Cheviot Medical Group

Quality Report

Cheviot Primary Care Centre
Padgepool Place
Wooler
Northumberland
NE71 6BL
Tel: 01668281575
Website: www.cheviotmedicalgroup.co.uk

Date of inspection visit: 23 and 24 October 2014
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We inspected the practice on 23 and 24 October 2014. We inspected this service as part of our new comprehensive inspection programme. Overall, we rated the practice as good. Our key findings were as follows:

- Patients reported good access to the practice, including the provision of same day appointments for those with urgent needs;
- Patients reported they were treated with kindness and respect, and received safe care and treatment which met their needs;
- Patient outcomes were either in line with, or better than average, when compared to other practices in the local Clinical Commissioning Group (CCG) area;
- Practice staff followed guidance produced by the National Institute for Health and Care Excellence (NICE) when providing care and treatments to patients;
- The practice was involved in research to help improve the treatment they provided to their patients;
- The practice was clean and hygienic, and good infection control arrangements were in place;
- The practice learned from significant events and incidents and took action to prevent their recurrence;
- The practice was well-led, and had good governance arrangements and staff felt well supported.

We saw an area of outstanding practice:

- Cheviot Medical Group is an accredited research and training practice and runs a number of research studies at any one time.

However, there was also an area of practice where the provider could make improvements:

- The practice should review its systems and processes for the safe handling of prescriptions to make sure it complies with guidance issued by NHS Protect in August 2013 regarding the security of prescription forms.

Professor Steve Field CBE FRCP FFPH FRCGP

Summary of findings

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 safe.

Data showed patient outcomes for effective were either in line with, or better than average, when compared to other practices in the local Clinical Commissioning Group (CCG) area. Patients' needs were assessed and care was planned and delivered in line with current legislation, and best practice guidance produced by the National Institute for Health and Care Excellence (NICE.) Staff had received training appropriate to their roles and responsibilities. Arrangements had been made to support clinicians with their continuing professional development. There were systems in place to support effective multi-disciplinary working with other staff in the area. Staff had access to the information they needed to deliver effective care and treatment

Are services effective?

Good

The practice is rated as good for effective. We have also awarded an outstanding rating for the research being carried in relation to one of the population groups.

Data showed patient outcomes for effective were either in line with, or better than average, when compared to other practices in the local CCG area. Patients' needs were assessed and care was planned and delivered in line with current legislation, and best practice guidance produced by the NICE. Staff had received training appropriate to their roles and responsibilities. Arrangements had been made to support clinicians with their continuing professional development. There were systems in place to support effective multi-disciplinary working with other staff in the area. Staff had access to the information they needed to deliver effective care and treatment.

Are services caring?

Good

The practice is rated as good for caring.

Data showed patient outcomes for caring were either in line with, or better than average, when compared to other practices in the local CCG area. Patients said they were treated with compassion and were involved in making decisions about their care and treatment. Arrangements had been made to ensure their privacy and dignity was respected. Patients had access to information on health

Summary of findings

promotion and advice when needed, and they received support to manage their own health and wellbeing. Staff demonstrated they understood the support patients needed to cope with their care and treatment.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive.

Data showed patient outcomes were either in line with, or better than average, when compared to other practices in the local CCG area. Services had been planned so they met the needs of older patients, and those with long-term conditions. Initiatives were also in place to meet the needs of other key population groups. Patients were able to access appointments in a timely way. They reported good access to the practice and told us urgent same day appointments were always available. The practice had taken steps to reduce emergency admissions for patients with complex healthcare conditions, and older patients had been given a named GP to help promote continuity of care. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to any issues raised.

Are services well-led?

Good

The practice is rated as good for well-led.

The leadership, management and governance of the practice assured the delivery of person-centred care which met patients' needs. The practice had a clear vision for improving the service and promoting good patient outcomes, including the making of plans to provide patients with access to their medical records. An effective governance framework was in place. Staff were clear about their roles and understood what they were accountable for, and also felt well supported. The practice had a range of policies and procedures covering the activities of the practice, and these were regularly reviewed. Systems were in place to monitor, and where relevant, improve the quality of the services provided to patients. The practice actively sought feedback from patients and used this to improve the services they provided.

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 patients.

Nationally reported data showed the practice had achieved good outcomes in relation to the conditions commonly associated with older people. The practice offered proactive, personalised care to meet the needs of older people. It provided a range of enhanced services including, for example, end of life care and a named GP who was responsible for their care. Clinical staff had received the training they needed to provide good outcomes for older patients.

People with long term conditions

Outstanding

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

Nationally reported data showed the practice had achieved good outcomes in relation to those patients with commonly found long-term conditions. The practice had taken steps to reduce unplanned hospital admissions by improving services for patients with complex healthcare conditions. All patients on the practice's long-term conditions registers received healthcare reviews that reflected the severity and complexity of their needs. Person-centred care plans had been completed for each patient. These included details of the outcome of any assessments patients had undergone, as well as the support and treatment that would be provided by the practice. The practice nurse had received the training they needed to provide good outcomes for patients with long-term conditions. Cheviot Medical Group had been accredited as a research practice and was carrying out research to help improve patient outcomes.

Families, children and young people

Good

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

Nationally reported data showed the practice had achieved good outcomes in relation to child health surveillance, contraception and maternity services. Systems were in place for identifying and following-up children who were considered to be at risk of harm or neglect. For example, the needs of all at-risk children were regularly reviewed at multidisciplinary meetings involving child care professionals, such as school nurses and health visitors. Appointments were available outside of school hours and the

Summary of findings

premises were suitable for children and babies. Arrangements had been made for new babies to receive the immunisations they needed. New mothers had access to twice monthly child development clinics, where child health checks were carried out by a health visitor. Ante-natal clinics were also provided.

Working age people (including those recently retired and students)

Good

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

The needs of this group of patients had been identified and steps taken to provide accessible and flexible care and treatment. The practice was proactive in offering on-line services to patients. Repeat prescriptions could be ordered, and appointments booked, on-line. Appointments were available until 6.00pm each weekday and an extended hours service was provided once a week. Health promotion information was available in the waiting area and on the practice web site. The practice provided additional services such as travel information and vaccinations, smoking cessation support and minor surgery.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of patients whose circumstances may make them vulnerable.

The practice had achieved good outcomes in relation to meeting the needs of patients with learning disabilities. The practice held a register which identified which patients fell into this group, and used this information to ensure they received an annual healthcare review and access to other relevant checks and tests. Staff worked with multi-disciplinary teams to help meet the needs of vulnerable patients. The practice sign-posted vulnerable patients to various support groups and other relevant organisations. Staff knew how to recognise and report signs of abuse in vulnerable adults and children. They were also aware of their responsibilities regarding information sharing when reporting a concern and how to contact relevant agencies, in and out of hours.

People experiencing poor mental health (including people with dementia)

Good

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

The practice had achieved good outcomes in relation to meeting the needs of patients with mental health needs. The practice kept a register of these patients which it used to ensure they received

Summary of findings

relevant checks and tests. Where appropriate, a comprehensive care plan had been completed for patients who were on the register. The care plans had been agreed with patients and their carers. The practice referred patients with alcohol and drugs addictions to appropriate support services. The practice regularly worked with multi-disciplinary teams to help meet the needs of vulnerable patients.

Summary of findings

What people who use the service say

During the inspection we spoke with five patients and reviewed eight Care Quality Commission (CQC) comment cards completed by patients. The feedback we received indicated most patients were satisfied with the care and treatment they received. Patients told us they received a good service which met their needs. They said they were treated with dignity and respect and they felt their privacy was protected. We received positive feedback about the practice's appointment system and patients told us they found it easy to get through to the practice on the telephone. Patients said they were able to obtain an appointment within a reasonable amount of time.

Findings from the 2014 National GP Patient Survey for the practice indicated a high level of satisfaction with the care and treatment it provided. For example, of the patients who responded:

- 97% said they found it easy to get through to the practice by telephone;
- 95% said the GP they saw, or spoke to, was good at listening to them, and they had confidence and trust in them;
- 85% said they were satisfied with the practice's opening hours;
- 86% said they would recommend the surgery to someone new to the area.

All of the above results were higher than the CCG regional averages. These results were based on 108 surveys that were returned from a total of 244 sent out. The response rate was 44%. Information from a survey of patients carried out by the practice in 2013, showed the majority of patients were satisfied with the reception area and access to information.

Areas for improvement

Action the service SHOULD take to improve

- The practice should review its systems and processes for the safe handling of prescriptions to make sure it complies with guidance issued by NHS Protect in August 2013 regarding the security of prescription forms.

Outstanding practice

- Cheviot Medical Group is an accredited research and training practice and runs a number of research studies at any one time.

Cheviot Medical Group

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a GP.

Background to Cheviot Medical Group

The practice is one of two based at the Cheviot Primary Care Centre in the centre of Wooler. Services are provided from:

Cheviot Primary Care Centre

Padgepool Place

Wooler

Northumberland

NE716BL

The practice is a rural dispensing practice and covers the North Northumberland area. It provides services to 2,467 patients of all ages based on a Primary Medical Services (PMS) contract agreement for general practice.

The practice occupies part of a large purpose built building. The building also accommodates district nursing, physiotherapy and chiropody staff, as well as a 24-hour emergency ambulance service. A range of services and clinics are provided including, for example, clinics for patients with heart disease, hypertension and asthma. The practice consists of two GP partners (one male and one female), a practice manager, a practice nurse (female), and a small team of reception and dispensing staff. The practice is part of NHS Northumberland Clinical Commissioning Group (CCG). The practice has a higher percentage of patients in the over 65 age group. It also has lower levels of income deprivation for both children and older people than the England average.

When the practice is closed patients can access out-of-hours care via Northern Doctors and the NHS 111 service. An 'extended hours' service is available one evening a week for patients who are unable to attend the practice during its usual opening hours.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

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, we always ask the following five questions of every service and provider:

Detailed findings

• 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 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
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Before visiting we reviewed a range of information we held about the practice and asked other organisations to share what they knew about the services it provided. We carried out an announced inspection on 23 and 24 October 2014. During this we spoke with a range of staff including both GP partners, a GP Specialist Registrar, the practice manager, the practice nurse and staff who worked in the reception and dispensing team. We spoke with a member of the practice's Patient Participation Group (PPG), and five patients who visited the practice on the day of our inspection. We reviewed eight CQC comment cards where patients had shared their views and experiences of the service with us. We also observed how patients were being cared for and looked at some of the records kept by the practice.

Are services safe?

Our findings

Safe Track Record

When we first registered this practice in April 2013, we did not identify any safety concerns that related to how it operated. Also, the information we reviewed as part of our preparation for this inspection did not identify any concerning indicators relating to the safe domain. The Care Quality Commission (CQC) had not been informed of any safeguarding or whistle-blowing concerns regarding patients who used the practice. The local Clinical Commissioning Group (CCG) did not raise any concerns with us about how this practice operated.

The practice used a range of information to identify potential risks and to improve quality in relation to patient safety. This information included, for example, significant event reports, national patient safety alerts, and comments and complaints received from patients. Staff we spoke to were aware of their responsibilities to raise concerns and knew how to report incidents and near misses.

We saw that records were kept of significant events. We reviewed significant event reports completed by practice staff over the previous 12 months, and the minutes of meetings where these were discussed. These showed the practice had managed such events consistently and appropriately during the period concerned and this provided evidence of a safe track record for the practice.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. All of the staff we spoke with were aware of the system in place for raising issues and concerns.

Records were kept of significant events that had occurred during the last 12 months and these were made available to us. Those we looked at included details about what the practice had learned from these events, as well as information about the changes that had been introduced to prevent further reoccurrences.

The practice also reported incidents to the local CCG, using the local safeguarding incident reporting system. This required them to grade the degree of risk using a traffic light system, and score the potential impact of the incident on patients using their service. We were told that, where significant events or incidents had occurred, these would be discussed at the relevant practice staff meeting. There was evidence that appropriate learning from incidents had taken place and that the findings were disseminated to relevant staff. For example, one significant event report stated staff had been reminded of the importance of checking patient's identification, to help ensure they received the right care from the right member of staff.

National patient safety alerts were disseminated by the practice manager to the relevant staff. For example, medicines related safety alerts were forwarded to the medicines manager for action. The practice manager was able to give examples of recent alerts and how these had been responded to. We were told where safety alerts affected the day-to-day running of the practice, all staff would be advised via an email or in a practice meeting.

Reliable safety systems and processes including safeguarding

The practice had systems in place to manage and review risks to vulnerable children, young people and adults. Safeguarding policies and procedures were in place and these had been reviewed within the previous 12 months. These included, for example, a factsheet for identifying self-harming and suicidal behaviour in children and young people.

Practice training records showed all staff had received relevant, role specific training on safeguarding. For example, both GPs partners had completed Level 3 child protection training, to enable them to fully carry out their safeguarding duties and responsibilities. We confirmed that the GP Registrar had also recently completed their safeguarding training. Staff we spoke with were aware of which GP had lead safeguarding responsibilities.
Non-clinical staff had also completed basic safeguarding awareness training. The practice nurse had also completed Level 3 child protection training. They told us they knew how to recognise and report signs of abuse in vulnerable adults and children. They were also aware of their responsibilities regarding the reporting of safeguarding concerns and sharing information within the practice and with other relevant professionals. Information about how to report safeguarding concerns and contact the relevant agencies was easily accessible. We saw evidence which confirmed that practice staff had identified a potential safeguarding concern and had taken appropriate action to protect a patient's health and wellbeing.

Are services safe?

A chaperone policy was in place and information about this was displayed in the reception area. Chaperone training had been undertaken by all staff who carried out chaperone duties. This was confirmed by the practice nurse.

Patients' records were kept on an electronic system. This system stored all information about patients, including scanned copies of communications from hospitals. Audits had been carried out to ensure they were comprehensive and up-to-date. There was a system on the practice's electronic records to highlight vulnerable patients. Children and vulnerable adults who were assessed as being at risk were identified using READ codes. These codes alerted clinicians to their potential vulnerability. (Clinicians use READ codes to record patient findings and any procedures carried out).

Systems were in place which ensured any incoming safeguarding information was scanned to patients' medical records. We were told the GPs attended child protection case conferences when they were given sufficient notice. Where this was not possible, we were told the GP partners would provide the local social services staff with the information they requested prior to the start of the meeting.

The practice manager confirmed the practice had not been involved in any serious case reviews. A system was in place to follow up children who failed to attend appointments to help ensure they did not miss important immunisations.

Practice staff used their multi-disciplinary team (MDT) meetings to review each patient considered to be at risk and, where appropriate, to share any relevant information they had access to. A member of staff told us that, prior to the monthly MDT meetings, the practice manager ran a search of the records to identify all patients considered to be at risk of harm or neglect.

Medicines Management

We checked medicines stored in the dispensing room and found they were stored securely and were only accessible to authorised staff. Records were kept of all medicines received into the dispensary and stock control ensured older stocks of medicines were used first. Arrangements had been made to ensure the dispensary maintained sufficient stocks of medicines, especially in advance of foreseeable poor weather where it might be difficult to replenish stocks. We identified a minor concern about the arrangements for monitoring the temperatures of medicines. We shared this with the practice manager who agreed to address this matter following our inspection.

Processes were in place to check medicines were within their expiry date and suitable for use. Records confirming these checks were undertaken were in place. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of promptly.

The practice had made arrangements which ensured the cold chain was maintained for the storage of vaccines and other medicines requiring refrigeration. (A cold chain is an uninterrupted series of storage and distribution activities which ensure and demonstrate that a medicine is always kept at the right temperature.) Refrigerator temperature checks were carried out daily and stock control was practised. Vaccines were administered by the practice nurse. We confirmed they had received appropriate training in how to do this.

There was a protocol for repeat prescribing which we saw being followed in practice. The protocol provided dispensing staff with guidance about how to handle requests for repeat prescriptions, and any changes requested. This helped to ensure patients' repeat prescriptions were still appropriate and necessary. We observed staff taking telephone requests for repeat prescriptions. They checked the patient's electronic records to confirm the requested medicines had been placed on repeat by their GP. Dispensing staff at the practice were aware prescriptions should be signed by one of the GP partners before being dispensed. Dispensing staff placed each signed prescription in a small tray into which they then placed the labelled medicines. Each tray was then checked by another trained member of staff prior to dispensing. We observed staff dealing with repeat prescriptions in a competent manner. These procedures demonstrated that the practice followed a safe process for handling requests for repeat prescriptions.

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 procedures that set out how they were managed. These were being followed by the practice staff. For example, the keys to the controlled drugs cupboard were

Are services safe?

kept secure at all times, and a log was maintained by dispensary staff each time they took responsibility for the keys. There were arrangements in place for the destruction of controlled drugs.

Dispensing staff maintained an error and near-misses log. This contained details of any concerns that had occurred and what action was taken in relation to them. A member of the dispensing team told us all errors were reported to the local CCG using the Safeguarding Incident and Risk Management System. This system requires the member of staff completing the form to identify and record any actions that have been taken to minimise the risk of reoccurrence, and to confirm that the risk has been addressed. We identified that some of the 'near-misses' recorded were as a result of dispensing staff nearly dispensing the wrong quantities of medicines. We saw these had been identified before the patients received their medicines and had been recorded in a 'near-misses' log. The practice manager told us that all 'near-misses' were audited and acted upon by the practice's medicines manager.

Blank prescription forms were kept securely at all times. However, we did note they were not tracked through the practice in accordance with national guidance. The practice manager agreed to address this matter following the inspection.

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. This rewards practices for providing high quality services to patients of their dispensary. We saw records showing all members of staff involved in the dispensing process had received appropriate training and had regular checks of their competence in the form of an appraisal.

Cleanliness & Infection Control

The premises were clean and hygienic throughout. There was an infection control policy (and associated procedures) setting out the standards of cleanliness and hygiene expected of staff. The practice nurse acted as the infection control lead providing additional guidance and advice to staff when needed.

Cleaning schedules were in place and records were kept of the cleaning that had been carried out. Patients told us the practice was always clean. Staff had completed infection control training that was relevant to their role. A representative from a local hospital trust had recently carried out an infection control audit which covered all aspects of the running of the practice. We saw the practice was assessed as being 100% compliant with the standards that were looked at.

Practice staff confirmed they had access to the personal protective equipment they needed to provide safe care such as, for example, disposable gloves and aprons. The practice nurse was able to describe how they used these to prevent the spread of infection. Hand hygiene signage was displayed in staff and patient toilets. There were hand washing sinks, antiseptic gel and hand towel dispensers in the treatment and consultation rooms.

We saw records indicating that an external agency had carried out regular checks of the water system to prevent the growth of legionella. (Legionella is a bacteria found in the environment which can contaminate water systems in buildings).We contacted this agency and they confirmed a legionella risk assessment had been completed and tests had been carried out to check for the presence of the bacteria.

Minor surgery was carried out in one of the treatment rooms. The room was suitably equipped and the surfaces, including the floor covering, were easy to clean. The practice nurse confirmed they had access to all of the cleaning materials they needed to maintain the treatment room in a hygienic condition. They spoke knowledgeably about what cleaning they undertook and why this was important. We did not identify any concerns.

Equipment

Staff told us they had access to the equipment they needed to carry out diagnostic examinations, assessments and treatments. They said all the equipment was inspected and maintained regularly and we saw records confirming this. For example, all the portable electrical equipment had been tested within the last 12 months. Fire equipment checks were carried out regularly and a fire risk assessment had been completed. Current gas safety and electrical installation certificates were in place.

Staffing & Recruitment

The practice had a recruitment policy which provided clear guidance about the pre-employment checks that should be carried out. The sample of records we looked at contained evidence that such checks had been undertaken prior to the appointment of staff. These included, for

example, references from previous employers and criminal records checks via the Disclosure and Barring Service (DBS.) Non-clinical staff working at the practice had not undergone a DBS check. A risk assessment to determine which staff were eligible for a DBS check and at what level had not been carried out. We checked the General Medical and Nursing and Midwifery Councils' records and confirmed all of the clinical staff were licensed to practice. All the staff carried NHS Smart cards which contained a recent identification photograph. We were told staff's identities had been verified under the NHS Employment Check Standards process.

The practice manager told us about the arrangements for planning and monitoring the number and mix of staff needed to meet patients' needs. Regular locums who knew the practice and how it operated, covered the leave arrangements for both GP partners. The practice nurse told us that, although their clinics were always busy, they had sufficient hours to carry out the chronic disease management, and other clinical work they were contracted to provide. Cover was not provided when the practice nurse was on leave. We were told patients' needs could be met without this being provided.

Monitoring Safety & Responding to Risk

The practice had systems and policies in place to manage and monitor risks to patients, staff and visitors to the practice. This included carrying out monthly and annual checks of the premises and equipment. The practice had a health and safety policy which provided staff with guidance about their role and responsibilities, and what steps they should take to keep patients safe. The premises were safe and free from hazards. Staff told us the practice was a safe place to work. None of the patients we spoke to raised any concerns about health and safety.

Risk assessments had been completed identifying a range of potential hazards and the action taken to minimise or manage them. Staff knew how to identify and respond to changing risks to patients. For example, arrangements were in place to reduce unplanned admissions into hospital for patients with long-term conditions. Emergency care plans were in place for the practice's high risk patients. These had been linked to patients' medical records to help ensure a rapid medical response when this was needed.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing the majority of staff had received training in basic life support, provided by the North East Ambulance Service paramedic based the Centre. Plans had been made for the practice nurse to update their cardiopulmonary resuscitation training.

Emergency equipment was available in the Centre, including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). The staff we spoke to knew the location of this equipment and records we saw confirmed these were checked regularly to make sure they were in good working order.

Emergency medicines were stored securely so that only practice staff could access them. These included medicines for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Emergency oxygen was also available. Arrangements were in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date. Practice staff were aware of where the emergency medicines were kept.

There was a business continuity plan for dealing with a range of potential emergencies that could impact on the daily operation of the practice. Mitigating actions had been recorded to reduce and manage the risk. Risks identified included incapacity of the GP partners and the loss of the practice building. The plan contained relevant contact details for staff to refer to, for example, contact details of the company responsible for servicing the building.

Are services safe?

Our findings

Safe Track Record

When we first registered this practice in April 2013, we did not identify any safety concerns that related to how it operated. Also, the information we reviewed as part of our preparation for this inspection did not identify any concerning indicators relating to the safe domain. The Care Quality Commission (CQC) had not been informed of any safeguarding or whistle-blowing concerns regarding patients who used the practice. The local Clinical Commissioning Group (CCG) did not raise any concerns with us about how this practice operated.

The practice used a range of information to identify potential risks and to improve quality in relation to patient safety. This information included, for example, significant event reports, national patient safety alerts, and comments and complaints received from patients. Staff we spoke to were aware of their responsibilities to raise concerns and knew how to report incidents and near misses.

We saw that records were kept of significant events. We reviewed significant event reports completed by practice staff over the previous 12 months, and the minutes of meetings where these were discussed. These showed the practice had managed such events consistently and appropriately during the period concerned and this provided evidence of a safe track record for the practice.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. All of the staff we spoke with were aware of the system in place for raising issues and concerns.

Records were kept of significant events that had occurred during the last 12 months and these were made available to us. Those we looked at included details about what the practice had learned from these events, as well as information about the changes that had been introduced to prevent further reoccurrences.

The practice also reported incidents to the local CCG, using the local safeguarding incident reporting system. This required them to grade the degree of risk using a traffic light system, and score the potential impact of the incident on patients using their service. We were told that, where significant events or incidents had occurred, these would be discussed at the relevant practice staff meeting. There was evidence that appropriate learning from incidents had taken place and that the findings were disseminated to relevant staff. For example, one significant event report stated staff had been reminded of the importance of checking patient's identification, to help ensure they received the right care from the right member of staff.

National patient safety alerts were disseminated by the practice manager to the relevant staff. For example, medicines related safety alerts were forwarded to the medicines manager for action. The practice manager was able to give examples of recent alerts and how these had been responded to. We were told where safety alerts affected the day-to-day running of the practice, all staff would be advised via an email or in a practice meeting.

Reliable safety systems and processes including safeguarding

The practice had systems in place to manage and review risks to vulnerable children, young people and adults. Safeguarding policies and procedures were in place and these had been reviewed within the previous 12 months. These included, for example, a factsheet for identifying self-harming and suicidal behaviour in children and young people.

Practice training records showed all staff had received relevant, role specific training on safeguarding. For example, both GPs partners had completed Level 3 child protection training, to enable them to fully carry out their safeguarding duties and responsibilities. We confirmed that the GP Registrar had also recently completed their safeguarding training. Staff we spoke with were aware of which GP had lead safeguarding responsibilities.
Non-clinical staff had also completed basic safeguarding awareness training. The practice nurse had also completed Level 3 child protection training. They told us they knew how to recognise and report signs of abuse in vulnerable adults and children. They were also aware of their responsibilities regarding the reporting of safeguarding concerns and sharing information within the practice and with other relevant professionals. Information about how to report safeguarding concerns and contact the relevant agencies was easily accessible. We saw evidence which confirmed that practice staff had identified a potential safeguarding concern and had taken appropriate action to protect a patient's health and wellbeing.

Are services safe?

A chaperone policy was in place and information about this was displayed in the reception area. Chaperone training had been undertaken by all staff who carried out chaperone duties. This was confirmed by the practice nurse.

Patients' records were kept on an electronic system. This system stored all information about patients, including scanned copies of communications from hospitals. Audits had been carried out to ensure they were comprehensive and up-to-date. There was a system on the practice's electronic records to highlight vulnerable patients. Children and vulnerable adults who were assessed as being at risk were identified using READ codes. These codes alerted clinicians to their potential vulnerability. (Clinicians use READ codes to record patient findings and any procedures carried out).

Systems were in place which ensured any incoming safeguarding information was scanned to patients' medical records. We were told the GPs attended child protection case conferences when they were given sufficient notice. Where this was not possible, we were told the GP partners would provide the local social services staff with the information they requested prior to the start of the meeting.

The practice manager confirmed the practice had not been involved in any serious case reviews. A system was in place to follow up children who failed to attend appointments to help ensure they did not miss important immunisations.

Practice staff used their multi-disciplinary team (MDT) meetings to review each patient considered to be at risk and, where appropriate, to share any relevant information they had access to. A member of staff told us that, prior to the monthly MDT meetings, the practice manager ran a search of the records to identify all patients considered to be at risk of harm or neglect.

Medicines Management

We checked medicines stored in the dispensing room and found they were stored securely and were only accessible to authorised staff. Records were kept of all medicines received into the dispensary and stock control ensured older stocks of medicines were used first. Arrangements had been made to ensure the dispensary maintained sufficient stocks of medicines, especially in advance of foreseeable poor weather where it might be difficult to replenish stocks. We identified a minor concern about the arrangements for monitoring the temperatures of medicines. We shared this with the practice manager who agreed to address this matter following our inspection.

Processes were in place to check medicines were within their expiry date and suitable for use. Records confirming these checks were undertaken were in place. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of promptly.

The practice had made arrangements which ensured the cold chain was maintained for the storage of vaccines and other medicines requiring refrigeration. (A cold chain is an uninterrupted series of storage and distribution activities which ensure and demonstrate that a medicine is always kept at the right temperature.) Refrigerator temperature checks were carried out daily and stock control was practised. Vaccines were administered by the practice nurse. We confirmed they had received appropriate training in how to do this.

There was a protocol for repeat prescribing which we saw being followed in practice. The protocol provided dispensing staff with guidance about how to handle requests for repeat prescriptions, and any changes requested. This helped to ensure patients' repeat prescriptions were still appropriate and necessary. We observed staff taking telephone requests for repeat prescriptions. They checked the patient's electronic records to confirm the requested medicines had been placed on repeat by their GP. Dispensing staff at the practice were aware prescriptions should be signed by one of the GP partners before being dispensed. Dispensing staff placed each signed prescription in a small tray into which they then placed the labelled medicines. Each tray was then checked by another trained member of staff prior to dispensing. We observed staff dealing with repeat prescriptions in a competent manner. These procedures demonstrated that the practice followed a safe process for handling requests for repeat prescriptions.

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 procedures that set out how they were managed. These were being followed by the practice staff. For example, the keys to the controlled drugs cupboard were

Are services safe?

kept secure at all times, and a log was maintained by dispensary staff each time they took responsibility for the keys. There were arrangements in place for the destruction of controlled drugs.

Dispensing staff maintained an error and near-misses log. This contained details of any concerns that had occurred and what action was taken in relation to them. A member of the dispensing team told us all errors were reported to the local CCG using the Safeguarding Incident and Risk Management System. This system requires the member of staff completing the form to identify and record any actions that have been taken to minimise the risk of reoccurrence, and to confirm that the risk has been addressed. We identified that some of the 'near-misses' recorded were as a result of dispensing staff nearly dispensing the wrong quantities of medicines. We saw these had been identified before the patients received their medicines and had been recorded in a 'near-misses' log. The practice manager told us that all 'near-misses' were audited and acted upon by the practice's medicines manager.

Blank prescription forms were kept securely at all times. However, we did note they were not tracked through the practice in accordance with national guidance. The practice manager agreed to address this matter following the inspection.

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. This rewards practices for providing high quality services to patients of their dispensary. We saw records showing all members of staff involved in the dispensing process had received appropriate training and had regular checks of their competence in the form of an appraisal.

Cleanliness & Infection Control

The premises were clean and hygienic throughout. There was an infection control policy (and associated procedures) setting out the standards of cleanliness and hygiene expected of staff. The practice nurse acted as the infection control lead providing additional guidance and advice to staff when needed.

Cleaning schedules were in place and records were kept of the cleaning that had been carried out. Patients told us the practice was always clean. Staff had completed infection control training that was relevant to their role. A representative from a local hospital trust had recently carried out an infection control audit which covered all aspects of the running of the practice. We saw the practice was assessed as being 100% compliant with the standards that were looked at.

Practice staff confirmed they had access to the personal protective equipment they needed to provide safe care such as, for example, disposable gloves and aprons. The practice nurse was able to describe how they used these to prevent the spread of infection. Hand hygiene signage was displayed in staff and patient toilets. There were hand washing sinks, antiseptic gel and hand towel dispensers in the treatment and consultation rooms.

We saw records indicating that an external agency had carried out regular checks of the water system to prevent the growth of legionella. (Legionella is a bacteria found in the environment which can contaminate water systems in buildings).We contacted this agency and they confirmed a legionella risk assessment had been completed and tests had been carried out to check for the presence of the bacteria.

Minor surgery was carried out in one of the treatment rooms. The room was suitably equipped and the surfaces, including the floor covering, were easy to clean. The practice nurse confirmed they had access to all of the cleaning materials they needed to maintain the treatment room in a hygienic condition. They spoke knowledgeably about what cleaning they undertook and why this was important. We did not identify any concerns.

Equipment

Staff told us they had access to the equipment they needed to carry out diagnostic examinations, assessments and treatments. They said all the equipment was inspected and maintained regularly and we saw records confirming this. For example, all the portable electrical equipment had been tested within the last 12 months. Fire equipment checks were carried out regularly and a fire risk assessment had been completed. Current gas safety and electrical installation certificates were in place.

Staffing & Recruitment

The practice had a recruitment policy which provided clear guidance about the pre-employment checks that should be carried out. The sample of records we looked at contained evidence that such checks had been undertaken prior to the appointment of staff. These included, for

example, references from previous employers and criminal records checks via the Disclosure and Barring Service (DBS.) Non-clinical staff working at the practice had not undergone a DBS check. A risk assessment to determine which staff were eligible for a DBS check and at what level had not been carried out. We checked the General Medical and Nursing and Midwifery Councils' records and confirmed all of the clinical staff were licensed to practice. All the staff carried NHS Smart cards which contained a recent identification photograph. We were told staff's identities had been verified under the NHS Employment Check Standards process.

The practice manager told us about the arrangements for planning and monitoring the number and mix of staff needed to meet patients' needs. Regular locums who knew the practice and how it operated, covered the leave arrangements for both GP partners. The practice nurse told us that, although their clinics were always busy, they had sufficient hours to carry out the chronic disease management, and other clinical work they were contracted to provide. Cover was not provided when the practice nurse was on leave. We were told patients' needs could be met without this being provided.

Monitoring Safety & Responding to Risk

The practice had systems and policies in place to manage and monitor risks to patients, staff and visitors to the practice. This included carrying out monthly and annual checks of the premises and equipment. The practice had a health and safety policy which provided staff with guidance about their role and responsibilities, and what steps they should take to keep patients safe. The premises were safe and free from hazards. Staff told us the practice was a safe place to work. None of the patients we spoke to raised any concerns about health and safety.

Risk assessments had been completed identifying a range of potential hazards and the action taken to minimise or manage them. Staff knew how to identify and respond to changing risks to patients. For example, arrangements were in place to reduce unplanned admissions into hospital for patients with long-term conditions. Emergency care plans were in place for the practice's high risk patients. These had been linked to patients' medical records to help ensure a rapid medical response when this was needed.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing the majority of staff had received training in basic life support, provided by the North East Ambulance Service paramedic based the Centre. Plans had been made for the practice nurse to update their cardiopulmonary resuscitation training.

Emergency equipment was available in the Centre, including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). The staff we spoke to knew the location of this equipment and records we saw confirmed these were checked regularly to make sure they were in good working order.

Emergency medicines were stored securely so that only practice staff could access them. These included medicines for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Emergency oxygen was also available. Arrangements were in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date. Practice staff were aware of where the emergency medicines were kept.

There was a business continuity plan for dealing with a range of potential emergencies that could impact on the daily operation of the practice. Mitigating actions had been recorded to reduce and manage the risk. Risks identified included incapacity of the GP partners and the loss of the practice building. The plan contained relevant contact details for staff to refer to, for example, contact details of the company responsible for servicing the building.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent data available for the practice regarding levels of patient satisfaction. This included information from the 2014 National GP Patient Survey and patient surveys carried out by the practice in 2013. The evidence from all these sources showed the majority of patients were satisfied with how they were treated and the quality of the care and treatment they received.

Data from the 2014 National GP Patient Survey showed the practice was rated above the regional Clinical Commissioning Group (CCG) average in most of the areas covered. For example, of the patients who responded: 95% said the last GP they saw, or spoke to, was good at giving them enough time; 83% said the last nurse they saw, or spoke to, was good at listening to them; 94% said the last GP they saw, or spoke to, was good at treating them with care and concern, and 80% said the same in respect of the last nurse they saw or spoke to.

We received eight completed Care Quality Commission (CQC) comment cards. The feedback was positive and no concerns were raised. We also spoke with five patients on the day of our inspection. These patients told us the practice offered a good service and staff were helpful and caring. They said staff treated them with dignity and respect and said that overall they were satisfied with the care provided by the practice.

All consultations and treatments were carried out in the privacy of a consulting or treatment room. There were disposable curtains in these rooms to enable patients' privacy and dignity to be maintained during examinations and treatments. Consultation and treatment room doors were kept closed when the rooms were in use so conversations could not be overheard. In the reception area, a barrier had been placed a small distance away from the reception desk so only one patient could approach the reception desk at a time. This helped to ensure patients could speak to reception staff without being overheard by others.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients were positive 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 GP Patient Survey showed: 82% of respondents said their GP involved them in decisions about their care; 91% felt the GP was good at explaining treatment and results. Both of these responses were above the regional CCG average. The patients who completed CQC comment cards did not raise any concerns about their involvement in decisions about their care and treatment, and neither did the patients we spoke to on the day of our inspection.

Staff told us translation services were available for patients who did not have English as a first language. The practice manager told us staff would arrange for an interpreter to be used where this would help patients to understand the care and treatment options open to them.

Patient/carer support to cope emotionally with care and treatment

We observed patients in the reception area being treated with kindness and compassion by staff. None of the patients we spoke with, or who completed CQC comment cards, raised any concerns about the support they received to cope emotionally with their care and treatment. Notices and leaflets in the waiting room sign-posted patients to a number of relevant support groups and organisations, such as the Alzheimer's Society. The practice website included information for carers such as how to access the Carers Emergency Scheme, Carers Direct and the Princess Royal Trust for Carers. The practice's computer system alerted clinicians if a patient was also a carer, so this could be taken into consideration when clinical staff assessed their needs for care and treatment. We also saw the practice had been awarded a Carers Northumberland Excellence Award (2012-2013). This award recognises people or organisations who do more than what is expected of them to make sure carers are supported and looked after.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Systems were in place to address patients' needs and the practice was responsive to them. The practice had used a risk assessment tool to profile patients according to the risks associated with their conditions. This had enabled staff to identify patients at risk of, for example, an unplanned admission into hospital.

Practice staff supported their Patient Participation Group (PPG) to promote the health and wellbeing of patients living in the Wooler area. We looked at minutes of recent PPG meeting and saw efforts had been made to arrange speakers to help members of the PPG understand how patients' healthcare needs are commissioned and delivered. For example, a member of the local Clinical Commissioning Group (CCG) had given a presentation on health commissioning.

A member of the PPG told us they were in the process of planning a healthcare seminar which the GP partners had agreed to support by, for example, providing funding for the hire of a venue. The PPG had taken advice from the representative of a local community group about the sort of healthcare issues that could be covered during the seminar. We were told leaflets were to be delivered to every household in Wooler and the outlying rural areas inviting local people to attend the seminar. Poster and leaflets were also being prepared to help publicise the event. The focus for the seminar was to cover the wellbeing of men and women, mental health and activities.

The practice had a register of all patients in need of palliative care. Multi-disciplinary team (MDT) meetings took place every week to discuss and review the needs of each patient on the register. We were told care management plans were completed following discussion within the MDT meetings. The needs of palliative care patients were also reviewed at each weekly practice team meeting in order to check if the services being provided were effective in meeting their needs. Community nursing staff looking after the practice's palliative care patients had access to the GP partners' mobile numbers enabling them to obtain any advice and information they needed. Each patient had a care plan which healthcare professionals working at the Centre could access at any time. Following the death of a patient on the palliative care register, the practice arranged a multi-disciplinary meeting to review the support they provided, and whether there was anything that could have been done better.

Arrangements had been made to meet the needs of pregnant women, mothers, children and young people. Patients were able to access maternity services provided by a midwife based at the Berwick Infirmary Hospital. The minutes of a recent primary care team meeting showed that practice staff were provided with updates on the ante-natal support pregnant women received. This included, for example, confirming that Birth to five books are no longer given out, and instead women are referred to the NHS Choices web site where this information can now be accessed.

Pregnant women and new mothers have access to baby change and breastfeeding facilities, and a quiet area. The practice manager confirmed the GPs partners gave pregnant women 'Screening for You and Your Baby' booklets to help them make informed choices about the care and treatment they wanted. New mothers had access to a breast feeding nurse which they were able to access at the practice. Staff at the practice had received a training update on the local breast feeding guidelines delivered by the breastfeeding nurse.

The practice had recently taken on responsibility for delivering the C Card system which provides young people with access to condoms. The practice nurse confirmed they had recently completed the training they needed to deliver this service, and it had been agreed that they would provide this service for the other practice in the building.

The practice had planned its services to meet the needs of the working age population, including those that had recently retired. Of those respondents to the 2014 National GP Patient Survey of the practice: 85% said they were satisfied with the practice's opening times, and 97% described their experience of making an appointment as good.

The practice provided an extended hours service one evening a week to facilitate better access to appointments for working patients. The practice manager told us reception staff were aware that, when offering appointments to patients living in outlying rural areas who did not have transport, they would need to take into account bus arrival times into the village. We were told a lot

Are services responsive to people's needs?

(for example, to feedback?)

of people chose to retire and move to the North Northumberland area, and that the GP partners would use the first appointment to discuss these patients' healthcare needs following their retirement.

The practice website provided working age patients with information about how to book appointments and order repeat prescriptions. Patients had access to a video library which provided helpful advice and information about how to cope with common health problems and long-term conditions. Various healthcare self-assessments were available on the practice website, such as for example, 'Are you a healthy eater'. Patients could also access useful factsheets, such as a shopping planner for health eating and a 'Know the Facts Alcohol Mythbuster'.

The practice had identified those patients who were also carers. This was flagged on the computer system to alert clinicians so it could be taken into account when assessing these patients' care and treatment needs. The GP partners had received a Carers' Northumberland Excellence Award in 2012/2013 which acknowledged the care and support they provided to patients who were also carers. Information about how to access carer support groups was available in the reception area.

The practice worked collaboratively with other agencies and regularly shared patient information to ensure good, timely communication of changes in care and treatment. The practice provided the out-of-hours and emergency care services with access to care plan information, for patients who had palliative care or complex health needs. This enabled these services to access important information about these patients when necessary. The practice manager told us the local out-of-hours service updated patients' medical records following any contact they had had with them. She also said herself, and both GPs, received a summary of any contact patients had with the out-of-hours service so that clinical decisions could be made about whether any follow up was required and who would do this.

Advice on the criteria for requesting a home visit was available on the practice website. GP visits to the one residential care home for older people located within the practice boundary were made when requested. We were told longer appointments were available if patients requested this. Research carried out by the practice concluded that patients were capable of choosing an appropriate consultation length, of either ten or twenty minutes, with a reasonable degree of accuracy.

Turnover of staff at the practice was low. We were told a practice nurse had been recruited over a year ago, but that most other staff, including the GP partners, had worked at the practice for a considerable number of years. The practice manager said the staff group was settled and up to full capacity and that patients were able to access appointments with their preferred GP.

Tackle inequity and promote equality

The majority of patients did not fall into any of the marginalised groups that might be expected to be at risk of experiencing poor access to health care, for example, homeless people and Gypsies and Travellers. We were told the practice took whatever action it could to meet the needs of patients who fell within this population group. For example, homeless people wishing to register with the practice would be allowed to do so even though they did not have a fixed address. The practice had a small number of patients with learning disabilities. Suitable arrangements had been made to meet their needs.

The practice manager told us 'lots of telephone consultations' took place throughout the day with patients who might find it difficult to get into the practice but did not need a home visit. Home visits were offered to patients whose clinical needs met the criteria set out by the practice.

Reasonable adjustments had been made which helped patients with disabilities and patients whose first language was not English to access the practice. The practice premises, and the Centre within which it was located, had been adapted to meet the needs of patients with disabilities. For example, the GP and nurse consultation rooms and the practice reception area were located on the ground floor. A disabled toilet was available, with aids and adaptations and a pull chord alarm. Lift access was provided to the first floor. The waiting area was large enough to accommodate patients with wheelchairs and prams, and enabled easy access to the treatment and consultation rooms. Baby changing facilities were

Are services responsive to people's needs?

(for example, to feedback?)

available. Entrance to the practice was through an automatic door. Disabled parking was available at the front of the building and the pavements were adapted for wheelchair use.

The practice had a very small number of patients whose first language was not English. The practice had access to a telephone translation service but the practice manager said this was seldom used. The practice nurse confirmed they knew how to access this service if they needed to do so.

Access to the service

Appointments were available from 08:30am to 6:00pm each weekday. Extended hours were provided fortnightly for one evening a week between 6:30pm and 8:00pm and patients could access either a GP or a nurse. Patients were able to book appointments by telephone, by visiting the practice or on-line via the practice web site.

Information about how to make appointments was available on the practice website. The practice manager said patients presenting with urgent needs would never be refused a same day appointment. We were also told that if the emergency appointment slots for the day had all been used, the GPs would be tasked to triage urgent requests for an appointment and would always see additional patients on the day when necessary. Additional on-the-day appointments were arranged in advance of, for example, bank holidays, to ensure patient demand could be met. Patients were also able to book appointments up to three months in advance. One of the GP partners we spoke to said 90% of appointment requests were met within 48 hours. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. Information about how to access out-of-hours care and treatment was available on the practice website and in the practice leaflet. When the practice was closed there was an answerphone message giving the relevant telephone numbers patients should ring.

Patients were satisfied with the practice's appointments system. Of the patients who participated in the 2014 National GP Patient Survey: 81% of these who had a preferred GP, usually got to see or speak to that GP; 97% said they found it 'easy' to get through on the telephone to someone at the practice; 85% said the practice opened at times that were convenient to them; 78% said they usually waited 15 minutes or less after their appointment time to be seen, and 76% said that they didn't normally have to wait too long to be seen. We talked to five patients about their experience of using the practice. Three had no concerns about access to appointments. Two said that whilst they were generally happy with the overall care and treatment they received, they felt the practice should offer appointments at the weekend.

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 the contractual obligations for GPs in England. The practice manager was the designated responsible person for handling all complaints.

Information was available to help patients understand the complaints process. Information on the practice website encouraged patients to contact staff if they had a complaint. None of the patients we spoke with said they were aware of the practice's complaints policy. However, they all said they had never had to make a complaint but would feel comfortable in doing so. A suggestions box was available in the waiting area providing patients with an opportunity to raise concerns anonymously.

The practice had not received any formal complaints during the previous 12 months. The practice manager told us they kept a record of any informal concerns raised with them. We looked at the records of these and found they had been dealt with in a timely manner and to the satisfaction of the patient concerned.

Are services well-led?

(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 practice's strategic plan, dated 2013, included details of the steps it would take to deliver its vision and improve the quality of care and treatment provided to patients. The plan included the following aims: 'As a practice we want to embrace opportunities to deliver services based in the local community; we want to work with patients to prioritise and champion the services they need and to be able to set up new and innovative services; the only way to deliver this is to have a motivated, well trained and supported healthcare team who are fulfilled in their work.' Staff told us they knew and understood what the practice was committed to providing and what their responsibilities were in relation to these aims.

Governance Arrangements

The practice had a range of policies and procedures in place concerning its activities and the services it provided to patients. Staff were able to access these via the practice intranet. Some of the policies and procedures we looked at had been reviewed within the previous 12 months. However, for some of the policies and procedures we were given during the inspection, review dates had not been included.

The practice used data from the Quality Outcomes Framework (QOF) to measure their performance. In 2013/14, the QOF measured achievement against 121 indicators. When we checked the most recent information available to us, we saw the practice had achieved the maximum points possible. This confirmed that the practice had delivered care and treatment in line with expected national standards.

We saw that QOF data was discussed at practice management meetings. This helped to ensure all staff were aware of how the practice was performing and to reach consensus about any actions that needed to be taken. Reference to QOF data was also included in the practice's strategic plan, particularly in relation to ensuring they got the most up to date performance information at the earliest possible time. In addition to this, the practice manager regularly reviewed the QOF data in order to identify how outcomes for patients could be maintained or improved. They provided the practice management team with up-to-date feedback regarding the performance of the practice. QOF data confirmed the practice participated in an external peer review with other practices in the same Clinical Commissioning Group (CCG) group, in order to compare data and agree areas for improvement.

The practice had completed a number of clinical audits. We looked at these and saw they had been used to improve the quality of care and treatment given to patients.

The practice had suitable arrangements in place for identifying, recording and managing risks. For example, an up-to-date fire safety risk assessment was in place, and there were risk assessments to minimise the risks associated with the use of IT equipment.

Leadership, openness and transparency

The practice had a clear leadership structure which was known to staff. There were clear lines of accountability with specific tasks being delegated to, and undertaken by, designated staff. For example, one of the GP partners acted as the adult and children's safeguarding lead. The other GP partner was responsible for overseeing training placements at the practice. The staff we spoke to were clear about their own roles and responsibilities. They all told us that they felt valued, well supported and knew who to go to with any concerns.

Regular practice and multi-disciplinary team (MDT) meetings took place where operational issues and patients' needs were discussed. Staff told us there was an open culture within the practice and they were happy to raise issues at team meetings. Practice away days took place. These were used to discuss practice based issues and significant events, and to agree ways of working together to improve how the practice operated and outcomes for patients.

A range of human resource policies and procedures were in place, and these included harassment and bullying at work. Staff we spoke with said they were able to access all the practice policies and procedures via paper based files.

Practice seeks and acts on feedback from users, public and staff

Patients were provided with opportunities to comment on the services provided by the practice. For example, the practice website included a link to the new 'GP Friends and Family Test'. The link encouraged patients to complete a

Are services well-led?

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

one minute on-line questionnaire. The practice carried out a survey of patients in 2013. This focussed on how patients accessed on-line appointments and used the practice website. It also looked at whether patients would be interested in participating in the practice's patient participation group (PPG.) We were told that the feedback provided by 45 patients had been analysed and evaluated, and used to plan how to encourage patients to access the on-line services provided by the practice.

Patients had also been asked to complete a questionnaire about the waiting room and what improvements could be made to this area. The practice had received feedback that information boards could be tidier and patient information could be set out better. We were able to confirm improvements had been made following this survey. For example, we were told all information boards had been tidied up to make them more presentable.

The practice website included information about how to express an interest in joining the PPG. The PPG regularly invited speakers to make presentations to the group. Agendas and meeting minutes for all PPG meetings held had been uploaded onto the website so that patients could find out about the work the group undertook.

The staff we spoke to felt valued and said they felt they were an important part of the practice team. Staff also said team work was good. The practice nurse said the whole team worked well together in a positive manner to deliver good patient care. A member of the reception team said they felt involved in how the practice was managed and services were delivered.

Management lead through learning & improvement

Staff told us the practice supported them to maintain their clinical and professional development through training and mentoring. We looked at a sample of staff files and saw that each member of staff had undergone an appraisal. Staff also told us the practice was very supportive of training and that they had received the training they needed to carry out their roles and responsibilities. The practice had completed reviews of significant events and other incidents, and shared the outcomes with staff via meetings and an annual away day to help ensure the practice improved outcomes for patients.

The practice had achieved accreditation as a training practice. This meant the practice had to meet higher than usual standards of performance in areas such as patient medical records and providing a safe working environment.