:

- The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence-based guidelines, for example in relation to antibiotic prescribing.
- The practice encompassed a holistic approach to meet individual patient needs, particularly in relation to mental health and chronic conditions.
- Frail older people were well supported by the practice employed care coordinator and their engagement with social prescribing.
- The practice had developed innovative ways of supporting people to live healthier lives across all age groups. For example the prescribing of allotments scheme, the art and crafts programmes sourced and delivered by the practice and a health resilience programme for primary schools.
- Staff involved and treated patients with compassion, kindness, dignity and respect. The practice was above average for its satisfaction scores on consultations with GPs and nurses.

Summary of findings

- Patients found the appointment system easy to use and reported that they were able to access care when they needed it.
- Services were tailored to meet the needs of individual people and delivered in a way that ensured flexibility and choice. For example, the practice worked collaboratively with local practices to set up a travel clinic accessed by the entire locality and delivering a sexual health clinic at their practice for the locality.
- There was a strong focus on continuous learning and improvement at all levels of the organisation. When incidents did happen, the practice learned from them and improved their processes.
- At the core of the practices ethos, was learning and development, across all staff groups.
- Feedback from patients was consistently positive and higher than local and national averages.

We saw two areas of outstanding practice:

- Patients with mental health issues were well supported within the practice and the practice had prioritised non-medical treatments in this area. For example, the practice employed an artist to run art classes within the practice for eight weekly sessions. Impact was assessed by the Warwick Edinburgh wellbeing score taken before the first session and at the last session and showed a 19% improvement in patient's wellbeing.
- The practice had been at the centre, of the initiation and maintenance of a project called the Vale Hospital Allotments which supported people with a variety of chronic health conditions as well as those suffering from bereavement. There were 46 allotments shared between local people and patients who received an allotment prescription by their GP. The practice has seen benefits to their patients in a number of ways. For example a patient was able to reduce the number of medicines taken from 11 to two items only and reported improved wellbeing in relation to their mental health.

The areas where the provider **should** make improvements are:

- The practice should ensure that there are systems in place to monitor that policies are adhered to by all staff, in relation to roles and responsibilities.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Population group	Rating
Older people	Good
People with long term conditions	Outstanding
Families, children and young people	Outstanding
Working age people (including those recently retired and students)	Good
People whose circumstances may make them vulnerable	Good
People experiencing poor mental health (including people with dementia)	Outstanding

Care Quality Commission

Walnut Tree Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector**.** The team included a GP specialist adviser and a second CQC inspector.

Background to Walnut Tree Practice

Walnut Tree Practice, www.walnuttreepractice.co.uk, provides primary medical services to approximately 4,800 patients living in Dursley and the surrounding area. The provider is registered to deliver services from May Lane Surgery, Dursley, Gloucestershire GL11 4JN. Dursley is situated 12 miles south of Gloucester and 25 miles north of Bristol.

Data from Public Health England shows that the practice had a higher than average population of patients over 65, 23%, in comparison with the national average of 17%. The practice was situated in an area with lower deprivation with a deprivation score of 13% compared to a clinical commissioning group average of 15% and the national average of 22%.

The practice, whilst registered separately with the Care Quality Commission, shares the premises with another practice. Nursing and administrative staff are employed and shared by both practices and the practice manager has responsibility for both practices.

Good

Are services safe?

Our findings

We rated the practice, and all of the population groups, as good for providing safe services.

Safety systems and processes

The practice had clear systems to keep patients safe and safeguarded from abuse.

- The practice conducted safety risk assessments. It had safety policies which were regularly reviewed and communicated to staff. Staff received safety information for the practice as part of their induction and refresher training. The practice had systems to safeguard children and vulnerable adults from abuse. Safeguarding policies had been recently reviewed and were accessible to all staff. Staff were able to easily access information on who to go to for further guidance.
- The practice worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect. We saw examples of where the practices processes had operated effectively.
- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an on-going basis. Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check. Only clinical staff carried out chaperone duties within the practice.
- There was a system to manage infection prevention and control.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed.
- There was an effective induction system for temporary staff tailored to their role.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections, for example, sepsis. Reception staff knew how to recognise when a patient required immediate referral to a clinical member of staff and we saw posters in the administrative areas that supported non-clinical staff in this

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Referral letters included all of the necessary information.

Safe and appropriate use of medicines

The practice had reliable systems for appropriate and safe handling of medicines.

- The systems for managing medicines, including vaccines, medical gases, and emergency medicines and equipment minimised risks.
- The practice kept prescription stationery securely and monitored its use.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance most of the time. However, we found that injections administered by one of the health care assistant for one specific condition did not meet standards of best practice. When this was raised with the practice on inspection they took immediate action to resolve the situation to ensure safe administration and documentation of the treatment. The practice treated the incident as a significant event. Patients were identified and the practice were assured that these patients had received treatment appropriately and actions were taken and documented to minimise the risk of the same thing happening again.

Good

Are services safe?

- The practice had audited antimicrobial prescribing. There was evidence of actions taken to support good antimicrobial stewardship.
- Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately. The practice involved patients in regular reviews of their medicines.

Track record on safety

The practice had a good safety record.

- There were comprehensive risk assessments in relation to safety issues.
- The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff that we spoke with understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons identified themes and took action to improve safety in the practice. For example, there was a breach of confidentiality when a patient received test results for the wrong patient. Ways of minimising the risk of reoccurrence was discussed with staff at a practice meeting. Changes to systems and processes were made to prevent the same thing happening again and the incident had been comprehensively documented.
- There was a system for receiving and acting on safety alerts. The practice manager received the safety alerts and passed them on to the relevant members of staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

We rated the practice as good for providing effective services overall and across all population groups.

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- In 2015 the practice had recognised that their antibiotic prescribing was above that of similar surgeries and invited a consultant microbiologist to advise the practice on their antibiotic usage. Following this advice, the practice put into place an action plan and further analysis in November 2017 demonstrated that the practice had achieved a 53% reduction in antibiotics use.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- Older patients who are frail or may be vulnerable received a full holistic assessment of their physical, mental and social needs using the nationally recognised comprehensive geriatric assessment (CGA) toolkit. Frailty was assessed using the Rockwood scale, (a nationally recognised tool for assessing frailty). Those identified as being frail had a clinical review to identify and support any additional needs including a review of medication.
- The practice employed a care coordinator who visited patients at home as well as in the practice and where appropriate, made referrals to other voluntary services and supported an appropriate care plan. The practice participated in the county wide social prescribing scheme that supported patients with needs that were non-medical, such as social isolation.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP and nurses worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- 96% of patients diagnosed with chronic obstructive disease (a chronic lung disease) had received a review including an assessment of breathlessness which was significantly higher than local the average of 81% and the national average of 80%.
- The number patients diagnosed with high blood pressure in whom the last blood pressure reading (measured in the preceding 12 months) was within normal limits was 82% which was comparable to the local and national averages.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. The percentage of children aged one who had received a received a full course of recommended vaccines was 94%. However published data available showed that uptake rates for other vaccines given were lower than the target percentage of 90% or above. For example 85% of children aged two had received the measles mumps and rubella vaccine. When we raised this with the practice they reported that the shared data base with the other practice could have impacted on the reliability of data. They were able to demonstrate from their own data, which has not been externally verified, that 93% of two year olds had received the measles, mumps and rubella vaccine.

Working age people (including those recently retired and students):

- The practice's uptake for cervical screening was 86%, which was higher than the 80% coverage target for the national screening programme
- The practice wrote to each eligible patient inviting them to attend the surgery to have the meningitis vaccine, for example before attending university for the first time.

Are services effective?

(for example, treatment is effective)

Good

- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.

People experiencing poor mental health (including people with dementia):

- 95% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This is higher than the local average of 87% and the national average of 84%.
- 100% of patients diagnosed with a serious mental health disorder had a comprehensive, agreed care plan documented in the previous 12 months. This was than the national average of 90%.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example 100% percent of patients experiencing poor mental health had received discussion and advice about alcohol consumption compared to the CCG average of 80% and the national average of 88%.

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. For example, the practice undertook regular clinical audits to monitor the quality of care at the practice. We reviewed a complete cycle clinical audit where actions had been implemented and improvements monitored. An audit was undertaken of patients who were taking high risk medicines found that not all patients were receiving monitoring and care as recommended by nationally recognised guidelines. Changes to systems were implemented and a follow up audit demonstrated that 100% of patients were now receiving this standard of care.

Where appropriate, clinicians took part in local and national improvement initiatives. For example, the practice ensured that a health care assistant received training in smoking cessation which led to increased opportunistic as well as planned interventions to encourage patients to participate in smoking cessation programmes with good effect. Data showed that the percentage of patients successfully quitting was 3.2% compared to the CCG average of 1.8%.

The most recent published Quality Outcome Framework (QOF) results were 98% of the total number of points available compared with the clinical commissioning group (CCG) average of 98% and national average of 96%. Published data for the practice's exception reporting rate was 0%, however the practice felt that this was incorrect and a result of the shared data base with the other practice, which was likely to have impacted on the reliability this data. The practice was able to demonstrate from their own data that the exception reporting was within expected parameters or low for all clinical domains. (QOF is a system intended to improve the quality of general practice and reward good practice. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.)

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.

- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with on-going support. This included an induction process, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. The practice ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing. We were told that the nurse practitioner received monthly clinical supervision and tutorials from a GP partner.

Good

Are services effective?

(for example, treatment is effective)

- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their health.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately.

Good

Are services caring?

Our findings

We rated the practice, and all of the population groups, as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private area to discuss their needs.

- All of the 22 patient Care Quality Commission comment cards we received were positive about the service experienced. This is in line with the results of the NHS Friends and Family Test and other feedback received by the practice.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. Of the 219 surveys sent out 118 were returned. This represented about 2% of the practice population. The practice was above average in a number of areas for its satisfaction scores on consultations with GPs and nurses. For example:

- 94% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 92% and the national average of 89%.
- 91% of patients who responded said the GP gave them enough time; CCG - 92%; national average - 86%.
- 100% of patients who responded said they had confidence and trust in the last GP they saw; CCG - 96%; national average - 95%.
- 94% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG – 90%; national average - 86%.
- 92% of patients who responded said the nurse was good at listening to them; (CCG) - 93%; national average - 91%.
- 96% of patients who responded said the nurse gave them enough time; CCG -94%; national average - 91%.
- 99% of patients who responded said they had confidence and trust in the last nurse they saw; CCG - 93%; national average - 91%.
- 97% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG - 93%; national average - 91%.
- 94% of patients who responded said they found the receptionists at the practice helpful; CCG - 90%; national average - 87%.

Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care and were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given):

- Interpretation services were available for patients who did not have English as a first language.
- Staff communicated with patients in a way that they could understand, for example, communication aids and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.

The practice proactively identified patients who were carers. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 89 patients as carers (approximately 2% of the practice list).

- The practice's care coordinator signposted carers to appropriate support agencies and the practice had given talks at the local carers group.
- If families had experienced bereavement, their usual GP contacted them and sent them a sympathy letter. In the letter patients were invited to call and speak to, or make an appointment with their GP for advice and further support.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages:

Good

Are services caring?

- 96% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 90% and the national average of 89%.
- 93% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG - 86%; national average - 82%.
- 90% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG - 92%; national average - 90%.
- 88% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG - 88%; national average - 85%.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The practice complied with the Data Protection Act 1998.

Outstanding

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We rated the practice, outstanding for providing responsive services and across the population groups, People with long-term conditions, Families, children and young people and People experiencing poor mental health (including people with dementia).

Responding to and meeting people's needs

The practice was proactive in their approach to understanding the needs and preferences of different groups of people. Services were tailored to meet the needs of individual people and delivered in a way that ensured flexibility and choice.

- The practice improved services where possible in response to unmet needs. For example, initiating and facilitating innovative approaches to provide a holistic approach to health improvement such as allotments on prescription and art courses within the surgery.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services. For example a hearing loop was available for those hard of hearing.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.
- The practice participated in a clinical commissioning group led initiative called Choice Plus which allowed additional emergency slots to be available for patients to be seen by a GP at the local community hospital. The appointments were triaged at the practice and available under strict criteria and this resulted in greater emergency appointment availability for patients.
- The practice had created a wall display in the reception area to inform patients of the various avenues of support available to them.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GP and care coordinator also accommodated home visits for those who had difficulties getting to the practice.
- The practice had recognised from data evaluation of the locally initiated Variation Project in 2015 that they were in the upper quartile for falls and fractures caused by falls. In response to this, the practice undertook a review of these patients to identify ways to better support these patients and improve their care. Out of 22 falls it was found that 20 of these occurred in the home setting and all patients were recognised as being frail. The care coordinator role evolved into undertaking comprehensive holistic reviews of these patients and identifying areas where interventions could be made to reduce these risks.
- In order to promote health and wellbeing of older people the practice ensured appropriate patients were actively encouraged to participate in wellbeing services such as arts, dance, better balance and walking groups which were all available within the local community and supported by the practice and reflected activities that the local population would be receptive to.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met.
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.
- A GP from the practice cited evidence that supported improvement in mental health status when horticultural therapy was undertaken. A proposal was developed to initiate a project called the Vale Hospital Allotments. In addition to mental health status the project supported people with a variety of long-term health conditions. The GP formed a committee to take the project forward and gained funding from a number of charitable organisations and the local councils. There were 46 allotments that were shared between local people and patients who have received an allotment on prescription by their GP. The practice has seen benefits to their patients in a number of ways. For example a patient was able to reduce the number of medicines taken from 11 to two items and reported improved wellbeing in relation to their mental health.
- The practice were focussing on identifying pre-diabetic patients and ensuring that health interventions were made to try and prevent these patients becoming diabetic. For example the practice was proactive in referring patients at risk to slimming world where

appropriate. Data showed that 64% of those patients referred to slimming world had lost weight reducing their risk of developing health risks associated with obesity. Patients diagnosed with obesity could also be allocated an allotment on prescription to encourage outdoor activity and the development of healthy eating habits.

- The practice had recognised that patients with a long term condition and associated health anxiety, had poorer outcomes. In order to try and address this, the practice had made plans to incorporate the health anxiety scores (used within the research project they were participating in, on medically unexplained symptoms) onto the practice database in order to identify high scores in patients with long term conditions. Identified patients would have an alert put on their medical records so that they could be opportunistically invited to attend for cognitive behaviour therapy (a form of counselling) with the objective of reducing health related anxiety.

Families, children and young people:

- There were systems 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 accident and emergency (A&E) attendances.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- The practice initiated in 2010 a health resilience programme for primary schools called facts4life when a GP recognised that patients and doctors do not share the same language. A programme to communicate effectively with patinets from a young age could have a positive impact on future health. Health resources for primary schools were initially developed and continually revised. In 2017 a resource for secondary schools to use was introduced. Evaulation of the first phase demonstrated positives impacts on childrens attitudes and increased confidence in taking responsibility for their own health. Evaulation of the second phase in 2015 showed improvements in aspects of pupils' health-related attitudes, knowledge and behaviour relating to illness management . Following the success of these initial phases funding had been gained until 2018 for the scheme to be adopted throughout Gloucestershire. A GP from the practice worked as a special advisor to the programme and was undertaking work to take the programme nationwide.
- The practice regularly attended the local school to talk to students about sex and relationships and alcohol and drugs awareness.

Working age people (including those recently retired and students):

- The needs of this population group 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, extended opening hours on a Monday evening until 8pm.
- Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.
- Due to the rurality of Dursley access to family planning clinics was difficult for local residents. The practice employed a nurse practitioner who, with a GP from the adjoining practice, ran sexual health clinics within the surgery for the whole locality and not just patients registered with them.
- The practice was working with other local GP practices to develop a system of bookable appointments on a Saturday morning to provide improved access for working age patients.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice worked with the local food bank and issued food vouchers for those patients that would benefit from this support.
- The practice worked collaboratively with the substance misuse service provided by the practice located in the same building to ensure their patients benefitted from this service.

People experiencing poor mental health (including people with dementia):

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice was engaged in research with a local university to provide a service for patients with

medically unexplained symptoms and associated psychological distress. Having identified appropriate patients they, with their consent, were referred for counselling sessions with a psychologist at the surgery. Outcomes from the programme were being monitored and used to inform development of a county wide service.
- Patients with mental health issues were well supported within the practice and the practice had prioritised non-medical treatments in this area. For example, the practice employed an artist to run art classes within the practice for eight weekly sessions. Of the 447 appointments that were used by patients in the last 12 months a cohort of 90 referred patients were studied to assess the impact of these classes on patient well being.to have attended the classes 90 were selected to assess the impact. A Warwick Edinburgh wellbeing score was taken before the first session and at the last session which showed a 19% improvement in wellbeing scores.
- The practice employed care coordinator visited all dementia patients in their home setting to ensure needs had been appropriately met.
- The practice engaged with innovative treatments for patients diagnosed with dementia and had initiated a variety of sessions at the practice for patients. For example poetry, art and music sessions as well as a visit from a theatre company for reminiscence therapy.

Timely access to the service

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- The appointment system was easy to use.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was comparable to local and national averages.

- 81% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 78% and the national average of 76%.
- 94% of patients who responded said they could get through easily to the practice by phone; CCG – 81%; national average - 71%.
- 96% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment; CCG - 89%; national average - 84%.
- 96% of patients who responded said their last appointment was convenient; CCG - 87%; national average -81%.
- 90% of patients who responded described their experience of making an appointment as good; CCG - 87%; national average - 81%.
- 70% of patients who responded said they don't normally have to wait too long to be seen; CCG - 62%; national average - 58%.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available and it was easy to do. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. Seven complaints were received in the last year. We reviewed two complaints and found that they were satisfactorily handled in a timely way.
- The practice learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care. For example, when a breach of confidentiality occurred we saw that this had been discussed at a practice meeting and a change to process had been made to ensure the risks of this happening again were minimised.

Are services well-led?

Outstanding

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

Our findings

We rated the practice, outstanding for providing well led services and across the population groups, People with long-term conditions, Families, children and young people and People experiencing poor mental health (including people with dementia):

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders had the experience, capacity and skills to deliver the practice strategy and address risks to it.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them. The practice worked collaboratively with other local practices to deliver improved services for patients. For example travel vaccine services had been streamlined, by setting up one clinic for the locality, delivering improved efficiency for the health economy and improved access for patients.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice. Succession planning was proactively managed by the leadership team. A new partner had joined the practice recently and another GP had been appointed to start on the retirement of a current partner.
- The practice leadership was committed to meeting the needs of its population. A GP within the surgery who had been instrumental in delivering improved services to all population groups within the local community had recently been awarded the Member of the British Empire **(**MBE) for his leadership and services to healthcare and wellbeing in Gloucestershire.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.

- There was a clear vision and set of values. The practice had a realistic strategy and supporting business plans to achieve priorities.
- Strategies and plans were aligned with plans in the wider health economy and there was a demonstrated commitment to a system wide collaboration and leadership. For example delivering a sexual health clinic for the whole community and not just their own registered patients.
- The practice developed its vision, values and strategy jointly with patients, staff and external partners.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. For example identifying patients at risk of developing diabetes and encouraging them to lose weight by proactively referring to the clinical commissioning group funded weight loss programme and the allotment on prescription project.
- The practice planned its services to meet the needs of the practice population. For example the employment of a care coordinator to support frail patients in their own homes to ensure their medical and social needs were met.
- The practice monitored progress against delivery of the strategy.

Culture

The practice had a culture of high-quality sustainable care.

- Staff stated they felt respected, supported and valued. There were high levels of satisfaction across all staff groups, demonstrated by a very low staff turnover for many years. They were proud to work in the practice.
- The practice focused on the needs of patients and worked to initiate and then deliver innovative holistic approaches to improving the health and wellbeing of their patients. For example the allotment on prescription scheme which the practice had initiated and continued to develop further.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff at all levels that we spoke with, told us they were able to raise concerns and were actively encouraged to do so. The staff meeting structure, which ensured all staff were able to attend as well as the inclusive culture

of the practice supported this. The practice maximised opportunities for shared learning across both practices located in the building by holding joint meetings on a bimonthly basis.

- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff, including nurses, were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work. For example, the nurse practitioner received regular clinical supervision with a GP.
- There was a strong emphasis on the safety and well-being of all staff. They recognised that staff retention was integral to delivering a high quality service and encouraged staff development in line with the needs of the individual, as well as the practice, and worked hard to ensure high staff satisfaction.
- The practice actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control.
- Practice leaders had established proper policies, procedures and activities. If it was found that agreed policies were not being adhered to, the practice acted quickly and effectively to resolve the issue in an open and transparent way and within a culture that promoted learning in order to minimise future risks. For example the processes for health care assistants to give injections.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Practice leaders had oversight of MHRA alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality. For example the practice's proactivity in improving their antibiotic prescribing to ensure good antimicrobial stewardship.
- The practice had plans in place and had trained staff for major incidents.
- The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The practice used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.

Are services well-led?

Outstanding

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

- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high-quality sustainable services.

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. Whilst the practice initiated and ran a number of projects for their patients they also recognised that there were community groups that would benefit patients and could be accessed, without the need to be referred by a GP. To address this the practice worked in partnership with a local trust and a local artist to produce a pack to promote local groups and activities that people could get involved with close to their homes in order to improve health and wellbeing.
- There was an active patient participation group (PPG). We spoke with members of the PPG on the day of the inspection who told us that the practice were receptive to their suggestions. The PPG had conducted a patient survey which led to the practice making changes to the telephone system benefitting patients.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement at all levels within the practice. An example of this was the research being undertaken with a local university to support people with medically unidentified symptoms and associated psychological distress.
- Central to the culture of the practice was one of learning and development. The practice was a training practice for GP registrars and had been selected to provide training and mentoring for GP registrars who required additional support. GP trainees spoken to on the day of the inspection, reported high satisfaction.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.