DRHC Ltd, known as Grange Farm 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	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Outstanding
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Grange Farm Medical Centre on 20 July 2016. Overall the practice is rated as Good.

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

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events and near misses, and we saw evidence that learning was applied.
- There was easy access to appointments for patients with a range of appointments on offer, including a daily morning drop in clinic with an advanced nurse practitioner and telephone consultations, reducing waiting times for patients. This was evident from the above average patient satisfaction results from the national survey.
- The practice responded to the needs of their patients by offering services which were no longer commissioned locally, such as a non-fee paying toe nail cutting service for the elderly in need of foot care.
- The practice supported patients to live healthier by offering a weekly Lifechangers Class, a weight management and healthy eating clinic. Feedback from patients indicated they had achieved positive outcomes from the class.
- The practice planned and co-ordinated patient care with the wider multi-disciplinary team to deliver effective and responsive care to keep vulnerable patients safe.
- 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).
- The practice actively reviewed complaints to see if there were any recurrent themes, and identified issues where learning could be applied to improve patient experiences in the future.
- The practice had a clear vision which had quality and safety as its top priority. The strategy to deliver this vision was documented and reviewed by the management on a regular basis and staff told us that they were well-supported and felt valued by the partners.

Summary of findings

We also found some outstanding features as follows:

- The practice is rated Outstanding for caring. There was evidence of a caring approach to patients through offering various support groups for patients and carers on site, such as the support group for relatives of patients with Alzheimer's and the Admiral Nurses clinics.
- The practice was awarded the 'You're Welcome' status for meeting the criteria for young people friendly health services. Teenage patients were actively encouraged to use online services to book their own appointments to ensure they were involved in their healthcare.

However, the areas where the provider should make improvements are:

- Consider enhancing the security arrangements for signed uncollected prescriptions out of hours, and arrangements for regular monitoring of patients who have not collected them.

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 open culture in which all safety concerns reported by staff were dealt with effectively, and a system was in place for reporting and recording significant events.
- These were investigated and lessons were shared at team meetings to make sure action was taken to improve safety in the practice.
- When things went wrong patients received reasonable support 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 designated leads in areas such as safeguarding children and infection control with training provided to support their roles.
- Risks to patients were recognised by all staff and were well managed. The practice had effective systems in place to deal with emergencies, and arrangements for managing medicines. However, there were uncollected signed prescriptions, including those for controlled drugs, which were kept in the reception area and not locked away at the end of the day. In addition, the practice had not checked if patients still needed the prescriptions for over three months. The arrangements were reviewed on the day and the practice procedure was updated showing the uncollected prescriptions would be locked away and checked at regular intervals.

Are services effective?

Good

The practice is rated as good for providing effective services.

- 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.
- Data showed that the practice was performing broadly in line with local practices on QOF indicators, although the overall achievement was marginally lower than the CCG average . Patient outcomes for indicators such as heart failure and hypertension were better than the local CCG averages.
- Clinical audits demonstrated quality improvement. The practice had undertaken a number of audits in the last year, some of which were completed this year.

Summary of findings

- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs. Formal monthly multidisciplinary meetings were held to discuss patients at high risk of admission to hospital.

Are services caring?

Outstanding ☆

The practice is rated as outstanding for providing caring services.

- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care. For example, 98% of patients said the last nurse they saw or spoke to was good at treating them with care and concern, compared to the CCG average of 91% and national average of 91%.
- There were several support groups initiated by the practice, for example support groups for patients with dementia and their carers, including clinics by Admiral Nurses for patients who were carers.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. This aligned with feedback from completed comment cards.
- 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.
- Views of external stakeholders were positive and aligned with our findings.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- Patients said they found it easy to make an appointment with a nurse practitioner or a GP, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice offered a range of services within its premises such as the acupuncture service. Patients were encouraged to self-refer to the service as well as to counselling and physiotherapy services.
- Extended opening hours were offered to facilitate access for working patients.

Summary of findings

- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

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

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- 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 practice meetings.
- The provider was aware of and complied with the requirements of the duty of candour. The practice encouraged a culture of openness and honesty. The practice had systems in place for reviewing 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. There was a well engaged patient participation group (PPG) which influenced practice development.
- The practice was committed to continuous improvement and engaged in pilot schemes to enhance their skills.

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.

- The practice offered proactive, personalised care to meet the needs of the older people in its population. They offered home visits, same day telephone appointments and urgent appointments for those with enhanced needs. Phlebotomy, ear syringing, joint injections and chronic disease monitoring.
- Home visits were offered to housebound patients.
- The practice provided an in-house toe nail cutting service which was not funded by the NHS, to enable better foot care in the elderly. Seven 30 minute appointments were provided weekly, and there was no fee charged to patients using the service.
- The GPs discussed elderly patients who may be at risk of being vulnerable with multi-disciplinary teams including district nurses, social workers and local care coordinators, to ensure patient needs were met and referrals to other services were made promptly.
- All over 75s had a named GP for continuity of care. There were 227 patients aged 75 years and over, 75% of whom had been invited for annual health checks in the preceding 12 months as part of the chronic disease management recall system.
- Practice supplied data showed 55% of eligible patients were given flu vaccinations and these included patients over 65 years old.
- Nationally reported data showed that outcomes for patients for conditions commonly found in older people, including heart failure were in line with or above local and national averages.
- There were two GPs experienced in providing joint injections at the practice, with additional support provided by a GP with specialist training at their 'sister practice' Derby Road Health Centre, reducing the need to go to hospital for the service.
- The practice had good access for wheelchairs and height adjustable couches for patients who may need them.
- We saw evidence of collaborative working with the district nurses and community matrons, particularly for palliative patients using the Gold Standard Framework (GSF). The Nottinghamshire Electronic Palliative Care Co-ordination Systems (ePaCCs) register and Special Patient Notes were used to ensure effective communication between agencies including the Ambulance Service and out of hours GP service.

Summary of findings

People with long term conditions

Good

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

- The practice had a recall system for patients with long term conditions, audited on a monthly basis to identify patients who are due for a review. Patients were sent reminders in the month of their birthday to attend an annual check, which incorporated a review of their long term conditions, and those who did not attend were followed up to book another appointment.
- All clinical staff had various roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- A structured annual review was carried out 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.
- There was evidence of coordinated care with multi-disciplinary teams between the nursing staff and community matrons, diabetic specialist nurses, respiratory specialist nurses and care coordinators to improve the outcomes for the patients, with most of the allied health professionals using the practice rooms for their clinics.
- There were a large number of leaflets providing education and self-care advice and patients were directed to online resources. A specialist diabetes nurse visited the practice regularly to review more complex patients and provide support to the nursing staff.
- QOF (Quality Outcomes Framework) achievement on indicators for diabetes was consistently in line with CCG averages. For example, the percentage of patients with diabetes on the register who had influenza immunisations in the preceding 12 months was 93%, compared to a CCG average of 93% and national average of 94%.
- Longer appointments and home visits were available and offered when needed.
- The practice provided weight management clinics with referrals offered to local gyms for exercise. They promoted self-referral to services such as acupuncture, podiatry, physiotherapy and psychological therapies, some of which had clinics offered in the practice premises.

Families, children and young people

Outstanding

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

Summary of findings

- The practice worked closely with midwives, health visitors and family nurses attached to the practice. 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.
- The practice held meetings every six weeks with the health visitor and midwife, and also reviewed any children on a child protection plan at their clinical meetings.
- The health visiting service held weekly drop in clinics on Wednesday afternoons from the practice which ran concurrently with the midwife's antenatal clinic. This was used as an opportunity for the different agencies to share information and coordinate care. In addition, the health visitors delivered the 'Baby, Birth and Beyond' antenatal course from the practice premises.
- Immunisation rates were in line with the CCG averages for standard childhood immunisations. Vaccination rates forchildren under two years ranged from 81% to 100%, compared a gainst a CCG average ranging from 91% to 96%.
- The premises were suitable for children and babies. Baby changing facilities were available and the practice accommodated mothers who wished to breastfeed.
- Appointments were available outside of school hours with urgent appointments available on the day for children and babies.
- The practice was awarded the 'You're Welcome' status for meeting the criteria for young people friendly health services. Teenage patients were actively encouraged to use online services to book their own appointments to ensure they were involved in their healthcare.
- There was a full range of family planning services offered to patients of the practice and those registered elsewhere, which included fitting of intra-uterine devices (coil), contraceptive implant fitting and emergency contraception. Urgent same day sexual health appointments were available.
- A common childhood illnesses booklet was available in the waiting area, which contained information for parents and carers of children on managing health at home and using the various health services.

Working age people (including those recently retired and students)

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

Good

Summary of findings

- 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. This included access to appointments after 5pm every day and telephone appointments. The practice opened until 8pm on Wednesdays.
- Online appointments services included booking and cancelling appointments, and ordering prescriptions. Additionally, there was a 24 hour automated telephone booking and cancelling of appointments service. Mobile phone text reminders were used for appointments, including the option to cancel an appointment via text.
- There was a full range of health promotion and screening information in the practice that reflects the needs for this population group. Services provided from the premises included phlebotomy, sexual health, dermatoscopy and minor surgery provided by the practice in-house at Derby Road Health Centre, and physiotherapy, smoking cessation, and counselling provided by commissioned services.
- The practice supported patients returning to work after illness through referrals to the Fit for Work service, with self-referrals encouraged. Practice supplied data indicated six patients had been referred by the practice to the service.
- The practice's uptake for cervical screening for eligible patients was 88%, higher than the CCG average of 81% and the national average of 82%. Breast cancer screening was marginally lower than the CCG and national averages, and bowel cancer screening data was higher than the CCG and national averages. They were aware of their performance and offered more opportunistic testing to improve uptake rates.
- There were services tailored to the needs of younger patients. For example, the practice provided a meningitis vaccination for students going to university for the first time up to 25 years old, sexual health screening and C cards, which is a scheme for the provision of free condoms.

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. In addition to this register, there was a 'Tender Loving Care' list for people who needed extra support, for example, people at risk of harm due to illness and those newly diagnosed with cancer. Patients on this list had a code entered on their medical records

to ensure all staff were aware of their needs. They were offered 'open' appointments to attend the practice whenever they felt they needed to see a healthcare professional, in addition to having a named GP or nurse who saw them on a regular basis.

- Practice supplied data indicated there were 22 patients on their learning disabilities register, and 15 had been reviewed in a face to face appointment in 2015/16.
- There were 6 patients registered with the practice who were resident in a local care home for people with learning disabilities. Feedback from one care home indicated a named GP carried out regular review visits and responded to urgent requests promptly when required to ensure continuity of care.
- The practice offered longer appointments for patients with a learning disability and for those who required it.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients. Formal monthly multidisciplinary meetings were held to discuss patients at high risk of admission to hospital. In addition, palliative patients were reviewed at weekly GP meetings.
- 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.
- All staff had received training in domestic violence and one of the GPs had specialist training in drug misuse. They told us they informed vulnerable patients about how to access various support groups and voluntary organisations.
- Staff told us they were aware of how to access interpreting and text talk services for their patients with hearing impairment and there was a hearing loop in the practice. An interpreter could be arranged for those who could not speak in English through Language Line.
- Staff told us they were high referrers to a local social organisation which encourages social interaction to reduce isolation.
- The practice adapted their facilities to ensure they were accessible to disabled patients. Staff told us they were awarded a five-star rating for their access by an independent provider of access information for disabled people.
- The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 43 patients as carers (1.2% of the practice list).

Summary of findings

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).

- Data showed in 2014/15 there were 75% of patients diagnosed with severe mental health condition who had a comprehensive agreed care plan documented in their records in the last 12 months, compared to the CCG average of 84% and national average of 88% in 2014/15.
- In 2014/15, 56% of patients diagnosed with dementia had been reviewed in a face to face review in the preceding 12 months, compared to the CCG and national average of 84%. The practice had reviewed their patient lists and noted the majority of patients had reviews carried out but had not been coded appropriately on the computer system. Practice supplied data indicated this had improved to 69% in 2015/16.
- 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.
- There was a nominated dementia champion in the practice who had personal experience of caring for someone experiencing the condition. They offered support to patients and their carers about how to access various support groups and voluntary organisations. There were leaflets for mental health wellbeing support services available in the reception area.
- Staff had a good understanding of how to support people experiencing poor mental health, including young patients who may be at risk of self-harm and require urgent access to see the GPs. Patients were encouraged to self-refer to counselling services. Staff told us they routinely flag patients who have had recent poor mental health episodes and contact them for support.
- The practice had participated in a research project on young people at risk of harm, which involved local practices engaging in audits and peer discussions.

Summary of findings

What people who use the service say

The national GP patient survey results were published on 7 July 2016. The results showed the practice was performing mostly above local and national averages. 313 survey forms were distributed and 105 were returned. This represented a response rate of 34% and 3% of the total patient list lize.

- 80% of patients found it easy to get through to this practice by phone compared to the CCG average of 72% and national average of 73%.
- 96% of patients said the last appointment they got was convenient, compared to the CCG average of 92% and national average of 92%.
- 92% of patients described the overall experience of this surgery as good compared to the CCG average of 85% and national average of 85%.
- 82% 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 77% and national average of 78%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 24 completed comment cards, 23 of which were positive about the care and attention received from the whole practice team. One comment card made negative comments but not specific about the reasons. We spoke to 3 patients including a member of the PPG. There was a common theme around patients being treated with dignity and respect and treated with compassion and kindness, especially by the whole practice team. Patients told us they did not wait for long to be seen even during the drop in clinics.

The results of the practice Friends and Family test taken last year were positive with 96% of respondents saying they would recommend the practice to their friends and family.

DRHC Ltd, known as Grange Farm Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist adviser and a practice manager specialist adviser.

Background to DRHC Ltd, known as Grange Farm Medical Centre

Grange Farm Medical Centre provides primary medical services to approximately 3,500 patients through an alternative provider medical services (APMS) contract, set up by the Derby Road Health Centre practice.

Grange Farm Medical Centre is located in the Bilborough area of Nottingham city centre, approximately four miles from the city centre. It is located within purpose-built premises rented by the practice, built in 2011 when the practice was formed.

The practice deprivation scores indicate people living in the area were significantly more deprived than the CCG and national average. Data shows the proportion of patients aged 18 years and below registered at the practice, is significantly above the CCG and national average. The proportion of patients aged 65 years and above is significantly above the national average but in line with the CCG average.

The medical team comprises of three GPs, an advanced care practitioner, a practice nurse and a health care assistant. They are supported by nine members of the management and administration team. Some staff members including one GP and the management team also work at Derby Road Health Centre, located approximately three miles away. There are two female GPs and one male GP.

The practice is open between 8am and 6.30pm Monday to Friday. Appointment times start at 9am and the latest appointment offered at 5.50pm daily. There is a daily drop in clinic with the nurse practitioner where patients presenting before 11.30am are guaranteed to be seen within the morning. The practice provides the extended hours service, closing at 8pm on Wednesdays.

When the surgery is closed, patients are advised to dial NHS 111 and they will be put through to the out of hours service which is provided by Nottingham Emergency Medical Services.

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.

Detailed findings

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 20 July 2016. During our visit we:

- Spoke with a range of staff (GPs, nurse, administrative staff) 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

The practice had 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 were recording forms available in the practice. There was a comprehensive incident management procedure in place.
- The practice adopted a blame free culture once a significant event had been reported and supported staff through an investigation into the event. All significant events were discussed at monthly team meetings and were a standing item on the agenda. Staff told us they felt comfortable with raising concerns at any time. Minutes were recorded and shared with the practice team.
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, 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. Lessons learned were shared through discussion at routine meetings and training sessions.

Overview of safety systems and processes

The practice demonstrated they 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. There was a lead GP responsible for child and adult safeguarding and staff were aware of whom this was. 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. All staff had received training relevant to their role and GPs were trained to the appropriate level to manage child safeguarding (level 3) .
- A notice in the waiting room advised patients that chaperones were available if required. Staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. One of the practice nurses was the infection control clinical deputy lead (the lead was based at Derby Road Health Centre) 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. Bi-annual infection control audits were undertaken, and we saw evidence that action was taken to address any improvements identified as a result.
- We reviewed five employment files for clinical and non-clinical staff. We found all of the appropriate recruitment checks had been undertaken prior to employment. Checks undertaken included proof of identification, references, qualifications, registration with the appropriate body and the appropriate checks through the Disclosure and Barring Service (DBS).
- There were arrangements in place for managing medicines, including emergency medicines and vaccines to ensure the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). However, on the day of the inspection we found there were uncollected signed prescriptions, including those for controlled drugs, which were kept in the reception area and not locked away at the end of the day. In addition, the practice had not checked if patients still needed the prescriptions for over three months. The arrangements were reviewed on the day and the practice procedure was updated showing the uncollected prescriptions would be locked away and checked at regular intervals.
- Processes were in place for handling repeat prescriptions which included the review of high risk medicines. 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. The Health Care Assistant was trained to administer vaccines and medicines against a patient specific prescription or direction from a prescriber.

Good

Are services safe?

- The system in place for acting on information received from the Medicines and Healthcare Regulatory Agency (MHRA) was managed centrally at Derby Road Health Centre, and circulated to all GPs. There was evidence of how they had responded to alerts in checking patients' medicines and taking actions to ensure they were safe.

Monitoring risks to patients

Risks to patients and staff were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a comprehensive health and safety policy available 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 skill 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.
- 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. First aid kit and accident books were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the 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 and a copy of the plan was kept off site.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice staff demonstrated that they assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including the local Clinical Commissioning Group (CCG) and 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 through email notifications, and regular meetings were held within the practice for both GPs and nursing staff which helped to ensure staff were aware of changes and updates.
- The practice monitored that these guidelines were followed through risk assessments, audits and checks of patient records.

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 showed that the practice had achieved 88.8%. This was slightly lower than the CCG average of 91.5% and the national average of 94.8%. The exception reporting rate was 17.1%, compared to the CCG average of 8.9% and national average of 9.2% (The exception reporting rate is the number of patients which are excluded by the practice when calculating achievement within QOF where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects.). A review of the exception reporting data showed that the practice was following guidance in relation to excepting patients (when they have declined three invitations for a review), and this was clinically driven. However, further discussions revealed some patients were being excluded too early in the year, therefore the practice missed out on opportunities to review the patients for QOF when they attended appointments after they had already been excluded.

Data from 2014/15 showed:

- Performance for diabetes related indicators was 86.5%, which was above the CCG average of 79% and marginally below the national average of 89%. The exception reporting rate for diabetes indicators was 19%, which was significantly higher than the CCG average of 10% and national average of 11%. The practice attributed their results to poor engagement of young patients with diabetes care who did not attend screening appointments. They told us they continued to work with integrated diabetes service to encourage patients to attend.
- Performance for mental health related indicators was 82.8%, below the CCG average of 89% and the national average of 93%. The exception reporting rate was 28%, which significantly higher than the CCG and national average of 11%.
- Performance for hypertension related indicators was 100%, better than the CCG average of 97% and national average of 95%. The exception reporting rate was 10%, higher than the CCG and the national average of 4%.

There was evidence of quality improvement including clinical audits.

- There had been five clinical audits undertaken in the last year and two of these were completed audits where the improvements made were implemented and monitored. For example, an audit was completed to review the provision of contraceptive implants. The practice analysed the reasons for removal, retention rates and any failures resulting in pregnancy. A repeat of the audit showed that the practice offered patients advice and alternative methods of contraception, where they decided to have their implants removed.
- Another audit had been carried out on the prescribing of methotrexate, a medicine classed as high risk, to check if NICE guidance was being followed appropriately. Other audits included minor surgery, urgent dermatology referrals.
- The practice participated in local audits, national benchmarking, accreditation and peer reviews. There was evidence of regular engagement with the CCG on medicines management and involvement in peer reviews.

Staff were proactive in supporting people to live healthier lives, with a focus on early identification and prevention

Good

Are services effective?

(for example, treatment is effective)

and treatment within primary care. The practice regularly assessed their performance in areas such as Accident and Emergency (A&E) attendances and emergency admissions. For example:

- Between April 2015 and March 2016, an average of approximately 309 patients per 1000 attended the A&E department, compared to a CCG average of approximately 250 patients per 1000. The practice was ranked 49 out of 58 practices for A&E attendances. The practice noted residents in the area had historically been the highest attenders at the A&E department, and encouraged them to make use of the daily drop in clinics if they felt they needed urgent medical help.
- Between May 2015 and April 2016, the practice was ranked lowest in the CCG for emergency admissions relating to Ear, Nose and Throat infections, and third lowest for overall emergency preventable admissions.

Vulnerable patients at risk of admission to hospital were managed proactively through the unplanned admissions register enhanced service. Under this service, all visit requests from patients on the register were triaged promptly and arrangements were in place to ensure they were seen as appropriate.

Effective staffing

We saw staff had a range of skills, knowledge and experience to deliver effective care and treatment.

- The practice had a comprehensive induction programme for all newly appointed staff including locum doctors. 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, staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence.
- 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, protected learning time, clinical supervision and facilitation and support for revalidating GPs and nurses. All staff had received an appraisal within the last 12 months.

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 made use of the close communication with the community teams who used rooms in the surgery by making referrals promptly and discussing them in person.
- Administration staff called patients to make appointments to review their medicines where they noticed repeat prescription requests, did not match with the medicines usually issued together. This encouraged patient's cooperation with their therapy.
- The practice had a system linking them to the hospitals so that they were able view test results completed in hospital instead of waiting to receive discharge letters. The GP out of hours service used the same clinical system as the practice, therefore sharing patient information occurred seamlessly.
- GPs had a buddy system for review of test results which ensured that results were viewed and acted upon on the day of receipt, and patients were informed in a timely manner if the initiating GP was away from the practice.
- Staff told us they worked collaboratively and were supported by the community care coordinator, district nursing team and community matrons and met regularly to coordinate care. We saw evidence of collaborative working with the district nurses and community matrons, particularly for palliative patients using the Gold Standard Framework (GSF). The Nottinghamshire Electronic Palliative Care Co-ordination Systems (ePaCCs) register and Special Patient Notes were used to ensure effective communication between agencies including the Ambulance Service and out of hours GP service.

Good

Are services effective?

(for example, treatment is effective)

Vulnerable patients were discussed at the monthly multidisciplinary meetings attended by a GP, community nurse, community matron and care coordinator with actions recorded for each patient.

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. We saw evidence of meetings 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

Staff were proactive in identifying patients who may be in need of extra support to live healthier lives and promote their health and wellbeing. For example:

- The practice held a weekly weight management clinic called The Lifechangers Class to support patients who wanted to lose weight, maintain their weight and/or learn about healthy eating. Patients were able to exchange recipes and there were regular food taster sessions during the clinics. A scale was available in the waiting area for patients who wished to weigh themselves.
- The practice promoted referrals to a local intervention service for patients at risk of cardiovascular disease, aimed at increasing patient physical activity levels and reduce the likelihood of getting the condition.
- A common childhood illnesses booklet was available in the waiting area, which contained information for parents and carers of children on managing health at home and using the various health services.
- The practice offered NHS health checks and alcohol screening to encourage healthy lifestyles and early detection of any potential long term conditions. There were 213 patients aged 40 to 75 years who were offered a health check in the preceding 12 months, and 57% of them attended for a health check. In addition to this, the practice offered a range of services such as smoking cessation, family planning, asthma clinics and child health surveillance.

The practice's uptake for the cervical screening programme was 88%, which was higher than the CCG average of 81% and the national average of 82%. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. For example, the proportion of patients who were screened for breast cancer in the previous 36 months was 61%, compared with a CCG average of 70% and a national average of 72%. Practice supplied data indicated breast cancer screening had improved to approximately 75% in 2015/16, although this was yet to be verified and published. The practice was aware of their performance and staff told us they were actively recalling patients and offering opportunistic checks when patients attended appointments for other reasons, in order to improve uptake.

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. Practice supplied data indicated 96% of patients over 16 years had their smoking status recorded, some of whom had accessed New Leaf smoking cessation services and 70 of them had quit smoking in the preceding 12 months.

Childhood immunisation rates for the vaccinations given were broadly in line with CCG averages. For example, vaccination rates for children less than two years ranged from 81% to 100%, compared to the CCG average ranging

Good

Are services effective?

(for example, treatment is effective)

from 91% to 96%. Vaccination rates for five year olds ranged from 85% to 97%, compared to the CCG average of 87% to 95%.The practice attributed their success to their active recall system and easy access to appointments.

Patients had access to appropriate health assessments and checks. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Outstanding ☆

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.

We received 24 completed comment cards, most of which were positive about the care and attention received from the whole practice team. There was a common theme around patients being listened to and given enough time during appointments. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

The practice regularly obtained patient feedback through their own patient feedback cards, asking for patients to comment on their visit and suggestions for improvement. Feedback from patients who used the service, carers and community teams was continually positive about the way staff treated people. Examples included:

- A health care assistant initiated a support group for patients caring for relatives with Alzheimer's after she noticed they were going through similar experiences. She arranged a group session with support agencies using practice premises, and offered patients the opportunity to meet for support on an ongoing basis.
- Other support groups organised by staff using practice rooms free of charge included inviting all patients with fibromyalgia to a coffee morning with an invited guest speaker who provided advice on diet and exercises. A group for people with disabilities was held every first Friday of the month.
- Staff delivered a prescription to an elderly patient's home on a cold Friday evening so that they did not spend the weekend without their medicine, or risk falling over on the ice attempting to collect the prescription from the practice.
- A GP visited a palliative care patient on his day off to discuss the patient's condition with their family because it was the most convenient time for the family.
- Staff regularly offered to look after young children attending the practice with their parents, whilst the parents had uninterrupted consultations with the GPs.
- GPs were described as approachable, respectful and very caring when treating patients in care homes.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice satisfaction scores were mostly above national averages. For example:

- 92% of patients said the GP was good at listening to them compared to the CCG average of 87% and the national average of 89%.
- 90% of patients said the GP gave them enough time, which was above the CCG average of 86% and national average of 87%.
- 90% of patients said they had confidence and trust in the last GP they saw compared to the CCG and national average of 95%.
- 87% of patients said the last GP they spoke to was good at treating them with care and concern which was above the CCG and national average of 85%.
- 98% of patients said the last nurse they spoke to was good at listening to them compared to the CCG and national averages of 91%.
- 85% of patients said they found the receptionists at the practice helpful compared to the CCG average of 88% 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.

Outstanding ☆

Are services caring?

Patient feedback from the comment cards we received was also positive and aligned with these views. Patients felt referrals were made appropriately and they were educated in the management of their long term conditions. 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 above local and national averages. For example:

- 90% of patients said the last GP they saw was good at explaining tests and treatment, which was above the CCG average of 85% and national average of 86%.
- 85% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG and national average of 82%.
- 97% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 86% and national average of 85%.
- 99% of patients said the last nurse they saw was good at explaining tests and treatment, which was above the CCG and national average of 90%.

Staff told us that translation services were available for patients who did not have English as a first language and used sign language services for deaf patients. Double appointments were provided for patients where an interpreter was involved.

Patient and carer support to cope emotionally with care and treatment

The practice engaged the Admiral Nurse service offered by Dementia UK to support carers and families affected by dementia, providing specialist assessment and identifying needs of the families from diagnosis to post bereavement support. The nurses held clinics once a month from the practice offering hour long appointments.

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.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 43 patients as carers (1.2% of the practice list). They were offered information about support groups at registration and there was a dedicated carers' champion with experience of caring for someone with dementia, who held monthly coffee mornings for patients with dementia and their carers. The practice told us they were working on identifying more carers, and had a dedicated carers section on their website as well as posters in the waiting room providing contact details for carers support groups.

Staff told us they were confident in recognising people in difficulty and those who could not cope with making appointments, allowing them to present themselves at reception and then ask the GPs to fit them in where possible.

Staff told us that if families had experienced bereavement, their usual GP contacted them by telephone and sent bereavement cards. Patients were offered referrals to specialist bereavement services including young bereavement services. We saw several examples of staff offering bereavement support by visiting families and offering comfort within the practice.

Good

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.

The practice worked to ensure its services were accessible to different population groups. For example:

- The practice offered a range of appointments which included telephone appointments, same day urgent and pre-bookable appointments. The practice remained open at lunch time, allowing patients access to the practice all day. There were longer appointments available for patients who needed them and they were encouraged to request longer appointments if required.
- There was a daily drop in clinic with an advanced nurse practitioner to ensure contact with patients was consistent, and those acutely unwell were guaranteed to be seen.
- The practice created services in response to the needs of their patients. For example the HCA provided a toe nail cutting service after the local community Falls healthcare team highlighted foot care concerns in the elderly, and the service was no longer provided by the local chiropody team. The HCA used the service to discuss patients' social support needs and flagged vulnerable patients to the GPs where appropriate.
- Staff monitored their QOF performance by carrying out opportunistic checks and reminding patients to attend their reviews when they presented in the practice, so that patients were not excluded because of non-attendance.
- The practice self-funded an extra contraceptive services session every month to meet the demand for coil fittings, because they provided the service to patients registered with the practice and elsewhere. Urgent same day appointments for sexual health were available with the nurse.
- The practice hosted physiotherapy clinics provided twice a week from the surgery premises. Patients were encouraged to self-refer to the service as well as smoking cessation, alcohol management, counselling, acupunctureand weight management clinics all hosted by the practice.
- 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 with medical problems that required same day consultation with an on call doctor. Drop in baby clinics were also offered on Wednesday afternoons.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately.
- There were disabled facilities, including dedicated parking; disabled access and toilet. Corridors and doors were accessible to patients using wheelchairs.
- The practice signed up to provide all additional services offered through the Any Qualified Provider services commissioned by their CCG, to ensure all services were available for registered and non-registered patients. These included phlebotomy, ear syringing, treatment room services and electrocardiography (ECGs: a process of recording electrical activity of the heart).
- All nursing staff were trained to carry out audiometry hearing tests to reduce the number of unnecessary visits to the hospital, with referrals made if further specialist assessment was required. This was a non-NHS funded service offered to benefit patients.

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday. Appointment times started at 9am and the latest appointment offered at 5.50pm daily. There was a daily drop in clinic in the mornings ran by the advanced nurse practitioner, who was able to issue prescriptions and make referrals for further specialist treatment if required. In addition to pre-bookable appointments that could be booked up four weeks in advance for the GPs, urgent appointments were available for people who needed them. Patients could access appointments online and request repeat prescriptions using the electronic prescriptions service. The practice provides the extended hours service closing at 8pm on Wednesdays.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was above local and national averages.

- 86% of patients were satisfied with the practice's opening hours, compared to the CCG average of 78% and the national average of 76%.
- 80% of patients said they could get through easily to the practice by phone compared to the CCG average of 72% and the national average of 73%.
- 70% of patients said they 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 the national average of 85%.
- 83% of patients described their experience of making an appointment as good, compared to the CCG and national average of 73%.

The results above concurred with feedback from patients we spoke to which indicated they were able to get appointments when they needed them, and they were happy with the daily drop in clinics.

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 in the reception area.

We looked at 7 complaints received in the last 12 months and found these were satisfactorily handled and dealt with in a timely way. Lessons were learnt from individual concerns and complaints and also from analysis of trends, and actions were taken to as a result to improve the quality of care. Apologies were given to people making complaints where appropriate. Complaints were discussed at meetings so that any learning is shared and changes to policies and procedures are implemented as a practice team.

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. The management of the practice was overseen by GP partners of Derby Road Health Centre, most of who had been with the practice for a long time, an arrangement which promoted stability of the team, and there was evidence of succession planning to maintain this structure for the foreseeable future.

- The practice had a mission statement centred on making a difference to the health outcomes of the local population by providing patient-centred and innovative care, and promoting professional and personal development of all staff. A patient charter was displayed in the waiting room.
- There was a documented practice strategy for the next two years which was discussed at quarterly away days attended by the GP partners. This included a review of their medical services contract, clinical services, staffing rotas, management structures as well as succession planning.
- There were plans in place to cope with the growing list size, particularly with the imminent closure of a practice in the area. These included extending the Advanced Nurse Practitioner role to full time, recruiting another GP and obtaining training status for doctors training to become GPs.
- The management team were working with the landlord and local providers to negotiate a pharmacy rental in the building adjacent to the practice to meet the needs of their patients.
- The practice website and a printed newsletter were used to keep patients informed of any changes, including changes to the strategy.

Governance arrangements

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

- The practice was overseen by the long established Derby Road Health Centre partnership with regular clinical sessions provided by the clinical lead GP.
- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. All staff had clear responsibilities in both clinical and non-clinical areas.
- There was an appointed Caldicott Guardian within the practice responsible for protecting the confidentiality of patients and enabling appropriate information-sharing.
- Nursing staff held nursing-specific monthly meetings and had supervision to support in their roles. Staff told us they were supported in their training and revalidation. The practice engaged external human resources expertise when required to ensure their management of staff followed best practice.
- GPs met daily to discuss any issues arising relating to patients and the practice.
- Practice specific policies were implemented and were available to all staff on a computer shared drive. We saw various meetings were held between the different staff groups in addition to the whole practice meetings held monthly, where policies and changes were discussed.
- There was a comprehensive understanding of the performance of the practice in respect of QOF achievement, access to appointments and patient satisfaction.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements. Topics of audits were relevant to the care being provided by the practice and were used to drive improvement for the practice.
- There were systems in place for identifying, recording and managing risks, issues and implementing mitigating actions.

Leadership and culture

On the day of inspection the GPs in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. These skills were used in providing care to patients within the practice. One of GPs used her expertise and experience as a trainer at a local contraceptive and sexual health clinic,

Are services well-led?

Good

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

to provide contraceptive services for registered and non-registered patients. Staff told us the GPs and practice manager were approachable and always took the time to listen to all members of staff.

The GPs and management team encouraged a culture of openness and honesty. Constructive challenges from patients, carers and staff were encouraged and complaints were acted on effectively. The practice had systems in place to ensure that when things went wrong with care and treatment:

- 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.
- The practice reviewed all complaints for emerging themes so that lessons could be learned to avoid recurrence.

There was a clear leadership structure in place and staff felt supported by management.

- Staff told us the practice held regular team meetings as a practice, which was evident from the minutes of meetings held.
- 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. They did not feel that a hierarchical structure existed between them and the GPs.
- Staff told us they felt valued by the management team. Milestones and achievements were celebrated as a team and staff received pay rises when appropriate.
- The managers looked at staffing issues and actively provided cover from within the practice during leave of absence, reducing the need for employing additional locum doctors. Staff were trained for multiple roles to build resilience within the team.

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 national patient survey and carried out their own patient surveys on a regular basis, in addition to patient feedback cards which were available in waiting rooms. They reviewed the results at team meetings and discussed ways to continually improve the results.
- Patient feedback was also gathered through the patient participation group (PPG), who reviewed patient surveys and feedback in order to submit proposals for improvements to the practice management team. The PPG had a membership of approximately seven members who met every three to six months with the assistant practice manager. Minutes were recorded and uploaded on the practice website to ensure they were accessible to all patients. Information about the group was available in the reception area and patients were encouraged to join.
- A member of the PPG told us they used surveys and text messages to gather patient opinions and worked with the practice to implement suggestions. They felt engaged, involved and respected by the management. For example, they were working with the practice to negotiate with the building owners so that they could have a pharmacy located on the premises.
- The PPG sought engagement with the local community by hosting various charity fund raising events with the local Scouts. These included collecting donations for refugee camps in Turkey and hosting weekend car boot sales. There was a party held to celebrate reaching 1000 patients registered with the practice, attended by up to 200 patients.
- There was evidence the practice acted on feedback from patients, for example, by reducing the telephone messages so that callers were put through to the receptionist straight away in response to survey results.
- Feedback from staff was obtained 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 and felt engaged to improve how the practice was run.
- The practice was awarded the Investors in People accreditation, a nationally managed framework which demonstrates that the management adhere to professional standards.

Are services well-led?

Good

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

Continuous Improvement

- There was a focus on continuous learning and improvement at all levels within the practice and the wider local health community. There was a strong focus on staff development. For example, some of the nurses had been supported in enhancing their roles by undertaking prescribing courses, and worked closely with local specialist nurses who assisted them in the management of chronic diseases such as diabetes and heart disease.
- The practice team were forward thinking and part of local pilot schemes to improve outcomes for patients in the area. For example, one of the GPs led on a research project on young people from poor backgrounds at risk of self-harm, in collaboration with the University of Nottingham, which involved local practices engaging in audits and peer discussions.