The Calverton Practice

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?	Outstanding ☆
Are services caring?	Good ●
Are services responsive to people's needs?	Outstanding ☆
Are services well-led?	Good ●

Summary of findings

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Overall summary

We carried out an announced comprehensive inspection at The Calverton Practice on 7 January 2015. Overall the practice is rated as outstanding.

Specifically, we found the practice to be outstanding for providing effective and responsive services. It was also outstanding for providing services for people with long-term conditions and working age people (including those recently retired and students).

It was good for providing safe, caring and well-led services. It was also good for providing services for older people, people with long-term conditions, families, children and young people, people whose circumstances may make them vulnerable and people experiencing poor mental health (including people with dementia)

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

We saw several areas of outstanding practice;

- The practice ran a tier 4 anticoagulant service overseen by the practice pharmacist which included

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providing services to all housebound patients by appropriately trained Heath Care assistants. This service was not routinely available in other practices within the CCG area.

- The practice employed a practice pharmacist who was also trained as an independent prescriber. The pharmacist offered clinics which were tailored to meet the needs of patients with complex conditions. This service was available to all registered patients. The practice was able to demonstrate very effective prescribing rates in terms of hypnotic usage, anti-inflammatory medication and antibiotic prescribing compared to the national average as a result of continuous quality improvement.
- The practice ran a morning walk in service for minor illness led by appropriately trained practice nurses. The practice was able to demonstrate lower accident and emergency (A&E) attendance rates than the average for the locality.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. The systems in place to safeguard vulnerable children and adults were robust and ensured that practice staff understood and could respond to risk.

Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Are services effective?

Outstanding

The practice is rated as outstanding for providing effective services.

Data showed patient outcomes were at or above average for the locality. The practice employed a practice pharmacist who was also trained as an independent prescriber. The pharmacist offered clinics which were tailored to meet the needs of patients with complex conditions. This service was available to all registered patients. The practice was able to demonstrate they had very effective prescribing rates in terms of hypnotic usage, anti-inflammatory medication and antibiotic prescribing compared to the national average as a result of continuous quality improvement.

The practice pharmacist supervised a tier 4 anticoagulation services which was not routinely offered by many of the surgeries in the CCG. They were able to demonstrate comprehensive training and supervision of the staff who participated in providing the services. The practice was also able to provide a domiciliary service for its house bound patients.

The practice was able to demonstrate a 100% appropriate prescribing of an antiplatelet medication to patients with atrial fibrillation with national average being 98%.

The practice ran a morning walk in service for minor illness led by appropriately trained practice nurses and also provided a consultant led muscular skeletal service which patients reported had been more convenient for them than attending hospital. The practice was able to demonstrate lower accident and emergency (A&E) attendance rates than the average for the locality.

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The practice used creative methods to reach out to its patient community and had a regular column in the local newspaper 'The Calverton Echo' which kept patients informed of what was happening in the practice, and informed patients about health promotion initiatives through this column.

Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services.

Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. The practice aimed to provide a personalised service and every patient aged 75 and over received a hand written birthday card from their named GP with an invitation to attend for an annual review.

Information to help patients understand the services available was easy to understand. We saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Outstanding

The practice is rated as outstanding for providing responsive services.

It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP with urgent appointments available the same day. The practice attempted to ensure that there was continuity of care by providing every patient had a named GP. The practice linked all family members to the same named GP, unless they were requested not to do so.

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

Are services well-led?

Good

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

Summary of findings

It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk.

The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) who are a group of patients who work together with the practice staff to represent the interests and views of patients so as to improve the service provided to them was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people.

Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services. Every patient aged 75 and over received a hand written birthday card from their named GP with an invitation to attend for an annual review.

It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. We spoke to the managers of three care homes and all three were very happy with the service they received from the practice. All three spoke positively about the GPs bedside manner, and said that the practice was very good at ringing back if the care home had a query or a concern.

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. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medicines needs were being met.

There was a system in place for reviewing repeat medicines for patients with several long-term conditions or those receiving multiple medicines to ensure prescribing was minimised and that the medicines prescribed were suitable and appropriate to maintain the health and wellbeing of patients.

The practice employed a pharmacist with prescribing rights. They were able to demonstrate better than national average prescribing rates for antibiotics, anti-inflammatories as well as hypnotics. The tier 4 anticoagulant service provided a service to housebound patients. The practice tailored its medication reviews to coincide with a patient's birthday by sending a hand written birthday card and invitation to attend for appointment.

For those people 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

Good

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

There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Immunisation rates were high for all standard childhood immunisations.

Regular multi-disciplinary meetings were held with school nurses, district nurses and health visitors to discuss children and families who may be at risk of harm or abuse. Staff we spoke with told us they followed up any children who persistently failed to attend appointments.

Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

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. The practice had a nurse led walk in treatment room session, where patients with minor ailments could be seen on the day, without having to make an appointment to see a GP. This was for non-emergencies, and patients said they had found it very useful. This service was available from 8:30 am to 11:00 am

Results from the 2014 national patient survey identified that 78% of patients found it easy to get through on the telephone, and 91% said they found the reception staff helpful. In addition 94% said the last appointment they got was convenient. These demonstrated high patient satisfaction in respect of access, a factor which is important for patients of working age.

The practice was able to demonstrate that by providing a daily walk in service for minor illness that they had one of the lowest uses of local emergency services within the locality. It also offered a consultant led muscular skeletal service. The practice had the services of a physiotherapist available to support and treat patients.

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The physiotherapist worked in the practice seeing patients on a part-time basis, with the practice having bought in the physiotherapist's services to supplement their work. Two patients spoke very positively about the services provided by the physiotherapist and the positive effect this had and how it had reduced the travel time and increased convenience for them.

The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.

People whose circumstances may make them vulnerable

Good

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

The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks for people with a learning disability and these patients had received a follow-up. It offered longer appointments for people with a learning disability.

Reception staff said they were aware of patients whose circumstances may make them vulnerable. A smaller waiting room was available if required for patients who found the main waiting room intimidating or threatening. It was clear that patients from vulnerable groups such as those with learning disabilities or experiencing poor mental health could access the practice without fear of stigma or prejudice. We observed staff treated patients in a sensitive and sympathetic manner.

People experiencing poor mental health (including people with dementia)

Good

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

The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia. There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments. For example if a patient had been diagnosed with dementia and this had made them vulnerable in ways they had not been before.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND and SANE. These are two organisations that offer support and advice to people experiencing

Summary of findings

poor mental health and their families. It had a system in place to follow up patients who had attended A&E where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

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What people who use the service say

The practice had conducted a patient survey through its patient participation group (PPG). The data collected related to 111 patient responses. Ninety six percent of respondents said they would recommend the practice to their family and friends, and only one person said they would not.

Eighty seven percent of patients said they found it easy to make an appointment, and 96% said the GP listened to them.

We considered the national patient survey in June 2014. 129 patients had completed the survey and of those 75% of patients described their experience of making an appointment as good, 98% had confidence and trust in the last GP they saw or spoke to and 87% described their overall experience of this surgery as good.

We received 19 completed comment cards. All 19 were positive expressing views that the practice offered an excellent service. Patients said they found all staff to be understating, caring and compassionate. The only area for improvement raised related to getting a face to face appointment with a named GP but telephone appointments were offered.

We spoke with six patients during our inspection. All six patients said they were happy with the care they received and all six thought the staff were all approachable, committed and caring.

The Calverton Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) inspector. The lead inspector was accompanied by a GP specialist advisor, and a practice manager specialist advisor.

Background to The Calverton Practice

The Calverton Practice provides primary medical care services to approximately 9,250 patients. The practice is based in the centre of the village of Calverton.

The practice offers a dispensary service, and the pharmacy is between 8.30am and 6.30pm

The practice has a Primary Medical Services (PMS) contract with NHS England. This is a contract for the practice to deliver primary care services to the local community or communities.

In addition the practice offers a number of enhanced services to its patients. These are services over and above the usual GP contract. The Calverton Practice offers: an alcohol-related risk reduction scheme, avoiding unplanned admissions to hospital or long-term care particularly for older patients, facilitating timely diagnosis and support for people with dementia, a learning disabilities health check scheme and a dementia identification scheme.

There are five GP partners at the practice and the practice provides current placements for doctors in training. The practice has male and female GPs and patients can choose the gender of the GP they see. In addition the nursing team comprises of five practice nurses and two healthcare assistants. The clinical team are supported by the practice manager and an administrative team.

The Calverton Practice has opted out of providing out-of-hours services to its own patients. Out-of-hours services are provided by Nottingham Emergency Medical Services – NEMS. Patients can also attend one of two walk in centres situated within Nottingham which deal with minor illness and injury.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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.

How we carried out this inspection

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?

Detailed findings

- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 7 January 2015. During our visit we spoke with a range of staff (GPs, nursing staff and administration and reception staff) and spoke with six patients who used the service. We observed how people were being cared for and talked with patients We reviewed 19 comment cards where patients shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients.

The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example following confusion created by staff using their initials rather than their full name on documentation the practice had reviewed this and taken corrective action to ensure patient safety.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last five years. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the past covering many years. We concentrated on reviewing significant events from the last two years.

Significant events were a standing item on the practice meeting agenda and a dedicated meeting was held every two months to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. They showed us the system used to manage and monitor incidents. We tracked 18 incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result.

For example, the practice had made improvements to the electronic communication between themselves and the local acute hospital following an issue where they had not been informed of a post discharge change in medicines which could have caused an adverse reaction to vaccination. The practice staff had identified this and ensured the patient was not placed at risk.

The practice or Pharmacist (Prescriber) shared national patient safety alerts with relevant practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They told us alerts were discussed at practice meetings if necessary to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to children, young people and vulnerable adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained to an appropriate level and could demonstrate they had the understanding of safeguarding risks and systems to enable them to fulfil this role. All of the staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments. For example if a patient had been diagnosed with dementia and this had made them vulnerable in ways they had not been before.

The practice's electronic records identified vulnerable patients including children and families who were at risk. We saw that the GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were

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Are services safe?

looked after or on child protection plans were clearly flagged and reviewed. Regular multi-disciplinary meetings were held with school nurses, district nurses and health visitors.

Nursing staff at the practice who were responsible for carrying out immunisation of children were aware of children and families who may be at risk of harm or abuse. Staff we spoke with told us they followed up any children who persistently failed to attend appointments.

The practice identified older people who were 'at risk' and there was a system for reviewing repeat medicines for patients with several long-term conditions or those receiving multiple medicines.

There was a chaperone policy, which was visible on the waiting room noticeboard and by the reception desk. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

Staff took this responsibility seriously and gave an example of where they had been able to guide a new doctor as to the practice policy to ensure this was followed and patients were safeguarded. All of the staff who undertook chaperoning duties had been checked by the Disclosures and Barring Service.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

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

The practice was a prescribing practice with an on-site dispensary. Discussions with the Pharmacist (Prescriber) identified that medicines were monitored at the practice with prescribing data being analysed and discussed with the partners and the clinical commissioning group (CCG). We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example, patterns of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice had all been reviewed.

The nursing staff administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses had received appropriate training to administer vaccines.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard operating procedures that set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. There were arrangements in place for the destruction of controlled drugs.

Practice staff with the guidance and support of the Pharmacist (Prescriber) undertook regular audits of controlled drug prescribing to look for unusual products, quantities, dose, formulations and strength. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

Dispensing staff at the practice were aware prescriptions should be signed before being dispensed. If prescriptions were not signed before they were dispensed, staff were able to demonstrate that these were risk assessed and a process was followed to minimise risk. We saw that this process was working in practice.

Good

Are services safe?

The practice had a system in place to assess the quality of the dispensing process and had signed up to the Dispensing Services Quality Scheme, which rewards practices for providing high quality services to patients of their dispensary.

Discussions with the Pharmacist (Prescriber) and records showed that all members of staff involved in the dispensing process had received appropriate training and their competence was checked regularly.

The practice had established a delivery service, so that patients who did not or could not leave their home could receive their medicines.

Cleanliness and infection control

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

The practice had a lead for infection control who had recently taken on the role. As a result they had not yet undertaken further training to enable them to carry out staff training but this had been identified as an area for action. They were working closely with the clinical team to develop the infection control policies. All staff received induction training about infection control specific to their role and received annual updates. We were told that the CCG infection control team had completed an audit in the past year.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy.

We saw evidence of a system for managing clinical waste. Staff we spoke with understood the importance of the effective and safe disposal of clinical waste and what actions to take. There was a policy for needle stick injury which was accessible to all staff through the shared drive of the practice's computer system. Staff knew the procedure to follow in the event of an injury.

Sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice did not have a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal).The practice could not when requested provide us with evidence to demonstrate they were carrying out regular checks to reduce the risk of infection to staff and patients during our inspection but they took action to test their water systems and assess this risk following our visit to ensure any risks could be identified and addressed.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this.

All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers (a machine used to help diagnose lung conditions most commonly chronic obstructive pulmonary disease COPD), blood pressure measuring devices and the fridge thermometer.

A visual check of equipment did not raise any concerns and staff were aware of how to report any problem or damage to equipment to either have the item replaced or repaired.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. We looked at six staff files. Those staff files contained evidence that recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications and registration with the appropriate professional body. All staff files contained a criminal records check through the Disclosure and Barring Service (DBS).

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always

Good

Are services safe?

enough staff on duty to keep patients safe. The practice manager discussed arrangements for covering staff sickness and ensuring there were enough staff to meet patient's needs. There was a system in place, and the practice manager was able to demonstrate how it had been used in the past.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly health and safety checks in respect of (for example) the building, the environment, and equipment. The practice had a health and safety policy which was accessible to all staff through the shared drive of the practice's computer system. The policy had been reviewed in September 2014. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

The practice had Identified risks within the practice. Risks were assessed and rated and actions recorded to reduce and manage the risk. We saw that any significant risks were discussed at partners meetings and within team meetings. For example, providing all staff with updates and detailed instructions on how to reset the fire alarm if it activated.

The practice demonstrated an awareness of potential risks to patients, and as a result there were emergency processes in place for patients whose health deteriorated suddenly. There were clear instructions for staff in reception about how and when to summon assistance including dialling 999 for an ambulance if a patient's health deteriorated suddenly. Staff gave us two examples of where they had put the guidance to use in emergency situations.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. We saw that refresher training for basic life support was booked for all staff in February 2015. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. The practice held a central supply of emergency drugs and each clinical area/room had a "shock box" for treating anaphylaxis. Processes were in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. All staff had access to the plan as an electronic copy was held on the practice's computer. In addition two hard copies were kept off site. The business continuity plan had last been updated in December 2014. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document contained relevant contact details for staff to refer to. For example, contact details for staff working at the practice and potential alternative accommodation if the practice building could not be used.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records did not clearly identify that staff were up to date with fire training and the practice manager provided assurances that this would be provided. Practice staff had completed two fire drills in 2014 when faulty smoke detectors had triggered the fire alarm.

Risks associated with service and staffing changes (both planned and unplanned) had been identified. We saw an example of this where heavy snow fall had prevented some staff from attending the practice. There were actions in place to manage this.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice employed a dispensary manager who was also a pharmacist with independent prescribing rights. They ran clinics which were available to all patients who were seeking advice with regard to their medication as well as supporting medicines optimisation for specific cohorts including patients with long term conditions.

The pharmacist had overseen continuous quality improvement programs in specific areas such as hypnotic prescribing where the practice, prior to starting this program had prescribing levels which were significantly above the national average. The practice was able to demonstrate similar effectiveness in prescribing with regard to lower inappropriate use of cephalosporin's at 4.74 compared to the national average of 5.33, and higher use of appropriate anti-inflammatories at 84.3 compared to a national average of 75% as a result of quality improvement initiates led by the practice pharmacist.

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners.

The GPs told us they led in specialist clinical areas such as diabetes, heart disease and asthma. They were supported by the practice nurses, which allowed the practice to focus on specific conditions.

One GP had a special interest in sports and exercise medicine. The practice offered a consultant led muscular skeletal service. This service had previously been run as a community clinic funded by the PCT [Primary Care trust and forerunner of the Clinical Commissioning Group (CCG)].

The practice had the services of a physiotherapist available to support and treat patients. The physiotherapist worked in the practice seeing patients on a part-time basis, with the practice having bought in the physiotherapist's services to supplement their work. Two patients spoke very positively about the services provided by the physiotherapist and the positive effect this had and how it had reduced the travel time and increased convenience for them.

Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines for a range of conditions. Our review of the clinical meeting minutes confirmed that this happened and clinical staff throughout the practice said they felt well supported by their colleagues.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes.

National data showed that the practice was performing in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of suspected cancers for example and patients were referred and seen within two weeks.

Management, monitoring and improving outcomes for people

The practice pharmacist supervised a tier 4 anticoagulation service which was not routinely offered by many of the surgeries in the CCG. They were able to demonstrate comprehensive training and supervision of the staff who participated in providing the services. The practice was also able to provide a domiciliary service for its house bound patients.

The practice was able to demonstrate a 100% appropriate prescribing of an antiplatelet medication to patients with atrial fibrillation with national average being 98%.

In addition to being able to demonstrate effective prescribing to patients with vulnerable circumstances, the practice was also able to demonstrate higher levels of comprehensive care planning at 100% for those with complex mental health conditions with the national average being 86%. This was also replicated in care planning for dementia with a practice level of 91% set against a national average of 83%.

The practice showed us five clinical audits that had been undertaken in the last year, and data from the last seven years. Four were completed audits where the practice was able to demonstrate the changes resulting since the initial audit.

For example one audit looked at whether patients with a diagnosis of rheumatoid arthritis had received regular

reviews and were monitored for signs of cardiovascular disease. As a result patients within the practice who had this diagnosis were reviewed, risk assessed and this resulted in patients being recalled for further health checks.

On re-audit the practice were able to demonstrate this group of patients were being pro-actively monitored. Other examples included audits of patients who had gout (a medical condition characterised by recurring episodes of inflammation of the joints, particularly in the lower legs.)

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures).

For example, the Pharmacist (Prescriber) told us there was a regular audit of medicines prescribed within the practice including an audit of the prescribing of analgesics (pain killers) and non-steroidal anti-inflammatory drugs (used to treat inflammation). Following audits by the Pharmacist (Prescriber), we saw the GPs had completed medicine reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines.

The practice used the information collected for the QOF and measured their performance against national screening programmes to monitor outcomes for patients. For example, 95.7% of patients with diabetes had received the influenza vaccine.

The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. GPs maintained records showing how they had evaluated the service and documented the success of any changes. We saw evidence to demonstrate that one GP was particularly pro-active with regard to QOF, and held regular 'how are we driving' meetings with staff. Staff spoke positively about the culture in the practice around audit and quality improvement.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. This was monitored by the Pharmacist (Prescriber).

The Pharmacist (Prescriber) explained that they shared information with GPs from medicines alerts, and the practice's computer system flagged up relevant information when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, they outlined the reason why they decided this was necessary.

The practice was working towards implementing the gold standards framework for end of life care. The practice had a palliative care register and had multidisciplinary meetings to discuss the care and support needs of patients and their families.

The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar practices in the area. This benchmarking data showed the practice had outcomes that were comparable or better than other services in the area. For example data showed that the practice was performing better than the local CCG average and the national (England) average; in relation to the care and treatment of patients with mental health issues, learning disabilities, dementia, diabetes and depression.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed six staff training records and saw that all staff were up to date with attending courses such as annual basic life support.

We noted a good skill mix among the GPs with two having additional diplomas in sexual and reproductive medicine; two with diplomas in children's health and obstetrics, and four with diplomas from the Royal College of Obstetricians and Gynaecologists. Another GP was a consultant in sports and exercise medicine.

All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals which identified learning needs from which action plans were documented. As part of the process nurses said they had completed a

self-assessment with aims and objectives set for their annual appraisal. Our interviews with staff confirmed that the practice was supportive of training and two nurses spoke positively about that support. Three members of the nursing team had attended a recent five day minor injuries and illnesses course and told us they were fully supported by the practice.

As the practice was a training practice, doctors who were training to be qualified as GPs (Registrars) were offered extended appointments and had access to a senior GP throughout the day for support.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post.

The practice had a protocol outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well and the evidence we observed confirmed this was the case.

The practice held weekly multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. On the day of our inspection the meeting had focussed on unplanned admissions (one of the enhanced services) and had been attended by practice staff, the community matron and a respiratory nurse. Decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were in place for making referrals, and the practice used the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that this system was easy to use, and patient feedback was positive.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, and said it was easy to use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. In addition the practice used Docman, a system for scanning and managing documents. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. There was a policy in place in respect of consent to treatment.

The practice had a protocol for the identification and care of vulnerable adults. This included the legal framework for consent and identified the five principles of the Mental Capacity Act (2005). The protocol identified how vulnerable adults would be identified and this would be recorded in their notes. Discussions with GPs, nurses and reception staff identified that they were aware of the protocol, and much of its content.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions.

The practice had patients registered who lived in three local care homes. Senior staff at the care homes confirmed the practice staff were aware of capacity issues and considered these appropriately when considering treatment. Staff we spoke with gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

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

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

Health promotion and prevention

It was practice policy to offer a health check with the health care assistant / practice nurse to all new patients registering with the practice. The GP was informed of any health concerns detected and these were followed up in a timely way. We spoke with a GP who said they used their contact with patients to help maintain or improve mental, physical health and wellbeing.

The practice offered NHS Health checks to all its patients aged 40 to 75 years. A GP showed us how patients were followed up within two weeks if they had risk factors for disease identified at the health check and how they scheduled further investigations.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability or a diagnosis of dementia. Patients with these diagnoses were offered an annual physical health check, usually during the month of their birthday.

The practice had identified that 2.58% of patients over the age of 16 were smokers. This was slightly above (0.1%) the CCG average, but below (3.05%) the national figure for England. The practice actively offered nurse-led smoking cessation clinics to these patients.

The practice's performance for cervical smear uptake was 85.8%, which was above the national average of 82%.

There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend. There was a named nurse responsible for following up patients who did not attend screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was above average for the CCG, and again there was a clear policy for following up non-attenders by the named practice nurse. The practice had guidance for clinical staff in their dealings with young people. Giving particular guidance in relation to contraception, sexual health and the Fraser Guidelines.

For older patients the practice kept a register of patients who were identified as being at high risk of admission to hospital of full time care. Patients who were at the end of their life had up to date care plans, and there were multi-disciplinary palliative care meetings held once every month with relevant health care professionals.

The practice was able to demonstrate effective outcomes for patients with diabetes with figures comparable to the national average except for effective blood pressure control where the practice average was 86% which was above the national average of 79%. Data showed that 96.3% of patients with diabetes had received retinal screening (checking their eyes for diabetes related problems) in the past 12 months which was above the CCG and national averages. In addition, 96.5% of patients had been checked for diabetes related foot problems.

A GP showed us the template used for the annual review of patients who had a diagnosis of dementia. This included a medicines review, blood tests, urine tests as well as a physical examination. Similar templates were used with other vulnerable groups such as patients with learning disabilities and patients experiencing enduring mental health problems.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the 2014 national patient survey. In addition a survey of 111 patients had been undertaken by the practice's patient participation group (PPG).

Patient satisfaction questionnaires had been sent out to patients by each of the practice's partners. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect.

For example, data from the national patient survey showed 93% of practice respondents said the GP was good at listening to them and 90% said the GP gave them enough time. These results were better than the CCG and national average.

We received 19 completed comment cards and 18 contained wholly positive comments about the service experienced. Patients commented the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. One comment card was less positive although this too carried some positive comments.

We spoke with six patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice was actively looking to move to new premises, as the current building did not meet all of their requirements. The waiting room was quite small, and staff acknowledged that confidentiality could on occasions be a problem. However the practice staff were aware of this and took measures to overcome the problem. The phone system was shielded by glass partitions which helped keep patient information private.

The practice had a system to allow only one patient at a time to approach the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

Reception staff said they were aware of patients whose circumstances may make them vulnerable, and a smaller waiting room was available if required for patients who found the main waiting room intimidating or threatening. It was clear that patients from vulnerable groups such as those with learning disabilities or experiencing poor mental health could access the practice without fear of stigma or prejudice. We observed staff treated patients in a sensitive and sympathetic manner.

Care planning and involvement in decisions about care and treatment

The 2014 patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the 2014 national patient survey showed 88% of practice respondents said the GP involved them in care decisions and 94% felt the GP was good at explaining treatment and results. Both these results were above average compared to the CCG area. The results from the practice's own satisfaction survey showed that 96% of patients said the felt their GP listened to them.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was positive and aligned with these views.

Good

Are services caring?

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available. Staff said that there were very few patients who did not have English as their first language.

We saw evidence that older patients and patients with long-term conditions had individual care plans, and patients had been involved in discussing and agreeing these.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day of our inspection and the comment cards we received highlighted that staff responded to patients with care and compassion when they needed help and provided support when required.

The practice tried to provide a personalised service to its older patients by sending a hand written birthday card each year for their 75th birthday signed by their named GP. The card included an invitation to come into the practice for an annual review. During our inspection we saw birthday cards being prepared, and a staff member told us that on average the practice sent out approximately 100 birthday cards each month.

Notices in the patient waiting room, on the TV screen and practice website told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population.

The practice had identified a move to new premises as top of its list of priorities. The practice had outgrown their premises. All of the practice staff and the members of the patient participation group (PPG) confirmed the need to move and they saw this as a priority action.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the PPG. The PPG had made suggestions to improve use of the on-line repeat prescription service. Over time this had increased partly as a result of the PPG making people aware of the service. A meeting with members of the PPG identified that the PPG was fully in support of the practice's plans to move to a new practice building.

Nationally every patient aged 75 years and over should have a named GP with responsibility for their care. The practice had taken this a step further by giving every patient their own named GP irrespective of their age.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. There were protocols in place for the identification of vulnerable adults and the practice provided an enhanced service to patients with a learning disability (an enhanced service is one over and above the basic GP contract.)

The practice was situated in an area of lower deprivation with a score of eight (ten being the least deprived and one being the most deprived). However, GPs identified that there were some pockets of deprivation within the practice area. The Calverton area was not an area with a high population of travellers, migrant workers or homeless people. As a result there were no specific services designed for these groups. However, a GP said that the practice could meet the needs of any of those groups should the need arise.

The practice had a population of 98% English speaking patients but staff had access to online and telephone translation services. Information about this was available in the waiting room, and reception staff were aware of the service and how to access it.

The practice had provided equality and diversity training for staff and refresher training had been booked in the weeks after our inspection visit. Staff we spoke with confirmed that they had completed the equality and diversity training, and that equality and diversity was regularly discussed at staff appraisals.

The practice was situated on the ground and first floors of the building with most services for patients on the ground floor. There was lift access to the first floor. There were wider corridors suitable for prams and patients using wheelchairs which made movement around the practice easier and helped to maintain patients' independence. Accessible toilet facilities were available for all patients attending the practice and there were baby changing facilities available.

Access to the service

Appointments were available from 8:30 am to 6:30 pm on weekdays. The practice closed for staff training on Wednesdays between 1:00 pm and 2:00 pm.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits. The practice planned to offer on-line appointment booking, but this was not yet available.

There were arrangements to ensure patients received urgent medical assistance when the practice was closed and an answerphone message gave the telephone number patients should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were available for patients who needed them and those with long-term conditions. This included appointments with a named GP or nurse. Home

visits were made to three local care homes on a specific day each week, by a named GP and to those patients who needed one. We spoke to the managers of all three care homes and all three were very happy with the service they received. All three spoke positively about the GPs bedside manner, and said that the practice was very good at ringing back if the care home had a query or a concern.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to. They said they could see another doctor if there was a wait to see the doctor of their choice.

The 2014 national patient survey identified that 78% of patients found it easy to get through on the telephone, and 91% said they found the reception staff helpful, in addition 94% said the last appointment they got was convenient. These results were above those for the CCG.

Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. For example, one patient on holiday had felt unwell while travelling home, a call to the practice resulted in an appointment for that evening, and the GP had rung back during the journey home to check how the patient was.

The practice had a nurse led walk in treatment room session, where patients with minor ailments could be seen on the day, without having to make an appointment to see a GP. This was for non-emergencies, and patients said they had found it very useful. This service was available from 8:30 am to 11:00 am

Discussions with GPs identified that home visits for older patients and patients with long-term conditions were available when needed and longer appointments in the practice if needed. For families, children and young people there were appointments available outside of school hours, up until 6:30 pm. For patients of working age and students there were appointments up until 6:30 pm. On-line booking was being introduced.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system. There were leaflets in the waiting room and the practice website, had detailed information including how to contact the Health Service Ombudsman if the complainant was not satisfied the complaint had been dealt with appropriately. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at eight complaints received in the last 12 months and found two complaints had been identified as significant incidents and were discussed in that meeting. Four complaints had been resolved and required no further action, one related to secondary care rather than the practice and one had been made through NHS England and was still on-going. The records showed that the practice had handled the complaints it received in an open and honest way, and learning points where appropriate had been taken and shared with staff.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's strategy and five year business plan. These values were clearly displayed in the waiting areas and in the staff room. The practice vision and values included having an open culture and offering a friendly, caring good quality service that was accessible to all patients and met their healthcare needs.

We saw that the staff and the culture within the practice strongly demonstrated the vision and values however staff were not aware of the formal vision statement. Patients were not made aware of the vision statement. We saw that patients were informed of the level of service they had the right to expect via the practice leaflet, although this did not detail the practice's vision and strategy.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at eight of these policies and procedures. All eight policies and procedures we looked at had been reviewed annually and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead GP for infection control and a GP was the lead for safeguarding. We spoke with eight members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example an audit of patients with gout had resulted in patients with gout being considered as part of the chronic disease birthday review. This allowed clinical staff to ensure that the urate levels (this is levels of uric acid, high levels of which can produce gout) were reviewed as part of the patient's medicines management.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us how risks were managed to address a wide range of potential issues. For example, providing all staff with updates and detailed instructions on how to reset the fire alarm if it activated. We saw that risks were regularly discussed at team meetings. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented.

The practice held bi-monthly governance meetings. We looked at minutes from the last meeting and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly, at least quarterly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example disciplinary procedures, the confidentiality policy and the management of sickness which were in place to support staff. Practice staff said that during their induction they had access to their own hard copy of the staff hand book. The staff hand book was produced by an external company and was not available as an electronic copy.

Practice seeks and acts on feedback from its patients, the public and staff

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received. We looked at the results of the annual patient survey. At a previous patient survey the need to improve communication with patients was highlighted. As a result the practice reviewed the type and provision of patient information available in the practice. In addition a new clinical system which allowed GPs and clinicians greater access to information leaflets was introduced. The practice moved to a new website with links to more information sources for patients.

Are services well-led?

Good

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

The practice had an active patient participation group (PPG). A PPG are a group of patients who work together with the practice staff to represent the interests and views of patients so as to improve the service provided to them. The PPG had been actively looking to recruit more members, including members from younger age groups and from different population groups. To help achieve this a member of the PPG took some surveys to the local sixth form college, to promote interest.

The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys are available on the practice website.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at six staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training, and gave examples of training courses they had attended which had been funded or supported by the practice.

The practice was a GP training practice and qualified doctors (registrars) from the Nottingham vocational training scheme spend between four and 12 months gaining experience in general practice. Medical students regularly attended the practice to observe GP consultations. The practice participated in research projects approved by the Local Research Ethics Committee. Information about training was available for patients on the practice website. The practice served as a placement for student nurses.