Dr Weir & Partners

Inspection report

Bell Lane
Minchinhampton
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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 location	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Good ●
Are services caring?	Good ●
Are services responsive?	Outstanding ☆
Are services well-led?	Outstanding ☆

Overall summary

This practice is rated as outstanding overall. (Previous inspection November 2015 – Outstanding)

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

We carried out an announced comprehensive inspection at Dr Weir & Partners (which is also known locally as Minchinhampton Surgery) on 24 April 2018 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.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Patients found the appointment system easy to use and reported that they were able to access care when they needed it.
- People's individual needs and preferences were central to the planning and delivery of tailored services. The services were flexible, provide choice and ensure continuity of care.
- The involvement of other organisations and the local community was integral to how services were planned and ensures that services meet people's needs.
- There was a proactive approach to understanding the needs of different groups of people and to deliver care in a way that meets these needs and promotes equality.
- Leaders had an inspiring shared purpose and strived to deliver and motivate staff to succeed.
- Feedback from patients about the service they received was positive.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.
- Results from the National GP Survey showed the practice was performing above the local and national averages in all areas surveyed.

We saw several areas of outstanding practice:

- The practice involved patients who were also carers in promoting good outcomes for those groups of patients.
- The patient participation group recognised there was poor public transport network in Minchinhampton and responded by working in collaboration with practice to deliver a volunteer transport service for patients.

The area where the practice should make improvements:

- Continue to monitor exception reporting to improve patient outcomes.

Professor Steve Field CBE FRCP FFPH FRCGPChief Inspector of General Practice

Population group ratings

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

Our inspection team

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

Background to Dr Weir & Partners

Dr Weir & Partners, also known locally as The Minchinhampton Surgery, is a GP practice providing primary medical services under a General Medical Services (GMS) contract to the patients of Minchinhampton. (GMS contract is a contract between NHS England and general practices for delivering general medical services and is the commonest form of GP contract). Minchinhampton Surgery provides services from a 1970s purpose built building on one floor to approximately 7500 patients.

The practice delivered service from the following address:

Bell Lane

Minchinhampton

Stroud

Gloucestershire

GL6 9JF

The practice has a higher patient population aged 65 and above than both the CCG and national average. The general Index of Multiple Deprivation (IMD) population profile for the geographic area of the practice shows the practice is in the least deprived decile. (An area itself is not deprived: it is the circumstances and lifestyles of the people living there that affect its deprivation score. Not everyone living in a deprived area is deprived and that not all deprived people live in deprived areas).

The practice has six partners which is equivalent to 4.5 whole time equivalent. The nursing team include one prescribing nurse practitioner, three practice nurses and two healthcare assistants. The practice management team consists of a practice manager, an assistant to the practice manager and administration and reception staff including an apprentice. The practice supports both training and teaching of doctors and medical students. The practice had two qualified doctors training to be GPs and one student nurse working with them at the time of our inspection.

The practice is registered to provide the following Regulated Activities:

- Diagnostic and screening procedures.
- Treatment of disease, disorder or injury.
- Maternity and midwifery services.
- Surgical Procedures.
- Family Planning.

The practice is open from 8am to 6.30pm Monday to Friday. Appointments are from 8.30am to 10.40am every morning and 4pm to 6pm daily. Extended hours surgeries are offered on Mondays from 6.15am and on Wednesdays until 8.15 pm.

The practice has opted out of providing out of hours service to its patients. Patients are redirected to the out of hours service provided by Care UK via the NHS 111 service.

Good

Are services safe?

We rated the practice as good for providing safe services.

Safety systems and processes

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

- The practice had appropriate systems to safeguard children and vulnerable adults from abuse. All staff received up-to-date safeguarding and safety training appropriate to their role. The practice held an annual Safeguarding learning event during protected time for all staff. They knew how to identify and report concerns. Reports and learning from safeguarding incidents were available to staff. Staff who acted as chaperones were trained for their role and had received a DBS check. (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.)
- Staff took steps, including working with other agencies, to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The practice carried out appropriate staff checks at the time of recruitment and on an ongoing basis. The practice told us that they had recently discarded information relating to proof of identification for staff in preparation for the new General Data Protection Regulation requirements. The practice was able to demonstrate that they had checked those documents during recruitment.
- There was an effective system to manage infection prevention and control.
- The practice had arrangements to ensure that facilities and equipment were safe and in good working order.
- Arrangements for managing waste and clinical specimens kept people safe.

Risks to patients

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

- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness, busy periods and epidemics.
- There was an effective induction system for temporary staff tailored to their role.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures.
- 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 including sepsis.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

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 staff. There was a documented approach to managing test results.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made timely referrals in line with protocols.

Appropriate and safe use of medicines

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

- The systems for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment, minimised risks.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with current national guidance. The practice had reviewed its antibiotic prescribing and acted to support good antimicrobial stewardship in line with local and national guidance.
- Patients' health was monitored in relation to the use of medicines and followed up on appropriately. Patients were involved in regular reviews of their medicines.

Track record on safety

The practice had a good track record on safety.

- There were comprehensive risk assessments in relation to safety issues.

Good

Are services safe?

- The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture of safety that led to safety improvements.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- Staff 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.
- The practice acted on and learned from external safety events as well as patient and medicine safety alerts.

Please refer to the Evidence Tables for further information.

Good

Are services effective?

We rated the practice as good for providing effective services overall and across all population groups except for people experiencing poor mental health (including people with dementia) which we rated as outstanding.

(Please note: Any Quality Outcomes (QOF) data relates to 2016/17. QOF is a system intended to improve the quality of general practice and reward good practice.*)*

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' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- The practice used their computer systems to undertake searches of suitable patients for clinical audits to improve their health outcomes and to monitor performance.
- Staff used appropriate tools to assess the level of pain in patients.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

We rated this population group as good.

- Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. The practice used an appropriate tool to identify patients aged 65 and over who were living with moderate or severe frailty. Those identified as being frail had a clinical review including a review of medication.
- Patients aged over 75 were invited for a health check. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan.
- 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.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.

People with long-term conditions:

We rated this population group as good.

- 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 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.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice had arrangements for adults with newly diagnosed cardiovascular disease including the offer of high-intensity statins for secondary prevention, people with suspected hypertension were offered ambulatory blood pressure monitoring and patients with atrial fibrillation were assessed for stroke risk and treated as appropriate.
- The practice was able to demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- The practice had identified through clinical audit that further improvements were required to ensure patients with asthma attended reviews and were followed up appropriately. The practice had therefore signed up to a research programme, which would help them identify ways to monitor those patients more effectively. This included further staff training and flagging "at risk" patients and those who tended to seek medical assistance only in times of crisis.

Families, children and young people:

We rated this population group as good.

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were below the target percentage of 90% or above. Published data for 04/2016 to 03/2017 showed the practice achieved 84% of immunisation for children aged one and between 82%

and 83% for children aged two. The practice had registered a cohort of children and their parents from a clinic which offered alternative therapies to its patients and the practice told us that those patients preferred to develop natural immunity instead of receiving vaccines. The practice actively invited those patients to attend immunisation. Patients were informed that they could receive the recommended vaccine at any time if they changed their mind.

- Following a recent outbreak of measles, one of the practice nurses phoned all parents of children who had not received the vaccine to offer them an appointment to receive immunisation.
- There was a co-ordinated approach to care for this population group with six weekly multi-disciplinary meetings with the health visitor and community teams.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation.

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

We rated this population group as good.

- The practice's uptake for cervical screening was 81%, which was above the clinical commissioning group (CCG) of 76% and national average of 72%.
- The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. The patient uptake for this service in the last two and a half years was 76%, compared to the CCG average of 62% and national average of 55%. The practice also encouraged eligible female patients to attend for breast cancer screening. The rate of uptake of this screening programme in the last three years was 79%, compared to the CCG average of 75% and national average of 70%.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- 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:

We rated this population group as good.

- End of life care was delivered in a coordinated way which considered the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including those with a learning disability. There was a lead GP who supported a local residential home for young people with complex learning disabilities.
- Practice data showed that 92% of registered patients with a learning disability had received an annual health check during the year 2017/18.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.

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

We rated this population group as outstanding.

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services. There was a system for following up patients who failed to attend for administration of long term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- 89% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This was comparable to the CCG average of 87% and national average of 84%.
- 100% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This was above the CCG average of

94% and national average of 90%. None of the patients registered with the practice for this domain had been excepted compared to the CCG average of 18% and national average of 13%.

- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example, 100% of patients experiencing poor mental health had received discussion and advice about alcohol consumption. This was above the CCG average of 93% and national average of 91%. The practice's exception rate for this domain was 3% compared to the CCG average of 16% and national average of 10%. There was a lead GP who had oversight of the register of patients with mental health problems. The practice told us they regularly phoned patients to encourage them to attend follow up appointments.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- The practice worked closely with the community dementia nurse who attended the practice weekly. This ensured patients were reviewed regularly as well as a source of advice for clinicians if patients and their carers needed additional support.

Monitoring care and treatment

The practice had a programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. For example, an audit was undertaken in 2016 following recommendation from the CCG that patients who were being prescribed an EpiPen (a device to administer a medicine needed in the case of a severe allergic reaction) should be switched to a different brand with a longer shelf life. The audit identified several adults and children patients who were receiving this medicine on repeat prescriptions. Parents were contacted to advise them of the change and the reasons why. Adult patients had the previous medicine removed from their repeat prescription and an alert placed on their medical record for their regular GP to switch to the recommended brand. This was also discussed at one of the practice's partner meetings to ensure all GPs were aware of the change. A follow up audit in January 2018 identified that all patients receiving this medicine were on the recommended brand of this medicine.

Where appropriate, clinicians took part in local and national improvement initiatives. For example, the practice had signed up to a research programme which was related to the running of asthma clinics and identifying patients who were at risk of asthma exacerbation to find more effective ways to recall patients who were asthmatic. This included additional training for staff on following up those patients, changing the way patients were recalled and adding flags to the patient's record.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

- Staff had appropriate knowledge for their role, for example, to carry out reviews for people with long term conditions, older people and people requiring contraceptive reviews.
- 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 ongoing 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.
- The practice was supporting the healthcare assistant who is a qualified nurse from outside the UK to complete an EU adaptation course. One of the practice nurses who was also a mentor had been identified to provide mentorship for her. It was discussed at appraisal about her willingness to practice as a nurse and the practice facilitated her to undertake the necessary conversion course.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

Good

Are services effective?

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 and organisations, were involved in assessing, planning and delivering care and treatment.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for people with long term conditions and when coordinating healthcare for care home residents. The shared information with, and liaised, with community services, social services and carers for housebound patients and with health visitors and community services for children who have relocated into the local area.
- 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 need 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 own health, for example through social prescribing schemes.
- 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.

Please refer to the Evidence Tables for further information.

Good

Are services caring?

We rated the practice as Good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from patients was positive about the way staff treat people.
- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- Results from the National GP Survey (01/2017 to 03/2017) showed the practice was in line with or above local and national averages in all areas. For example, 96% of patients stated they would definitely or probably recommend this GP surgery to someone who has just moved to the local area compared to the clinical commissioning group average of 84% and national average of 79%. The practice was above average in all areas surveyed compared to the CCG and national average.
- The practice told us that 229 patients registered with the practice following the closure of a nearby service which offered alternative therapies to conventional medical treatment. The wishes of those patients who refused treatment, such as immunisation, were respected. Nurses also telephoned those patients periodically to offer treatment to those patients and reassured them that if they change their mind, they would still be able to take up the treatment offered.

Involvement in decisions about care and treatment

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

- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available. Patients with learning disabilities were offered information and a health plan in easy read format.
- 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 carers, for example, during flu campaigns and local events. The practice had identified 248 patients as carers which was equivalent to approximately 3% of the practice population. The practice supported carers by providing them with additional support, such as exercise classes and counselling services from the Minchinhampton Charitable Trust (The Minchinhampton Charitable Trust is a charity set up by the practice to provide additional complementary therapies such as acupuncture and counselling, for patients who would benefit from these.)
- Results from the National GP Survey (01/2017 to 03/2017) showed the practice was performing above local and national averages to survey questions relating to patient's involvement in decisions about their care and treatment. For example, 94% of patients stated that the last time they say or spoke with a nurse, the nurse was good or very good at involving them in decisions about their care compared to the CCG average of 88% and national average of 85%.

Privacy and dignity

The practice respected patients' privacy and dignity.

- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Staff recognised the importance of people's dignity and respect. They challenged behaviour that fell short of this.

Please refer to the Evidence Tables for further information.

Outstanding ☆

Are services responsive to people's needs?

We rated the practice, and all of the population groups, as Outstanding for providing responsive services .

The practice was rated as outstanding for responsive because:

- People's individual needs and preferences were central to the planning and delivery of

tailored services. The services were flexible, provide choice and ensure continuity of care.

- The involvement of other organisations and the local community was integral to how

services were planned and ensures that services meet people's needs.

- There was a proactive approach to understanding the needs of different groups of people

and to deliver care in a way that meets these needs and promotes equality. This included people who were in vulnerable circumstances or who have complex needs.

- People could access appointments and services in a way and at a time that suited them. Patient data relating to accessing the service was significantly above average
- There was active review of complaints and how they were managed and responded to, and improvements were made as a result. People who used services were involved in the

review.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs. For example, the practice maintained early morning appointments on Monday mornings from 6.15am and late evening appointments on Wednesdays until 8:15pm for patients who needed these.
- Telephone appointments were available which supported patients who were unable to attend the practice during normal working hours.
- The facilities and premises were appropriate for the services delivered. The practice was in the process of planning for new premises to be built to improve services. They were working closely with the patient participation group (PPG) who undertook a survey to understand the needs and preferences of the local community so that these could be considered when building the new premises. For example, patients were asked for their views regarding the benefits of a community pharmacy to be co-located and for views on what other aspects of the new premises would be important.
- The practice made reasonable adjustments when patients found it hard to access services. For example, the practice recognised that there were poor public transport services in the local areas and worked with the PPG to deliver a volunteer patient transport service. The service not only supported patients to attend the surgery but also to hospital appointments where patients needed this.
- The practice identified opportunities to understand the needs of patients and used those opportunities to develop staff knowledge to improve services. For example, they had identified that a patient who was frustrated about the appointment system was also a carer. They invited the patient to one of the practice's meetings to talk to staff about the challenges experienced by patients who were also carers. Following this meeting, the practice developed a carer's information pack in association with the patient to ensure useful information was included to better meet carer's needs.
- The practice provided effective care coordination for patients who are more vulnerable or who have complex needs. They supported them to access services both within and outside the practice. For example, the practice hosted a range of services such as the hearing aid clinics, physiotherapy, psychological therapies and alcohol services so that these were accessible to patients locally.
- The practice maintained the continuation of The Minchinhampton Charitable Trust which underwrites services such as acupuncture, counselling services and exercise classes for the benefit of patients.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

Older people:

Are services responsive to people's needs?

- 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 practice nurse also accommodated home visits for those who had difficulties getting to the practice due to limited local public transport availability. Additionally, patients had access to a volunteer transport service to attend the surgery or hospital for their appointment.
- The practice had identified that patients could benefit from Doppler ultrasound at the practice (a doppler ultrasound is a quick, painless way to check for problems with blood flow). Practice nurses had received training in undertaking doppler ultrasound using an Ankle-brachial pressure index (ABPI) device (The ABPI is a non-invasive method of assessing the extent of chronic peripheral arterial disease in the lower limbs). They had presented a business case to the PPG who were funding the purchase of this device so that the service could be offered locally. The practice anticipates being able to offer this service as from July 2018. The practice told us this would benefit all patients at risk of leg ulcers, including patients diagnosed with diabetes (316 patients), patients with past history of leg ulcers or circulation problems, patients who need an assessment before they can be prescribed compression stocking and six-monthly assessments for those who have already been prescribed long term compression hosiery (196 patients).

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. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.
- The practice offered daily phlebotomy service and International Normalised Ratio (INR) clinics.
- The practice hosted diabetic retinal screening so patient could access this service locally.

Families, children and young people:

- We found 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. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.
- A drop in 'Under 25' clinic was held two evenings a week where patients aged between 13 and 25 could get confidential advice and information on sexual health.
- The practice was proactive in identifying opportunities for young people to join the PPG.

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. Additionally, the practice worked with other local practices in the locality to provide improved access to GP appointments until 8pm every evening and Saturday mornings.

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.
- There was a lead GP identified for patients with learning disabilities to ensure continuity of care.
- Practice data showed that 92% of patients with a learning disability had received a health check during 2017/18.
- The practice made active use of easy read materials for patients with learning disabilities. This included information on cervical screening and health action plans.
- The practice recognised the needs of those patients and hence offered longer appointments for patients who needed more time.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode

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

Outstanding ☆

Are services responsive to people's needs?

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice reviewed patients on the mental health register yearly. Patients who failed to attend mental health assessments were proactively followed up by a phone call from a GP.
- The practice held dedicated weekly dementia clinics. Patients who failed to attend were proactively followed up by a phone call from the dementia nurse.
- Patients who needed counselling could access this at the practice which was underwritten by The Minchinhampton Charitable Trust.

Timely access to care and treatment

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.
- Patients reported that the appointment system was easy to use.
- Results from the National GP Survey (01/2017 to 03/2017) showed the practice was performing significantly above local and national averages in areas relating to timely access to care and treatment. For example, 95% of patients stated that the last time they wanted to see or speak to a GP or nurse from their GP surgery they were able to get an appointment compared to the clinical commissioning group (CCG) average of 85% and national average of 76%. Ninety-four percent of patients responded positively to the overall experience of making an appointment compared to the CCG average of 79% and national average of 73%.

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. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. The practice learned lessons from individual concerns and complaints and from analysis of trends. It acted as a result to improve the quality of care. For example, when a number of patients complained that they found it difficult to use the practice's automated system to make an appointment, the practice changed their telephone system to make it easier for patients to speak with a member of staff. PPG members told us the practice shared information on actions they planned to take following complaints. They also told us they were involved in designing the practice's complaints leaflet.

Please refer to the Evidence Tables for further information.

Outstanding ☆

Are services well-led?

We rated the practice as outstanding for providing a well-led service.

The practice was rated as outstanding for well-led because:

- The strategy and supporting objectives were stretching, challenging and innovative, while

remaining achievable. For example, the practice identified ways to continue to accommodate services locally despite their limited premises facilities.

- The practice recognised the needs of their population and limited public transport service and hence, hosted a range of services so patients could access these locally. Additionally, the practice offered other therapies such as acupuncture and counselling which would be of benefit to patients.
- Governance and performance management arrangements were proactively reviewed and

reflected best practice.

- Leaders had an inspiring shared purpose and strived to deliver and motivate staff to

succeed.

- There were high levels of staff satisfaction. Staff were proud of the organisation as a place

to work and spoke highly of the culture. There were consistently high levels of constructive staff engagement. Staff at all levels were actively encouraged to raise concerns.

- There was a strong collaboration and support across all staff and a common focus on

improving quality of care and people's experiences. For example, nurses were supported and encouraged to develop their skills and knowledge so that services provided to patients could be improved.

- Innovative approaches are used to gather feedback from people who use services and

the public, including people in different equality groups. For example, the practice engaged with the patient participation group to undertake surveys and gather feedback from patients at local events and used this feedback to make improvements.

- Rigorous and constructive challenge from people who use services, the public and

stakeholders were welcomed and seen as a vital way of holding services to account. For example, the practice had used constructive challenges from patients as an opportunity to learn from their experience and develop the service.

The leadership drove continuous improvement and staff were accountable for delivering change. There was a clear proactive approach to seeking out and embedding new ways of providing care and treatment.

Leadership capacity and capability

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

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them. The practice recognised the need for improved facilities and had engaged with patients and the PPG to obtain their views on what would be important for the new premises.
- 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.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality, sustainable care.

- There was a clear vision and set of values. The practice had a realistic strategy and supporting business plans to achieve priorities. 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 practice planned its services to meet the needs of the practice population.
- The practice monitored progress against delivery of the strategy.

Culture

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

- The practice focused on the needs of patients. They identified services which would be beneficial for the

local population and worked towards implementing these. For example, they had identified a need to provide Doppler Ultrasound for patients. Nurses had attended the appropriate training and they had approached the PPG for funding the appropriate equipment so that this service can be provided locally.

- 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 we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- 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. Staff were also supported to attend additional training so that the service could be developed and improved. For example, the senior nurse was supported to attend clinical assessment training so they could undertake minor illness clinics. The health care assistant was also being supported to undertake their nursing conversion course.
- Clinical staff were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work. All staff were also offered quarterly protected time to undertake learning and development.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. 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 to ensure safety and assured themselves that they were operating as intended.

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 national and local safety 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.
- 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. The PPG were also involved in performance reporting and their views were sought on ways to improve the practice for patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.

Outstanding ☆

Are services well-led?

- 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. By taking part in research, the practice had identified new ways to use technology to improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were 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. There was an active PPG. The practice had also identified opportunities to involve young people in the PPG to ensure a range of patient views were represented.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There were evidence of systems and processes for learning, continuous improvement and innovation. These sometimes lacked a rigorous approach to evidence of impact and delivery of intended outcomes.

- There was a focus on continuous learning and improvement.
- Staff knew about improvement methods and had the skills to use them.
- 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.

Please refer to the Evidence Tables for further information...