Walnut Tree Practice

Quality Report

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

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Walnut Tree Practice on 18 August 2015. Overall the practice is rated as good. Specifically, we found the practice to be outstanding for providing responsive services. The practice was good for providing safe; effective; caring and well-led services.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice worked closely with other organisations to provide services to ensure that services meet people's needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

We saw several areas of outstanding practice including:

- The practice used innovative and proactive methods to improve patient outcomes and working with other local providers to share best practice. For example an arts in health project; a café for people living with

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dementia; providing healthy lifestyle sessions at the local school and patient led projects to reorganise community care in order to prevent unnecessary emergency admissions.

- The practice shared learning from significant events with other GP practices and partner agencies so action was taken to improve patient safety and share best practice.

However there were areas of practice where the provider should make improvements:

- The practice should make sure that the management of medicines and prescription security are proper and safe at all times.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

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

Are services effective?

Good

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

Are services caring?

Good

The practice is rated as good for providing caring services. National GP survey data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

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.

The practice 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. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other

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stakeholders. It acted on suggestions for improvements and changed the way it delivered services in response to feedback from the patient participation group (PPG). Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people.Nationally reported data showed that outcomes for patients were good for conditions commonly found in older patients. The practice offered proactive, personalised care to meet the needs of the older patients in its population and had a range of enhanced services. For example, the practice developed a new form of community care (Living Well) which meant more older patients were treated at home; they worked with a social prescribing coordinator; patients living in residential homes received a weekly GP visit and the practice developed a scheme for older patients and their carers to meet socially and receive support.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us 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 schools and school nurses. The practice provided a weekly drop in clinic at a local school and regularly taught young people healthy lifestyle sessions.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the

working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of patients whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those patients living with a learning disability. They had carried out annual health checks for people with a learning disability and 95% of these patients had received a follow-up.

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

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as outstanding for the care of people experiencing poor mental health (including people with dementia). We saw 93% of people experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. They had carried out advance care planning for patients living with a dementia.

They 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 extensive training on how to care for patients with mental health needs and dementia. GPs utilised recognised psychotherapy processes within patient appointments. For example, Cognitive Behaviour Therapy and Neuro Linguistic Programming.

The primary mental healthcare team held twice weekly appointments at the practice. We saw that the practice had a good relationship with these organisations; shared learning and discussed patient care.

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The practice had developed a project for patients living in a care home with dementia, 'trying to remember' which used poetry with patients with memory problems. Patients living with dementia were apart of the practices art for health project which provided artists and musicians as well as a theatre company providing reminiscence therapy.

The practice had learnt lessons following a tragic death in the local Polish community by providing Polish speaking counsellors.

Summary of findings

What people who use the service say

The national GP patient survey results published on 4 July 2015 showed the practice was performing in line with local and national averages. There were 116 responses and a response rate of 45.8%.

- 89.2% find it easy to get through to this surgery by phone compared with a Clinical Commissioning Group (CCG) average of 83.6% and a national average of 74.4%.
- 95.1% find the receptionists at this surgery helpful compared with a CCG average of 90.1% and a national average of 86.9%.
- 59.6% with a preferred GP usually get to see or speak to that GP compared with a CCG average of 68.5% and a national average of 60.5%.
- 94.8% were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 89.5% and a national average of 85.4%.
- 92.9% say the last appointment they got was convenient compared with a CCG average of 92.9% and a national average of 91.8%.
- 84.1% describe their experience of making an appointment as good compared with a CCG average of 80.9% and a national average of 73.8%.
- 69% usually wait 15 minutes or less after their appointment time to be seen compared with a CCG average of 69.1% and a national average of 65.2%.
- 69% feel they don't normally have to wait too long to be seen compared with a CCG average of 61.2% and a national average of 57.8%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 24 comment cards which were all positive about the standard of care received. Patients told us the practice was clean and hygienic; staff were motivated, supportive, caring, empathetic and patient focused whilst treating patients with dignity and respect.

Areas for improvement

Action the service SHOULD take to improve

The practice should make sure that the management of medicines and prescription security are proper and safe at all times.

Outstanding practice

- The practice used innovative and proactive methods to improve patient outcomes and working with other local providers to share best practice. For example an arts in health project; a café for people living with dementia; providing healthy lifestyle sessions at the local school and patient led projects to reorganise community care in order to prevent unnecessary emergency admissions.
- The practice shared learning from significant events with other GP practices and partner agencies so action was taken to improve patient safety and share best practice.

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 and a CQC analyst.

Background to Walnut Tree Practice

Walnut Tree Practice provides primary medical services to approximately 4,800 patients living in Dursley and the surrounding area. Dursley is situated 12 miles south of Gloucester and 25 miles north of Bristol. Data from Public Health England show that the practice had a higher than average population of patients over 65, 23.2%, in comparison with the Clinical Commissioning Group (CCG) average of 19.7% and a national average of 16.7%. The practice was situated in an area with lower deprivation with a deprivation score of 12.9 compared to the CCG average of 14.7 and the national average of 23.6.

The practice is located in May Lane Surgery, a purpose built surgery built in 1999 for Walnut Tree Practice and Acorn Practice to provide primary care services. At the time the building had won awards for design. It offers natural lighting as its primary source of daylight illumination which helps the building reduce energy consumption. Both practices located in the building share a waiting room area, reception and treatment rooms. The waiting room contained Arts Council sponsored activities which practice staff and patients had been involved in. For example, a book of poems published by patients and pieces of art that patients had created that reflected healthy living themes. The building has been awarded a young people's friendly badge. The two practices have regular joint staff meetings.

The practice team includes three part time GP partners (two male and one female); a salaried GP (female) and a part time nurse practitioner which provides the practice with 25 sessions. In addition there were four nurses; two health care assistants; a phlebotomist; a practice manager; reception and administrative staff and maintenance staff. The practice manager; nursing staff; receptionists and administration staff are employed jointly with Acorn Practice which is the other practice within the building. The district nursing service is based within the practice.

The practice is a training practice for medical students and GP trainees. At the time of our inspection a year 2 GP trainee was being supported by the practice. Two GPs are advanced trainers and the practice had recently received a grade A training award.

The practice had a General Medical Services contract (GMS) with NHS England to deliver general medical services. The practice provided enhanced services which included extended hours for appointments; facilitating timely diagnosis and support for people with dementia; learning disabilities and minor surgery.

The practice is open between 8:30am to 12.30pm and 1.30pm to 6pm Monday to Friday. Extended hours surgeries are offered on Mondays until 8.30 pm.

The practice has opted out of providing Out Of Hours services to their own patients. Patients can access NHS 111 and South Western Ambulance Service provided an Out Of Hours GP service.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was

planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

We carried out an announced visit to the practice on 18 August 2015 when we spoke with fifteen staff and seven patients, looked at documentation and observed how people were being cared for.

We reviewed comments cards, sent to the practice in advance of our visit for patients to complete. These were where patients and members of the public shared their views and experiences of the service. We spoke to the pharmacy located within the building which provided feedback on the practice.

In advance of the inspection we reviewed the information we held about the provider and asked other organisations to share what they knew.

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 were 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)

Good

Are services safe?

Our findings

Safe track record and learning

The practice prioritised safety. There was an open and transparent approach with a system in place for reporting and recording significant events. Patients affected by significant events received a timely and sincere apology and were told about actions taken to improve care. Staff told us they would inform the practice manager of any incidents and there was also a recording form available on the practice's computer system. All complaints received by the practice were entered onto the system and the complaints policy followed. The practice carried out an analysis of significant events and complaints and discussed them regularly at practice meetings.

We reviewed safety records including 30 significant events (from 2013 to 2015) and minutes of meetings where these were discussed. Lessons were shared between the practices in the building and with partner agencies to make sure action was taken to improve safety in the practice. We saw that changes in practice had taken place as a result of the events. For example, a patient from the Polish community had tragically died. We saw evidence that a significant event analysis had taken place which resulted in the practice developing links with a Polish speaking counsellor in order to provide a supportive service for this population.

Safety was monitored using information from a range of sources, including National Institute for Health and Care Excellence (NICE) guidance. This enabled staff to understand risks and provided a clear, accurate and current picture of safety. The practice used the National Reporting and Learning System (NRLS) eForm to report patient safety incidents.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe, which included:

- Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training relevant to their role.
- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office. The practice had up to date fire risk assessments and regular fire drills were carried out. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice also had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella.
- Appropriate standards of cleanliness and hygiene were followed. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.
- Recruitment checks were carried out and the three staff files we reviewed showed that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patient's needs. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty.

We saw that there was a chaperone policy and a notice informing patients of the service, which was visible on the waiting room noticeboard; in consulting rooms and on the practice web site. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff had been trained to be a chaperones. We were told that on a few occasions reception staff had acted as a chaperone if nursing staff were not available. Receptionists had not undertaken formal training to

understand their responsibilities when acting as chaperones or received Disclosure and Barring Service (DBS) checks. (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). Receptionists told us the principles around chaperones including where to stand to be able to observe the examination. We asked the practice to review their chaperone policy. The practice made a decision not to use reception staff as chaperones.

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 policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed refrigerator temperature checks were carried out which ensured medicines were stored at the appropriate temperature.

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 held stocks of controlled medicines (medicines that require extra checks and special storage arrangements because of their potential for misuse). We saw that controlled medicines were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. We saw that the stock check of controlled drugs held on the premises was not completed on a regular basis and that the practice did not regularly use this stock of medicines. There were arrangements in place for the destruction of controlled drugs and we saw that an appropriate procedure had been followed for the destruction of out of date controlled drugs. We asked the practice to review their policy around the checking of controlled drug stock. The practice implemented a monthly stock check by appropriate staff.

Blank prescription forms were tracked through the practice in accordance with national guidance. We found unattended and unlocked consulting rooms with blank prescriptions in printers. This meant blank prescriptions were not kept secure at all times. We spoke to the practice and we received documentation that confirmed that the practice had held a meeting and agreed new protocols that doors would remain locked when the room was unattended.

We saw that prescriptions awaiting patient collection were kept at the reception desk in an unlocked container. The door to access this area was kept unlocked and we saw that there was no secure system to prevent access to them. We spoke to the practice and received minutes from a practice meeting that confirmed that a new protocol was in place. Prescriptions awaiting collection were now held securely when reception was unattended.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw sets of PGDs that had been updated in 2014. The health care assistant administered vaccines and other medicines using Patient Specific Directions (PSDs) that had been produced by the prescriber. We saw evidence nurses and the health care assistant had received appropriate training and been assessed as competent to administer the medicines referred to either under a PGD or in accordance with a PSD from the prescriber.

Regular medicines audits were carried out with the support of the local CCG pharmacy teams to ensure the practice was prescribing in line with best practice guidelines for safe prescribing.

Arrangements to deal with emergencies and major incidents

There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. All staff received annual basic life support training and there were emergency medicines available in the treatment room. The practice had a

defibrillator (used in cardiac emergencies) available on the premises and oxygen with adult and children's masks. All the medicines we checked were in date and fit for use. There was also a first aid kit and accident book available. Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location.

Good

Are services safe?

The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice carried out assessments and treatment in line relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. There were systems in place to ensure all clinical staff were kept up to date. The practice had access to guidelines from NICE and used this information to develop how care and treatment was delivered to meet needs. For example, the practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. This is a system intended to improve the quality of general practice and financially reward good practice). The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. Current results were 98.3% of the total number of points available. This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2013 to 2014 showed:

- Performance for diabetes related indicators was 98% which was better than the CCG average of 95.6% and national average of 90.1%.
- The percentage of patients with a recorded mental health diagnosis who had regular blood pressure tests was 100% which was better than the CCG average of 80.4% and the national average of 82.9%.
- The diagnosis rate for dementia was 85.7% which was better than the CCG average of 77.8% and the national average of 73.6%.
- Performance for learning disability indicators was 100% which was better than the CCG average of 83% and the national average of 84.1%.

Clinical audits were carried out to demonstrate quality improvement and all relevant staff were involved to improve care and treatment and patient outcomes. We reviewed 14 clinical audits completed in the last ten years. In addition some re-audits had taken place where the improvements made were implemented and monitored. The Clinical Commissioning Groups (CCG) prescribing advisor had also carried out medicine and prescribing audits. The practice participated in local benchmarking. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes which were comparable or better than other services in the area. National benchmarking, accreditation, peer review and research were also utilised by the practice to improve care and treatment.

We saw that a significant event in 2013 had led to an audit to assess the process of care for patients with a learning disability which led to changes based on best practice guidelines. A re-audit in 2015 indicated improvement in care. We saw that there was a plan to re-audit in a year to see if further improvements are required to achieve the best practice standards of healthcare for patients living with a learning disability.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for newly appointed non-clinical members of staff that covered such topics as safeguarding, fire safety, health and safety and confidentiality.
- Trainee GPs had a comprehensive, well organised two week induction plan. The GP trainee praised the support they received from the GP and nursing staff.
- Practice nurses and health care assistants had job descriptions outlining their roles and responsibilities and we saw evidence that they were trained appropriately to fulfil these duties.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet these learning needs and to cover the scope of their work. This included on going support during sessions, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and facilitation and support for the revalidation of doctors. All staff received an appraisal within the last 12 months.

Good

Are services effective?

(for example, treatment is effective)

- Staff received training that included: safeguarding vulnerable people; fire procedures; basic life support and information governance awareness. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system. This included care and risk assessments, care plans, medical records and test results. Information such as NHS patient information leaflets were also available. All relevant information was shared with other services in a timely way, for example when people were referred to other services.

Staff worked together and with other health and social care services to understand and meet the range and complexity of patient needs and to assess and plan on going care and treatment. This included when patients moved between health services For example, when they were referred or after they were discharged from hospital. We saw evidence that multi-disciplinary team meetings took place on a weekly basis with mental health workers; a monthly basis with district nurses; quarterly with health visitors and when required for other health and social care providers. We saw that the practice had good liaison with palliative care nurses; psychiatrists; respiratory and diabetic consultants. We saw that care plans were routinely reviewed and updated.

Consent to care and treatment

Patients' consent to care and treatment was always sought in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, assessments of capacity to consent were also carried out in line with relevant guidance. Where a patient's mental capacity to consent to care or treatment was unclear the GP or nurse assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment. Advanced care plans and do not attempt cardio pulmonary resuscitation orders were appropriately in place and followed national guidelines.

Health promotion and prevention

Patients who may be in need of extra support were identified by the practice. These included patients in the last 12 months of their lives; carers; patients at risk of developing a long-term condition; patients requiring advice on their diet, smoking and alcohol cessation and patients diagnosed with obesity. Patients were then signposted to the relevant service. For example, smoking cessation support from a local support group.

The practice had a comprehensive screening programme. The practice's uptake for the cervical screening programme was 81.78% which was above the Clinical Commissioning Group (CCG) average of 79% and the national average of 76.9%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

Childhood immunisation rates for the vaccinations given were comparable to CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 90% to 96% and five year olds from 94% to 98%. Flu vaccination rates for the over 65s were 78.5% and at risk groups 60%. These were also above national averages.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people aged 40–74. Appropriate follow-ups on the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified. For example, 93% of over 45s have had a blood pressure check in the last 5 years.

We saw that:

- 88.6% of patients had a record of smoking status and 89.7% had been offered support to stop. This was above the CCG and national averages.
- Screening for chlamydia, a common sexually transmitted disease, was the highest in England.
- The practice had a high rate of prescribing long acting contraception in young people with 70 contraceptive implants prescribed since January 2015.
- The practice prioritised non-medical treatments for mental health conditions. For example, health walks; art therapy; music sessions and social prescribing.
- Art for health sessions were provided to increase wellbeing.

Good

Are services effective?

(for example, treatment is effective)

- 24% of patients with obesity had been referred to slimming world which is the highest referral rate in the locality and above the CCG average of 18%.
- The waiting room contained a health promotion and prevention advice board.

Patients could borrow health information books from the practice. These were available in the waiting room.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed throughout the inspection that members of staff were courteous and very helpful to patients both attending at the reception desk and on the telephone and that people were treated with dignity and respect. Curtains were provided in consulting rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. Nursing staff described to us the steps they took to ensure dignity was maintained. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

We were told about a recent incident when a patient had difficulty using the rail in the disabled toilet and had to pull the emergency cord. The practice manager told us that they had spoken to the patient and included them in the action plan to ensure patient dignity could be maintained in future if another incident happened.

All of the 24 patient CQC comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. We also spoke with three members of the patient participation group (PPG) on the day of our inspection. They also told us patients were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed patients were happy with how they were treated and that this was with compassion, dignity and respect. The practice was mostly above average for its satisfaction scores on consultations with doctors and nurses. For example:

- 93.2% said the GP was good at listening to them compared to the CCG average of 91% and national average of 88.6%.
- 94.7% said the GP gave them enough time compared to the CCG average of 89.3% and national average of 86.8%.
- 96.5% said they had confidence and trust in the last GP they saw compared to the CCG average of 96.6% and national average of 95.3%
- 93.5% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 87.9% and national average of 85.1%.
- 94.2% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 92.1% and national average of 90.4%.
- 95.1% patients said they found the receptionists at the practice helpful compared to the CCG average of 90.1% and national average of 86.9%

Care planning and involvement in decisions about care and treatment

Patients we spoke with 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 available to them. Patient feedback on the comment cards we received was also positive and aligned with these views.

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

- 92.8% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 89.1% and national average of 86.3%.
- 88.1% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 84.9% and national average of 81.5%

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available. We also saw information in languages that represented the practice population. For example, we saw a selection of leaflets in Polish about services available in the local community.

Patient and carer support to cope emotionally with care and treatment

Good

Are services caring?

The practice provided carers with an information pack and notices in the patient waiting room 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. There was a practice register of all patients who were carers and were being supported, for example, by offering health checks and referral for social services support. Written information was available for carers to ensure they understood the various avenues of support available to them.

The practice pioneered a scheme for older patients and their carers titled 'let's get together' which works with local community support organisations. GPs attend and contribute to annual carers meetings. The practice set up a support group for patients living with dementia which included art activities.

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 on how to find a support service.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice worked with the local Clinical Commissioning group (CCG) to plan services and to improve outcomes for patients in the area. For example, one GP Chairs the locality CCG and was instrumental in the building of a new community hospital in the town. The practice was also working with the CCG to implement their Living Well project into other GP practices in the area.

Services were planned and delivered to take into account the needs of different patient groups and to help provide ensure flexibility, choice and continuity of care. For example;

- The practice offered a 'Commuter's Clinic' on a Monday evening until 8.30 pm for working patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability and the practice had prioritised care for these patients.
- Home visits were available for patients who would benefit from these.
- Urgent access appointments were available for children and those with serious medical conditions.
- The nurse practitioner visited a local school weekly to provide appointments for young people.
- There were accessible facilities for patients with poor mobility, a hearing loop and translation services were available.
- The primary mental healthcare team held sessions twice weekly at the practice.
- The practice worked closely with Turning Point, a social enterprise, to provide specialist and integrated services which focus on improving lives and communities across mental health; learning disability; substance misuse; primary care; the criminal justice system and employment.
- The practice had an in-house drug worker who attended weekly to support patients with substance misuse.
- The GPs had an open door policy for agencies that were holding clinics in the practice.
- The practice had engaged in patient led projects to reorganise community care in order to prevent unnecessary emergency admissions and to ensure patients could have their health needs met by one health professional. For example, a physiotherapist would undertake minor wound care.
- The practice partially funded an arts in health project for patients. For example, poetry classes in the practice and healthy living classes in a local school.
- The practice provided a weekly nurse practitioner led sexual health clinic for the local population.
- A social prescribing coordinator was based in the practice once a week to link patients to activities in the local community.
- The practice issued food vouchers for the local food bank.

Access to the service

The practice was open between 08:30am to 12:30pm and 1:30pm to 6pm Monday to Friday with appointments available during these times. Extended hours surgeries were offered on Mondays between 6.30 and 8.30 pm. In addition to pre-bookable appointments that could be booked up to three months in advance, same day appointments were available. Urgent appointments and were also available for patients that needed them. As a result of the patient survey the practice had increased bookable telephone consultations. The practice provided 25 GP sessions per week.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was comparable to local and national averages and patients we spoke with on the day were able to get appointments when they needed them. For example:

- 76.5% of patients were satisfied with the practice's opening hours compared to the CCG average of 76.5% and national average of 75.7%.
- 89.2% patients said they could get through easily to the surgery by phone compared to the CCG average of 83.6% and national average of 74.4%.
- 84.1% patients described their experience of making an appointment as good compared to the CCG average of 80.9% and national average of 73.8%.
- 69% patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 69.1% and national average of 65.2%.

Listening and learning from concerns and complaints

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

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

We saw information was available in the waiting room and on the practice website to help patients understand the complaints system. The practice also provided a comments box in the waiting room. Patients we spoke with were aware of the process to follow if they wished to make a complaint.

We reviewed the four complaints received in the last 12 months and found these were satisfactorily handled and dealt with in a timely way. We saw that the practice was open and transparent when dealing with the complaints and kept patients up to date on any actions. For example, one complaint led to a serious adverse event investigation and the patient was advised of the process undertaken and the results of the analysis.

We saw lessons learnt from individual complaints had been acted upon and the complaints discussed at practice meetings and joint surgery meetings to improve the quality of care delivered.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care where patients were at the heart of any decision making so that good outcomes for patients could be delivered. Staff knew and understood the values. The practice had a robust strategy and supporting business plans.

Governance arrangements

The practice had an overarching governance framework which including the practice manager role and was shared with Acorn Practice. The framework supported the assessment, monitoring and improvement of the quality and safety of the services provided by the practice. This ensured that there was:

- A clear staffing structure and that staff were aware of their own roles and responsibilities.
- A clear leadership structure with named members of staff in lead roles.
- Practice specific policies to govern activity which were implemented and were available to all staff.
- A comprehensive understanding of the performance of the practice.
- A programme of continuous clinical and internal audit which is used to monitor quality and to make improvements.
- Robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

Leadership, openness and transparency

The partners in the practice have the experience, capacity and capability to run the practice and ensure high quality care. They prioritise safe, high quality and compassionate care. The partners were visible in the practice and staff told us that they were accessible and approachable and always took the time to listen to all members of staff. The partners encouraged a culture of openness and honesty.

Staff told us that regular team meetings were held. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and confident in doing so and felt supported if they did. We also noted that team away days and social occasions were held regularly. Staff said they felt respected, valued and supported, particularly by the leadership in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice. Staff described the practice as forward thinking.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients, proactively gaining patients' feedback and engaging patients in the delivery of the service. They had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. There was an active PPG which included representatives from various population groups. The group met on a regular basis in conjunction with the Acorn Practice PPG. We spoke with three members of the PPG and they were very positive about the role they played. For example, they carried out patient surveys and submitted proposals for improvements to the practice management team. For example, the PPG had worked with the practice to resolve patient queues at the reception desk and a new telephone system was put in place after patient requests to be able to wait in a queue. Both examples have seen a rise in patient satisfaction. A virtual PPG was also in place and a new PPG group which represented practices within the locality had recently started up.

The practice had also gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.

Innovation

There was a strong focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. For example, the practice provided partial funding for an arts in health project which took place at the practice and a local school; the living well project which as a result was being taken up by the Gloucestershire Clinical Commissioning Group; a CCG funded care coordinator project to reduce unplanned

Are services well-led?

Good

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

hospital admissions; working with a social prescribing coordinator to offer patients links to activities in the local community and a sexual health pilot for young people in a local school.

The practice also established a café for people living with dementia which had since been adopted by a local charity and been forefront in the planning and delivery of a new local community hospital.

We saw that the practice was developing a new rehabilitation program where patients with a long term condition and their carers will receive a mixture of physical, cultural and psychological support.