Winchcombe Medical Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Winchcombe Medical Centre on 25 August 2016. Overall the practice is rated as outstanding.

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- The practice used innovative and proactive methods to improve patient outcomes, working with other local providers to share best practice. For example delivering health awareness advice in local schools and working mens clubs.
- The practice had initiated dometic violence training for staff. In order that a single patients best interest was always at the heart of an individuals care, in instances of domestic violence, the practice ensured wherever possible, that the abused patient and their spouse were consulted with by different GP's, in order that confidence and confidentiality was maintained.
- Feedback from patients about their care was consistently positive.
- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they meet patients' needs. For example, the practice improved quality of care and improved outcomes for patients by working collaboratively with other stakeholders to reduce hospital admissions of frail elderly patients.
- The practice were proactive in identifying patients with atrial fibrillation (AF), resulting in a greater number of patients being effectively managed to prevent them having a stroke.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the patient participation group.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice actively reviewed complaints and how they are managed and responded to, and made improvements as a result.

Summary of findings

- The practice had a clear vision which had quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff.
- The practice had strong and visible clinical and managerial leadership and governance arrangements.

We saw two areas of outstanding practice including:

- The practice had identified patients at risk of hospital admission and worked with the community team, for example the rapid response team to prevent hospital admissions. To reduce hospital referrals the practice recognised the expertise of the GPs within the practice and initiated an in house referral system. Data showed that this approach had resulted in the practice having lower than average, referral and admission rates compared to local practices with a similar demography.
- The practice had delivered, in collaboration with the PPG health awareness sessions on men's health, at the local working men's club and teenage health at the local secondary school. This had provided the opportunity to deliver health education advice to hard to access cohorts of the population, who were unlikely to attend the practice for health advice.

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.

- There was an effective system in place for reporting and recording significant events
- Lessons were shared to make sure action was taken to improve safety in the practice.
- When things went wrong patients received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- There were systems in place to manage, dispense and supply medicines to patients. However monitoring of temperatures where medicines were stored should be carried out daily at peak temperature periods.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Our findings at inspection showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines. The practice had developed their own templates for use with their computer system that were linked to NICE guidelines to ensure effective evidence based care was consistently provided. Examples of these templates were, assessing chest pain, traffic light assessment for sick children and back pain.
- We also saw evidence to confirm that the practice used these guidelines to positively influence and improve practice and outcomes for patients. Examples were:
- Improving the diagnosis and monitoring of patients with coeliac disease (a disease which leads to difficulty in digesting food).
- Identification and review of patients living with asthma who were using their medicines inappropriately.
- Elderly patients diagnosed with diabetes who may be over treated were identified and reviewed to reduce the risks associated with this.

Summary of findings

- Data showed that the practice was performing highly when compared to practices nationally.
- The practice had lower than average rates for, hospital referrals and admissions compared to local practices with similar demographics.
- The practice had higher uptake rates for breast and bowel cancer screening compared to local and national averages.
- The practice used innovative and proactive methods to improve patient outcomes. For example. The practice was proactive in developing processes to identify patients with atrial fibrillation, an abnormal heart rhythm, and treating them appropriately. This had led to the practice having a significantly higher than national average prevalence rate. This meant a greater number of patients could be more effectively managed to prevent them having a stroke.

Are services caring?

Good 

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated comparably to 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 saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Outstanding 

The practice is rated as outstanding for providing responsive services.

- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they meet patients' needs. Examples were:
- The practice had recognised that due to the distance from the practice where diabetes education sessions were being held, patients diagnosed with diabetes who would benefit from these, were not able to attend. Following discussions with the local community dieticians, the practice gained agreement for the courses to be held at the practice.
- To support patients with needs that could be improved non medically, the practice participated in the Gloucestershire social prescribing scheme. This scheme provided support to improve their well-being and meet their wider needs.

Summary of findings

- To support patients experiencing poor mental health the practice hosted counselling and primary mental health care co-ordinator clinics.
- There were innovative approaches to providing integrated patient-centred care. For example. The practice worked closely with the palliative care teams and local charities to provide gold standard care for palliative care patients. Templates linked to the gold standard framework supported best practice care. When a patients GP was away they were asked which GP they would like to take over their care for that period of time.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the patient participation group (PPG). For example, following a suggestion made by the PPG the practice held health awareness days at locations that facilitated access for hard to reach sectors of the population, such as, teenagers at the local school and working men at the local working men's club.
- Patients can access appointments and services in a way and at a time that suits them.
- The practice had good facilities and was well equipped to treat patients and meet their needs. A recent extension provided the practice with the space that was needed to provide the community with improved services.
- Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Outstanding ☆

The practice is rated as outstanding for being well-led.

- The leadership, governance and culture were used to drive and improve the delivery of high-quality person-centred care.
- The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The strategy and supporting objectives were stretching, challenging and innovative, while remaining achievable. The practice leadership and culture was used to drive and improve the delivery of high quality person centred care. The practice sought opportunities to deliver tailored care in the local community and improve health outcomes for patients.
- 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.

Summary of findings

- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk. Governance and performance management arrangements were proactively reviewed and reflected best practice. The practice management had evaluated information and data from a variety of sources to inform decision making that would deliver high quality care.
- The provider was aware of and complied with the requirements of the Duty of Candour. The partners encouraged a culture of openness and honesty. The partners in the practice prioritised safe, high quality and compassionate care. The partners were visible and it was clear that there was an open culture within in the practice. There was a high level of constructive engagement with staff and a high level of staff satisfaction.
- The practice had systems in place for knowing about notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken
- The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active and very engaged which influenced practice development.
- There was a strong focus on continuous learning and improvement at all levels.

Summary of findings

The six population groups and what we found

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

Older people

Outstanding ☆

The practice is rated as outstanding for the care of older patients.

- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- The practice recognised that some of their patients who lived in rural areas were unable to collect their medicines from the practice. In response to this the practice employed a delivery driver for this purpose. The practice also held a list of volunteer drivers who assisted these patients getting to hospital and practice appointments.
- The practice provided medical services to a large local nursing home. To ensure high quality care a GP visited the home four times a week and the advanced nurse practitioner on one day a week.
- The practice participated in the Gloucestershire social prescribing scheme which provided non-medical support for older patients.
- The practice were proactive in identifying patients with atrial fibrillation (AF), resulting in a greater number of patients being effectively managed to prevent them having a stroke.
- Collaborative working with community teams and improved utilisation of in house expertise had resulted in elective admissions being 5% lower and emergency admissions being 10% lower than local practices with similar demographics.

People with long term conditions

Outstanding ☆

The practice is rated as outstanding for the care of people with long-term conditions.

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Collaborative working with community teams and improved utilisation of in house expertise had resulted in elective admissions being 5% lower and emergency admissions being 10% lower than local practices with similar demographics.
- Performance for diabetes related indicators was better than local and national averages. The percentage of patients with

diabetes, on the register, in whom the last blood test was within the target range in the preceding 12 months (2014 to 2015) was 83% compared to a local average of 80% and a national average of 78%.

- The practice had recognised that due to the distance from the practice where diabetes education sessions were being held, diabetics who would benefit from these were not able to attend. Following discussions with the local dieticians the practice gained agreement for the sessions to be held at the practice. During the first six sessions 30 patients had benefitted from these courses.
- The practice was aware that diabetic patients who had been transferred from tablets to injections often lacked confidence to adjust the amount of insulin given until the desired clinical effect, determined by their nurse or GP, was achieved. To support patients, the practice nurse telephoned the patient daily to support them until they felt confident to continue this on their own.
- In response to the National Review of Asthma Deaths the practice identified and reviewed all patients who were over using inhalers and at risk. This approach had led to a decrease in the number of patients over using inhalers from 11% to 8%. Auditing of this has continued, with the objective of further improvement.
- Data had highlighted the practice as having a low diagnosis rate and a low testing rate for coeliac disease (a disease which leads to difficulty in digesting food). A process to improve this had raised detection rates to nearly twice the national average, from 1/1000 to 5/1000 which was significantly higher than national average of 3/1000. Diagnosed patients were invited for annual reviews and templates were rewritten for the computer system to improve the quality of these reviews.
- The practice had participated in the chronic obstructive pulmonary disease (a chronic lung condition) winter pressures programme. The programme offered additional appointments to review these patients during the winter period, when exacerbations and hospital admissions were more likely.
- Longer appointments and home visits were available when needed.
- All these patients had a named GP and a structured annual review to check their health and 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.

Summary of findings

Families, children and young people

Outstanding ☆

The practice is rated as outstanding for the care of families, children and young people.

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- Health awareness days were held annually at the local secondary school. Working with the patient participation group (PPG) the practice ensured these days were relevant to teenage health.
- The practice's uptake for the cervical screening programme was 82%, compared to the local average of 84% and the national average of 82%.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw positive examples of joint working with midwives, health visitors and school nurses.

Working age people (including those recently retired and students)

Outstanding ☆

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

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- Telephone appointments were available as well as extended hours appointments held monthly on a Saturday morning for both the GP and nurse.
- 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.
- In collaboration with the PPG the practice had delivered a health advice session on men's health at the local working men's club. This had provided access to patients who were unlikely to attend the practice for health advice.

People whose circumstances may make them vulnerable

Outstanding ☆

The practice is rated as good for the care of people who circumstances may make them vulnerable.

Summary of findings

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice offered longer appointments for patients with a learning disability. The practice recognised that trust and rapport for these patients was very important and ensured they saw the same nurse each time they visited. This had resulted in patients being willing to accept the care they needed.
- The practice had undertaken training in identifying and supporting those at risk of domestic violence.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients. For examplethe practice improved quality of care and improved outcomes for patients by working collaboratively with other stakeholders to reduce hospital admissions of vulnerable patients. The practice informed 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)

Outstanding ☆

The practice is rated as outstanding for the care of people experiencing poor mental health (including people with dementia).

- 90% of patients diagnosed with dementia who had their care reviewed in a face to face meeting in the last 12 months, which was better than the local average of 86% and the national average of 84%.
- The percentage of patients with a serious mental illness who had a comprehensive, agreed care plan documented in the record, in the preceding 12 months (2014 to 2015) was 94% compared to a local average of 93% and a national average of 88%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice carried out advance care planning for patients with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.

Summary of findings

- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia.
- To support patients experiencing poor mental health the practice hosted counselling and primary mental health care co-ordinator clinics. Staff had been updated in this area by an education session from a consultant psychiatrist at the practice and an update of care pathways by the local elderly mental health consultant. The practice in collaboration with the patient participation group (PPG) had recently run an information session entitled “Mind Matters” for patients, which led to patients having a greater understanding to manage their condition.

Summary of findings

What people who use the service say

The national GP patient survey results were published in January 2016. The results showed the practice was performing in line with local and national averages. Of the 245 survey forms that were distributed 116 were returned. This represented a 47% response rate compared to a national average of 38% and about 1% of the practice population. Results from the survey showed;

- 70% of patients found it easy to get through to this practice by phone compared to the clinical commissioning group (CCG) average of 80% and a national average of 73%.
- 78% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 84% and a national average of 76%.
- 88% of patients described the overall experience of this GP practice as good compared to the CCG average of 89% and a national average of 85%.
- 85% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 84% and a national average of 79%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 31 comment cards which were all positive about the standard of care received. A number of cards commented on the fact that staff go above and beyond to provide care and attention. All staff groups were complimented on their professionalism and respectful attitudes.

We spoke with eight patients during the inspection. All eight patients said they were satisfied with the care they received and thought staff were approachable, committed and caring.

Winchcombe Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and included a GP specialist adviser, a practice manager specialist advisor, a CQC pharmacist specialist and a second CQC inspector.

Background to Winchcombe Medical Centre

Winchcombe Medical Centre is a dispensing practice located near to the centre of Winchcombe a small town in the Cotswolds. The practice has a dispensary offering pharmaceutical services to those patients on its practice list who live more than one mile (1.6km) from their nearest pharmacy premises. The practice dispenses medicines for approximately 2,900 patients. The practice has a higher than average patient population in the over 45 years age group and lower than average in the below 45 years age group. The practice is part of the Gloucester Clinical Commissioning Group and has approximately 7,000 patients. The area the practice serves is urban and semi-rural and has relatively low numbers of patients from different cultural backgrounds. The practice area is in the lowest range for deprivation, nationally.

The practice is managed by five GP partners (three female and two male). The practice is supported by one salaried GP, an advanced nurse practitioner (male), three practice nurses, two health care assistants and an administrative team led by the practice manager. The practice has five trained dispensers who dispense medicines for patients under the supervision of the GPs. Winchcombe Medical Centre is a training practice providing placements for GP registrars and medical students.

The practice is open between 8am and 6.30pm Monday to Friday. Appointments are available between 8.20am and 11.50am every morning and 3pm to 5.50pm every afternoon. Telephone appointments are also available to book. Extended hours appointments are offered 7.30am to 11am on every third Saturday. In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were available for patients that needed them.

When the practice is closed patients are advised, via the practice website and an answerphone message, to ring the NHS 111 service for advice and guidance. Out of hours service is provided by South Western Ambulance Service NHS Foundation Trust (SWASFT).

The practice has a General Medical services contract to deliver health care services. This contract acts as the basis for arrangements between the NHS England and providers of general medical services in England.

Winchcombe Medical Centre is registered to provide services from the following location:

Greet Road,

Cheltenham ,

Gloucestershire,

GL54 5GZ.

This inspection is part of the CQC comprehensive inspection programme and is the first inspection of Winchcombe Medical Centre .

Detailed findings

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. The 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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 25 August 2016. During our visit we:

- Spoke with a range of staff including three GP's, three nurses, six members of the administrative team and spoke with patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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 looked 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).

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

Good

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice carried out a thorough analysis of the significant events.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, following a cardiac arrest of a patient on the surgery premises, the practice identified that whilst resuscitation had been successful, further improvements could be made. Issues with the ambulance call centre had been communicated, improvements were made to the practices emergency trolley and their own emergency call system was improved. Plans were made to implement practice resuscitation scenarios at regular intervals to increase confidence and improve management of these situations in future.

Overview of safety systems and processes

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

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. 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 on safeguarding children and vulnerable adults relevant to their role. GPs and nurses were trained to child protection or child safeguarding level three. All other staff had been trained to level one or two as appropriate. The practice had initiated domestic violence training for staff. This had led to the practice ensuring that wherever possible different GPs cared for an abused patient and their spouse, in order that a single patient's best interest was always at the heart of an individual's care.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (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).
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. 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. For example flooring had recently been replaced which ensured compliance with infection control prevention. Infection control was a standard agenda item at meetings and the lead nurse regularly provided the practice on updates on hand hygiene.
- The arrangements for managing medicines, including emergency medicines and vaccines, kept patients safe (including obtaining, prescribing, recording, handling, storing and security). There was an automated system in place to monitor the temperature of all the fridges. This was not checked daily in line with national guidance but each of the fridges were alarmed and staff would know if medicines were not being stored at the correct temperature. Room temperatures were not monitored

but the areas where medicines were stored were air-conditioned and kept at appropriate temperatures to store medicines. All medicines were secure and there was an expiry date checking process in place.

- The practice carried out regular medicines audits, with the support of the local clinical commissioning group pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. (A PGD is a written instruction for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment). Health care assistants were trained to administer certain vaccines and medicines against a patient specific prescription or direction from a prescriber.
- Processes were in place for handling requests for repeat prescriptions which included the review of high risk medicines. Protocols were reviewed to further improve patient safety.
- There was a named GP responsible for the dispensary and all members of staff involved in dispensing medicines had received appropriate training and had opportunities for continuing learning and development. We saw a positive culture in the practice for reporting and learning from medicines incidents and errors. Any medicines incidents or 'near misses' were recorded for learning and was supported by a standard operating procedure. This helped make sure appropriate actions were taken to minimise the chance of similar errors occurring again.
- Dispensary staff showed us a comprehensive and up to date range of standard operating procedures (SOPs) which covered all aspects of the dispensing process (SOPs are written instructions about how to safely dispense medicines). These were up to date and accurately reflected current practice but had been signed by the dispensing staff to say they had read and understood them. The dispensing process was safe and effective. The practice signed up to the Dispensing Services Quality Scheme to help ensure processes were suitable and the quality of the service was maintained.
- The practice established a delivery service for patients who were less mobile and had systems to monitor how these medicines were managed. They also provided a safe monitored dosage system for those patients who required assistance with taking their medicine.
- The practice held stocks of controlled drugs (medicines that require extra checks and special storage because of their potential for misuse) and had procedures to manage them safely. There were also arrangements for the appropriate destruction of controlled drugs.
- We reviewed four personnel files and found 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.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- 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 which identified local health and safety representatives. The practice had up to date fire risk assessments and carried out regular fire drills. 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 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 (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to 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.

Good

Are services safe?

- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and staff knew of their location. All the emergency medicines we checked were in date and stored securely.
- 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 assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice had developed their own templates for use with their computer system that were linked to NICE guidelines to ensure effective evidence based care was consistently provided. Examples of these templates were, assessing chest pain, traffic light assessment for sick children and back pain.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records. For example, following attendance by a GP from the practice at a learning event a speaker highlighted the risks of over treating elderly patients with diabetes. All at risk patients were identified and reviewed by their GP to reduce these risks.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 99.9% of the total number of points available. The practices exception rating was 13% which was above the local average of 9% and the national average of 10%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). The practice was an outlier for QOF exception rating for a number of clinical areas. The practice had analysed these exceptions and had identified that a significant number of exceptions included in the national database figures, were not included in data provided by their own computer system or figures they had been supplied with by the clinical commissioning group (CCG). The practice had a protocol in place for the exception coding of patients and audited their excepted patients annually. Further investigation on the day of the inspection by the GP specialist advisor found that clinical care was in line with guidelines.

Data from 2014-2105 showed:

- Performance for diabetes related indicators was better than local and national averages. The percentage of patients with diabetes, on the register, in whom the last blood test was within target range in the preceding 12 months (2014 to 2015) was 83% compared to a local average of 80% and a national average of 78%.
- Performance for mental health related indicators was better than the local and national average . The percentage of patients with a serious mental illness who had a comprehensive, agreed care plan documented in the record, in the preceding 12 months (2014 to 2015) was 98% compared to a local average of 93% and a national average of 88%.

There was evidence of quality improvement including clinical audit.

- There had been 12 clinical audits completed in the last two years, eight of these were completed audits where the improvements made were implemented and monitored.
- The practice participated in local audits, national benchmarking, accreditation, peer review and research.
- Findings were used by the practice to improve services. For example, recent action taken as a result, included improving the monitoring and disease identification of patients with coeliac disease (a disease which leads to difficulty in digesting food). Data had highlighted the practice as having a low diagnosis rate and a low testing rate for at risk patients. Automated prompts were set up to ensure that patients with an appropriate clinical history were invited for testing. Identifying appropriate patients for testing demonstrated the practice had raised detection rates to nearly double the national average, from 1/1000 to 5/1000 which was significantly higher than national average of 3/1000. Diagnosed patients were invited for annual reviews and templates were rewritten for the computer system to improve the quality of these reviews.

Information about patients' outcomes were used to make improvements such as: Following the publication of the

Good

Are services effective?

(for example, treatment is effective)

national review of asthma deaths the practice identified all patients using more than the recommended number of inhalers that relieved symptoms of asthma rather than using inhalers to prevent symptoms. A review of these patients provided opportunities for improved patient education and self-management. The practice also made the decision to remove reliever inhalers from repeat prescribing to ensure improved monitoring of their condition. This approach had led to a decrease in the number of patients over using inhalers from 11% to 8%, resulting in improved symptom control and quality of life for these patients. Audit of this has continued, with the objective of further improvements.

Effective staffing

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

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions. Nurses had undertaken diplomas and further study in diabetes, respiratory disease and family planning. The practice supported staff to attend regular knowledge updates in all areas.
- The advanced nurse practitioner told us that all the GPs provided appropriate support and in addition a GP mentor had been allocated. Attendance at the tutorials run for GP registrars were also available for those topics that were relevant to the advanced nurse practitioner role.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- 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 their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. All staff had received an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. 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 investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.
- The practice had identified patients at risk of hospital admission and worked with the community team; for example, the rapid response team, to prevent hospital admissions. To reduce hospital referrals the practice recognised the expertise of the GPs within the practice and initiated an in house referral system. Data showed that this approach had resulted in the practice having lower than average, referral and admission rates compared to local practices with a similar demography. For example, outpatient attendances were 2% lower, elective admissions were 5% lower and emergency admissions were 10% lower.
- The practice were proactive in identifying patients with atrial fibrillation (AF), an abnormal heart rhythm, and treating them appropriately. Pulse rates were taken opportunistically. If found to be abnormal heart traces were performed on the same day and a GP referral made. The practice prevalence for AF was 3.3% compared to a national average of 2.13%. This meant a greater number of patients could be more effectively managed to prevent them having a stroke.
- Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from

hospital. Meetings took place with other health care professionals on a regular basis when care plans were routinely reviewed and updated for patients with complex needs.

Consent to care and treatment

Staff sought patients' consent to care and treatment 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, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored through patient records audits.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were signposted to relevant services as appropriate.
- The practice supported patient participation in adopting healthy lifestyles. For example Walk on Prescription a scheme involving Winchcombe for Walkers and the local organisers of the National Walk 4 Life campaign. The practice handed out maps of the local area and had sponsored a seat to act as an appropriate resting point.

The practice's uptake for the cervical screening programme was 82%, compared to the CCG average of 84% and the national average of 82%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability, by ensuring patients were seen by the same nurse each time to promote confidence and trust during procedures and they ensured a female sample taker was available.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. For bowel cancer 70% of eligible patients had been screened which was higher than the local average of 63% and the national average of 58%. For breast cancer 82% of the eligible patients had received screening compared to a clinical commissioning group (CCG) average of 77% and a national average of 72%. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Childhood immunisation rates were comparable to CCG averages. For example, childhood immunisation rates for the vaccines for the vaccines given were comparable given to under two year olds ranged from 78% to 100%, compared to a local average of 72% to 98% and five year olds from 89% to 96% compared to the local average of 90% to 95%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; 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.

All of the 31 patient Care Quality Commission 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 spoke with three members of the patient participation group. They also told us they 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 felt they were treated with compassion, dignity and respect. The practice was in line with local and national averages for its satisfaction scores on consultations with GPs and nurses. For example:

- 89% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 91% and the national average of 87%.
- 89% of patients said the GP gave them enough time compared to the CCG average of 90% and the national average of 87%.
- 96% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and the national average of 95%.
- 88% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 88% and the national average of 85%.
- 88% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 93% and the national average of 91%.
- 91% of patients said they found the receptionists at the practice helpful compared to the CCG average of 90% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients told us 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 from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

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

- 88% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 89% and the national average of 87%.
- 83% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 85% and the national average of 82%.
- 85% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 87% and the national average of 85%.

The practice provided facilities to help patients be involved in decisions about their care:

- Staff told us that translation services were available for patients who did not have English as a first language.
- Information leaflets were available in easy read format.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website.

Good

Are services caring?

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 84 patients as carers (1.2% of the practice list). We saw notice boards in the waiting areas dedicated to carers. This included information to support young carers. All identified carers were referred to the local carers support group. Written information was available to direct carers to the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP contacted them and sent them a sympathy card. 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 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. For example:

- The practice offered extended hours on one Saturday a month from 7.30am until 11am for working patients who could not attend during normal opening hours. Recently the practice had begun to offer nurse appointments during this time as well.
- There were longer appointments available for patients with a learning disability. Patients were invited for an annual review with the nurse and were then seen by the GP to ensure needs were met on the same day. The practice recognised that trust and rapport for these patients were very important and ensured they saw the same nurse each time they visited. This had resulted in patients being willing to accept the care they needed. For example, one patient refused any monitoring but over several visits the nurse was able to build trust and rapport and the patient allowed their blood pressure and weight to be measured.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccines available on the NHS as well as those only available privately.
- There were disabled facilities, a hearing loop and translation services available. Toilets were fitted with a visual fire alarm to assist deaf patients. The practice held regular hearing aid clinics for those patients who found it difficult travelling into the city.
- The practice had installed a lift to provide access to first floor consulting rooms.
- The practice had participated in the chronic obstructive pulmonary disease (a chronic lung condition) winter pressures programme. The programme offered additional appointments to review these patients during the winter period, when exacerbations and hospital admissions were more likely.
- The practice was aware that patients diagnosed with diabetes who had been transferred from tablets to injections often lacked confidence to adjust the amount of insulin given until the desired clinical effect, determined by their nurse or GP, was achieved. To support patients, the practice nurse telephoned the patient daily to support them until they felt confident to continue this on their own.
- The practice had recognised that due to the distance from the practice where diabetes education sessions were being held, patients diagnosed with diabetes who would benefit from these were not able to attend. Following discussions with the local dieticians the practice gained agreement for the sessions to be held at the practice. During the first six sessions 30 patients had benefitted from these courses.
- The practice worked closely with the palliative care teams and local charities to provide gold standard care for palliative care patients. Templates linked to the gold standard framework supported best practice care. When a patients GP was away they were asked which GP they would like to take over their care for that period of time.
- The practice had held a team building day between the community teams and practice staff at a local charity where they painted rooms and gardened with them. We received feedback from the clinical manager of a local charity providing hospice at home support which told us that the practice communicated well, delivered holistic, patient centred care whilst being proactive in meeting patient needs.
- To support patients with needs that could be resolved non medically, the practice participated in the Gloucestershire social prescribing scheme. This scheme provided support for people with issues such as loneliness and low level mental health problems, and offered support for healthy living and coping with caring responsibilities to help improve their well-being and meet their wider needs.
- The practice provided medical services to a large local nursing home. To ensure high quality care a GP visited the home four times a week and the advanced nurse practitioner on one day a week.
- The practice recognised that some of their patients who lived in rural areas were unable to collect their medicines from the practice. In response to this the practice employed a delivery driver for this purpose. The practice also held a list of volunteer drivers who assisted these patients getting to hospital and practice appointments.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

- To support patients experiencing poor mental health the practice hosted counselling and primary mental health care co-ordinator clinics. Staff were kept updated in this area by an education session from a consultant psychiatrist at the practice and an update of care pathways by the local elderly mental health consultant. The practice in collaboration with the patient participation group (PPG) had recently run an information session entitled "Mind Matters" to help patients to recognise, understand and manage mental health issues.
- In collaboration with the PPG the practice had delivered a health advice session on men's health at the local working men's club. This had provided access to patients who were unlikely to attend the practice for health advice.
- Health awareness days were held annually at the local secondary school. Working with the PPG the practice ensured these days were relevant to teenage health. Other agencies such as the police were also invited.
- The practice had recognised that the premises they occupied did not provide the space needed to deliver the highest standard of care to the growing population. Following long negotiations with NHS England, the clinical commissioning group (CCG) and the owners of the building, agreement was gained for an extension to be built. This was completed in June 2016 and the practice now had facilities that met the needs of the population. In order to ensure the practice dispensary was fit for purpose going forward, the practice financed improvements to this area.

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday. Appointments were from 8.20am and 11.50am every morning and 3pm to 5.50pm every afternoon. In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for people that needed them.

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.

- 92% of patients were satisfied with the practice's opening hours compared to the clinical commissioning group (CCG) of 80% and the national average of 78%.
- 95% of patients said they could get through easily to the practice by phone compared to the clinical commissioning group (CCG) of 78% and the national average of 73%.

People told us on the day of the inspection that they were able to get appointments when they needed them.

The practice had a system in place to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system on the practice website and leaflets and notices in the waiting rooms

The practice had received five complaints over the last 12 months and found that these were satisfactorily handled and dealt with in a timely way with openness and transparency. Lessons were learnt from individual concerns and complaints and also from analysis of trends and action was taken to as a result to improve the quality of care. For example, a mother was not happy with the response when she telephoned requesting an urgent appointment for her child. The practice ensured training and guidance was given to reception staff to help them deal with emergency situations to prevent this happening again.

Are services well-led?

Outstanding ☆

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

Our findings

Vision and strategy

The strategy and supporting objectives were stretching, challenging and innovative, while remaining achievable. The practice leadership and culture was used to drive and improve the delivery of high quality person centred care. The practice sought opportunities to deliver tailored care in the local community and improve health outcomes for patients with a systemic approach by working with other organisations.

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

- The practice had a mission statement which was displayed in the waiting areas and staff knew and understood the values.
- The practice had strategies and supporting business plans which reflected the vision and values and were regularly monitored. Partner and management away days were held twice a year to ensure current strategies were appropriate and planning for future challenges was addressed.
- The practice continually assessed skill mix within the practice, in order to address the changes required of general practice. A recent decision had been taken to employ an additional health care assistant to ensure nursing staff had the capacity to manage patients according to their skills and an additional salaried GP to ensure good access for patients was maintained.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and supported high quality care. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff. We looked at a number of these policies. For example, recruitment, chaperoning and infection control and found them to be in date and regularly reviewed.

A comprehensive understanding of the performance of the practice was maintained. The practice had used local and national data as well as in house data to identify areas where improvements could be made for the benefit of patients. There was a clear proactive approach to seeking out and embedding new ways of providing care and treatment which had led to improved outcomes for patients:

- The practice worked proactively with the local community teams which led to the practice being below the local average for referrals and emergency admissions.
- The practice had identified cohorts of the community who were difficult to access and worked with the patient participation group (PPG) to deliver health promotion in their own places of work, study and leisure, rather than restrict this activity to the practice premises.
- An extensive programme of continuous clinical and internal audit as well as research programmes that were part of the National Institute of Health and Research portfolio, the research arm of the NHS was used to monitor quality and to make improvements.
- The practice had developed their own templates for use with their computer system that were linked to NICE guidelines to ensure effective evidence based care was consistently provided.
- The practice had a GP lead on the clinical commissioning group which ensured involvement with sharing of best practice and further development of services within the local area.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

Leadership and culture

On the day of inspection the partners in the practice demonstrated they had the experience capacity and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. The practice culture promoted effective teamwork , where each team member was integral, in ensuring that high quality care was delivered to all of their patients.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. The

Are services well-led?

Outstanding ☆

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

practice had systems in place to ensure that when things went wrong with care and treatment: There was a clear process for learning and taking action promptly, to improve the quality of care and reduce the possibilty of reoccurence.

- The practice gave affected people reasonable support, truthful information and a verbal and written apology
- The practice kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure in place and staff felt supported by management.The practice had an experienced, stable team. They recognised that staff retention was integral to delivering a high quality service and encouraged staff development in line with the needs of the individual, as well as the practice, and worked hard to ensure high staff satisfaction.

- Management not only told us that they understood that their staff were their most valuable asset, but this was demonstrated by positive feedback from the staff. Staff told us the partners were approachable and always took the time to listen to all members of staff. Staff told us they felt confident to offer suggestions and feedback and that they felt valued within the practice.
- Morning meetings were for all staff, where they had open access. To promote team building and a united organisation, social events were regularly held. For example, a practice barbeque for all staff and their families was held annually at a partner's house.
- Staff we spoke with on the day of the inspection demonstrated that there were high levels of staff satisfaction and they felt proud of the practice and its culture.
- Staff told us the practice held regular team meetings. In addition to monthly staff group meetings, six protected practice learning time meetings, were held each year. Each day an informal coffee time meeting was open to all staff. This provided opportunities to raise issues and suggestions and contributed to the open culture of the practice.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- Staff said they felt respected, valued and supported, particularly by the partners 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 confirmed the whole practice team shared an ethos of open communication, where everyone's role was valued. The practice encouraged opportunities to learn from any training, development, incidents or reviews.

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

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. We saw that the practice fully engaged and had good working relationships with the PPG. The PPG met regularly, carried out patient surveys and submitted proposals for improvements to the practice management team. Examples of this were: a patient survey regarding the closure of the local hospital.
- The PPG had suggested that they and the practice held, health awareness events that would be relevant to a wide cross section of the local population, which had included, weight management, women's health, mental health, teenage health and men's health.
- The PPG had been fully involved and supportive to the practice during negotiations and building of the extension to the premises. Skills within the PPG had been welcomed by the practice to support them with planning procedures and communications with the local council and also retention of outpatient services locally.
- The PPG had been awarded the Corkill Award (an award given annually for outstanding work by a PPG in the preceding year) by the National Association of Patient Participation.
- The practice had gathered feedback from staff through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. For example, the nurse lead for diabetes told us that reviewing patients with pre diabetes was

Are services well-led?

Outstanding ☆

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

limiting the capacity to review other patients. A suggestion was made to develop an information lifestyle leaflet, which would be sent to patients initially, which the partners were happy to implement.
- Staff told us they felt fully involved and engaged to improve how the practice was run.
- Training for staff went beyond normal expectations and was demonstrated at upskilling their staff, as well as updating them.

Continuous improvement

The leadership drives 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. Examples of this were

- The practice were working with the CCG to improve the services provided to the local community, such as extending the minor surgery procedures that could be offered from the practice.
- Further training of the advanced nurse practitioner was being planned to enable tests to be requested and reviewed in the acute illness clinic, to ensure further development and maximum efficiency of this service for patients.
- The practice was a teaching and training practice and supported Registrars and medical students (Registrars are qualified doctors who undertake additional training to gain experience and higher qualifications in general practice and family medicine).
- The practice was working with the CCG to become the host site for physiotherapy services for the local area.