Felton Surgery

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?	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 carried out an announced comprehensive inspection at Felton Surgery on 14 February 2017. 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 for reporting and recording significant events.
- Risks to patients and staff were assessed and well managed.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. They had the skills, knowledge and experience to deliver effective care and treatment.
- The practice used the information collected for the Quality and Outcomes Framework (QOF), to monitor and improve outcomes for patients. The practice's overall achievement, for 2015/16, was better than the local clinical commissioning group (CCG) and England averages.
- All staff were actively engaged in monitoring and improving quality and patient outcomes. They were committed to supporting patients to live healthier lives through a targeted and proactive approach to health promotion. This included providing advice and support to patients to help them manage their health and wellbeing.
- Staff had been proactive in identifying patients with complex needs and multiple long-term conditions, to help ensure they received appropriate care planning and treatment.
- Services were tailored to meet the needs of individual people and were delivered in a way that provided flexibility, choice and continuity of care.
- Information about services and how to complain was available and easy to understand.

Summary of findings

- The practice had satisfactory facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt well supported by the management team. The practice had a very effective governance framework, which focussed on delivering safe, good quality care.
- Staff had a clear vision and strategy for the development of the practice and were committed to providing their patients with good quality care and treatment.

There was also an area of outstanding practice:

- The practice had been very proactive in taking steps to reduce emergency attendances by patients into hospital, at a time when the local care trust had seen these increase. They had identified a need to reduce emergency attendances and, to help them do this, they had implemented a new appointment system which provided patients with access to same day care. The practice had then audited the improvement they made and this showed that, although the local hospital trust had seen their emergency admissions rate rise by 3.9%, due to winter pressures, the emergency attendances by patients registered with the practice, had reduced by 14% over the same period of time. This included a 20% reduction in emergency attendances by patients aged over 65 years of age, as well as a 50% reduction in emergency attendances by patients aged under five years of age.

However, there were also areas where the provider should make improvements. The provider should:

- Carry out a recorded risk assessment in relation to any decision made not to obtain a Disclosure and Barring Service check for staff appointed to a particular post.
- Continue to review the practice's carers' register to make sure it accurately reflects the number of patients who are also carers.
- Display in the patient waiting area information about how to make a complaint.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

- There was an effective system for reporting on and learning from significant events. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned when things went wrong and shared with staff to support improvement.
- There was an effective system for dealing with safety alerts and sharing these with staff.
- The practice had clearly defined systems and processes that helped keep patients safe. Individual risks to patients had been assessed and were well managed. For example, there were effective medicines management systems and processes in the dispensary. It was clear that the new provider had been proactive in taking positive action to improve facilities within the dispensary. Also, dispensary staff were very organised, and regularly audited the quality of their work to help promote safe patient care. Required employment checks had been carried out for staff recently appointed by the practice. Clinical equipment had been serviced and, where appropriate, calibrated, to ensure it was safe and in good working order.
- The premises were clean and hygienic, and effective infection control processes were in place.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Staff were highly committed to supporting patients to live healthier lives through a targeted and proactive approach to health promotion. This included providing advice and support to patients to help them manage their health and wellbeing. Staff had been proactive in identifying patients with complex needs and multiple long-term conditions, to help ensure they received appropriate care planning and treatment. They had also taken steps to reduce emergency attendances by patients into hospital at a time when the local care trust had seen these increase, through the implementation of the new Doctor First appointment system and participation in the local clinical commissioning group's (CCG) High Risk Patient Pathway.

Summary of findings

- The practice used the information collected for the Quality and Outcomes Framework (QOF), and their performance against national screening programmes, to monitor and improve outcomes for patients. The practice's overall achievement, for 2015/16, was better than the local CCG and England averages.
- Patients' needs were assessed and care was planned and delivered in line with current evidence based guidance.
- Quality improvement activities, including clinical audits, were carried out to improve patient outcomes.
- Staff worked effectively with other health and social care professionals to ensure the range and complexity of patients' needs were met.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.

Are services caring?

Good

The practice is rated as good for providing caring services.

- There was a strong, visible, person-centred culture. Staff treated patients with kindness and respect and, overall, there were appropriate arrangements for maintaining patient and information confidentiality. Patients we spoke with, and those who had completed a Care Quality Commission comment card, were happy with the quality of the care and treatment they received from clinical staff.
- Data from the NHS National GP Patient Survey of the practice showed patient satisfaction levels regarding the quality of GP and nurse consultations and access to appointments, were similar to the local CCG and national averages.
- Information for patients about the range of services provided by the practice was available and easy to understand.
- Staff had made arrangements to help patients and their carers cope emotionally with their care and treatment.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- Services were tailored to meet the needs of individual people and were delivered in a way that provided flexibility, choice and continuity of care.
- Results from the NHS GP Patient Survey of the practice showed that patient satisfaction levels regarding access to appointments were similar to the local CCG and national averages. However, patients showed high levels of satisfaction in relation to telephone access. The practice had taken proactive steps to improve access by providing patients with

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same day appointments. Data collected during the early phase of the implementation of the Dr First appointment system showed that, after 24 weeks, the proportion of the practice's patient population who had either a face-to-face appointment, or telephone consultation each week, had risen from 3.5% to 10%. This meant that more patients were receiving care and support following the introduction of the new appointment system.

- The practice had satisfactory facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available on the practice's website and was easy to understand. There was evidence the practice had treated the complaints received seriously and made every attempt to resolve them.

Are services well-led?

Good

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

- The GP provider had a clear vision and strategy to deliver high quality care and promote good outcomes for patients.
- There was a clear leadership structure and staff felt well supported by the GP provider and practice manager. The practice had a very effective governance framework, which supported the delivery of their strategy to provide good quality care. This included arrangements to monitor and improve quality and, identify and mitigate potential risks, to help keep patients safe.
- The practice sought feedback from patients via their patient participation group (PPG). They had used patient feedback from the national NHS GP Patient Survey, to help improve the quality of care patients received.
- There was a very strong focus on, and commitment to, continuous learning and improvement at all levels within the practice.
- The provider was aware of, and had complied with, the Duty of Candour regulation. The GP provider and practice manager encouraged a culture of openness and honesty, and ensured that lessons were learned following significant events.

Summary of findings

The six population groups and what we found

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

Older people

Good

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

- The Quality and Outcome Framework (QOF) data, for 2015/16, showed the practice had performed very well, and was above all of the national averages, and most of the local clinical commissioning group (CCG) averages, in relation to providing care and treatment for the clinical conditions commonly associated with this population group.
- The practice offered proactive, personalised care which met the needs of older patients. For example, all patients over 75 years of age had a named GP who was responsible for their care.
- Staff worked in partnership with other health care professionals to ensure that older patients received the care and treatment they needed. The practice team actively participated in the local High Risk Patient Pathway, to help reduce unplanned admissions into hospital. Although the local hospital trust had seen their emergency admissions rate rise by 3.9%, due to winter pressures, the emergency attendances by patients registered with the practice, had reduced by 14% over the same period of time. This included a 20% reduction in emergency attendances by patients aged over 65 years of age.
- The practice participated in regular multi-disciplinary meetings, where the needs of high risk patients were discussed and plans put in place to meet them. There were good palliative care arrangements in place.

People with long term conditions

Good

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

- The QOF data, for 2015/16, showed the practice had performed very well, and was above all of the national averages, and most of the local CCG averages, in relation to providing care and treatment for the clinical conditions commonly associated with this population group.
- Patients with long-term conditions were offered annual reviews, to check that their health needs were being met and they were receiving the right medication. Longer appointments and home visits were available when needed. Patients at risk of an unplanned emergency admission into hospital were identified as a priority.

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- The practice held monthly palliative care meetings, using the Gold Standards Framework guidelines, to help manage the treatment needs of patients requiring end-of-life care. Clinical staff were working towards increasing the number of patients on their palliative care list to include patients with non-cancer diagnoses, to help ensure they received appropriate end-of-life care.

Families, children and young people

Good

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

- There were systems in place to protect children who were at risk and living in disadvantaged circumstances. For example, regular multi-disciplinary safeguarding meetings were held, where the needs of any vulnerable patients were discussed. Staff had completed appropriate safeguarding training.
- Appointments were available outside of school hours and the practice's premises were suitable for children and babies.
- The practice offered contraceptive services, and sexual health information was available in the reception area.
- The local hospital trust had seen their emergency admissions rate rise by 3.9%, due to winter pressures. However, the emergency attendances by patients registered with the practice, had reduced by 14% over the same period of time. This included a 50% reduction in emergency attendances by patients aged under five years of age.
- Nationally reported data showed that outcomes for patients with asthma were above average. The practice had achieved 100% of the QOF points available for providing the recommended care and treatment for patients with asthma. This was 1.1% above the local CCG average and 2.6% above the national average.
- The practice had a comprehensive screening programme. Nationally reported information showed the practice's performance was either above, or similar to, the national averages. For example, the uptake of cervical screening by females aged between 25 and 64, attending during the target period, was in line with the national average, 82.1% compared to 81.8%.
- The practice offered a full range of childhood immunisations and had performed above most of the local CCG averages in delivering these. For example, the immunisation rates for the vaccinations given to children under two years old, ranged from

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91.7% to 100% (the local CCG averages ranged from 95.3% to 98.1%). For five year olds, 100% of the eligible children had been immunised (the local CCG averages ranged from 91.9% to 96.3%).

Working age people (including those recently retired and students)

Good

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

- The practice was proactive in offering online services, as well as a full range of health promotion and screening that reflected the needs of their patients.
- The QOF data, for 2015/16, showed the practice had performed very well, and was above all of the national averages, and most of the CCG averages, in relation to providing care and treatment for the clinical conditions commonly associated with this population group.
- The Doctor First system used by the practice made it easier for working patients to obtain a face-to-face appointment, or a telephone consultation, that suited with their working hours. Extended hours appointments were offered each Tuesday evening until 7:30pm. Patients were able to use on-line services to request prescriptions.

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 registers of patients living in vulnerable circumstances, so clinical staff could take this into account when providing care and treatment to these patients. Patients with learning disabilities were provided with access to an annual healthcare appointment where their needs could be reviewed to ensure they were being met.
- Systems were in place to protect vulnerable children and adults from harm. Staff understood their responsibilities regarding information sharing and the documentation of safeguarding concerns, and they regularly worked with multi-disciplinary teams to help protect vulnerable patients. Staff were aware of how to contact relevant agencies during normal working hours and out-of-hours.
- Appropriate arrangements had been made to meet the needs of patients who had been identified as also being carers.

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People experiencing poor mental health (including people with dementia)

Good

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

- The QOF data, for 2015/16, showed the practice had performed well, and was above all the local CCG and national averages, in relation to providing care and treatment for this population group.
- The practice had taken steps to become 'dementia-friendly.' For example: there was a dedicated GP dementia lead who was able to provide advice and support to colleagues and act as a source of expertise; two members of staff acted as 'dementia friends', to help improve the quality of care and support patients with dementia received at the practice; the practice's dispensary provided a dosette box service for patients with memory difficulties, to help promote personal safety and improve medicines compliance.
- Patients experiencing poor mental health had access to information about how to access various support groups and voluntary organisations. They were also able to access on-site talking therapies support, making it easier for them to receive appropriate care and support.

Summary of findings

What people who use the service say

We spoke with three patients, including a member of the practice's patient participation group. Feedback about the way staff treated patients was very positive. Patients were very complimentary about the care and treatment clinical staff provided, and said they received enough time during appointments and felt listened to.

As part of our inspection we asked practice staff to invite patients to complete Care Quality Commission (CQC) comment cards. We received two completed comment cards and these were very positive about the standard of care and treatment provided. One respondent said, 'staff worked closely to plan ahead to create an effective supportive framework and achieve timely interventions' and, the other referred to receiving 'wonderful care.'

Data from the NHS National GP Patient Survey of the practice, published in July 2016, showed patient satisfaction levels regarding the quality of GP and nurse consultations and access to appointments, were similar to the local clinical commissioning group (CCG) and national averages. For example, of the patients who responded to the survey:

- 83% said the last GP they saw or spoke to was good at giving them enough time, compared to the local CCG average of 89% and the national average of 87%.
- 94% had confidence and trust in the last GP they saw, compared with the local CCG average of 97% and the national average of 95%.
- 86% said the last GP they saw was good at listening to them, compared to the local CCG average of 91% and the national average of 89%.
- 83% said the last GP they saw or spoke to treated them with care and concern, compared with the local CCG average of 89% and the national average of 85%.
- 95% said the last nurse they saw or spoke to was good at giving them enough time, compared to the local CCG average of 94% and the national average of 92%.
- 98% had confidence and trust in the last nurse they saw or spoke to. This was the same as the local CCG average and above the national average of 97%.
- 90% said the last nurse they saw was good at listening to them, compared to the local CCG of 94% and the national average of 91%.
- 95% said the last nurse they saw or spoke to treated them with care and concern, compared to the local CCG average of 93% and the national average of 91%.
- 92% found receptionists at the practice helpful, compared to the local CCG average of 89% and the national average of 87%.
- 94% said the last appointment they got was convenient, compared with the local CCG average of 93% and the national average of 92%.
- 89% were able to get an appointment to see or speak to someone the last time they tried, compared to the local CCG average of 86% and the national average of 85%.
- 97% found it easy to get through to the surgery by telephone, compared to the local CCG average of 77% and the national average of 73%.
- 70% said they usually waited 15 minutes or less after their appointment time, compared to the local CCG average of 73% and the national average of 65%.

  (206 surveys were sent out. There were 108 responses which was a response rate of 52%. This equated to 6.7% of the practice population.)

Areas for improvement

Summary of findings

Action the service SHOULD take to improve

- Carry out a recorded risk assessment in relation to any decision made not to obtain a Disclosure and Barring Service check for staff appointed to a particular post.
- Continue to review the practice's carers' register to make sure it accurately reflects the number of patients who are also carers.
- Display in the patient waiting area information about how to make a complaint.

Outstanding practice

- The practice had been very proactive in taking steps to reduce emergency attendances by patients into hospital, at a time when the local care trust had seen these increase. They had identified a need to reduce emergency attendances and, to help them do this, they had implemented a new appointment system which provided patients with access to same day care. The practice had then audited the improvement they made and this showed that, although the local hospital trust had seen their emergency admissions rate rise by 3.9%, due to winter pressures, the emergency attendances by patients registered with the practice, had reduced by 14% over the same period of time. This included a 20% reduction in emergency attendances by patients aged over 65 years of age, as well as a 50% reduction in emergency attendances by patients aged under five years of age.

Felton Surgery

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 advisor, a CQC medicines inspector and an expert by experience.

Background to Felton Surgery

The Felton Surgery is located in a rural area of Northumberland and provides care and treatment to 1604 patients of all ages, based on a General Medical Services (GMS) contract. The practice is part of the NHS Northumberland clinical commissioning group (CCG) and provides care and treatment to patients living in Felton and the surrounding area. The practice is a dispensing surgery which means they can, if they meet certain criteria, supply eligible patients with medicines directly. We visited the following location as part of the inspection:

Felton Surgery, Middle Farm, Main Street, Felton, Northumberland, NE65 9PR.

The practice serves an area where deprivation is lower than the England average. In general, people living in more deprived areas tend to have a greater need for health services. The Felton Surgery has fewer patients aged under 18 years of age, and more patients over 65 years, than the England average. Practice demographics indicate that the proportion of patients, aged over 65 years of age increased from 20.5% of the practice population in 2010 to 24.2% in 2014. The percentage of people with a long-standing health condition is above the England average, but the percentage of people with caring responsibilities is below. Life expectancy for women is similar to the England average, but higher for men. National data showed that 0.9% of the population are from non-white ethnic groups.

The practice occupies an annex that had been built onto the previous GP Provider's family home. A range of improvements had been made since the new GP provider took over including, for example, the installation of emergency lighting and improvements to the reception and dispensary areas. The consultation and treatment rooms are located on the ground floor. The practice has a GP provider (female) and two salaried doctors (male), a practice nurse (female), dispensing staff and a small team of administrative staff.

The practice is open Monday, Wednesday, Thursday and Friday between 8:30am and 6pm, and on Tuesdays between 8:30am and 7:30pm. The practice is closed at weekends.

The practice operates the Doctor First appointment system, which provides patients with same-day access to a GP. Telephone consultations usually commence at 8:30am and face-to-face consultations take place from 10:30am onwards.

When the practice is closed patients can access out-of-hours care via Vocare, known locally as Northern Doctors, and the NHS 111 service.

Why we carried out this inspection

We inspected this service as part of our 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.

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 14 February 2017. During our visit we:

- Spoke with a range of staff, including the GP provider, two salaried GPs, the practice manager, the practice nurse, and dispensing and administrative staff. We also spoke with three patients, including a member of the practice's patient participation group.
- Observed how staff interacted with patients in the reception and waiting area.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients shared their views and experiences of the service.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

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

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

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

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

Good

Are services safe?

Our findings

Safe track record and learning

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

- Staff had identified and reported on six significant events during 2017. The sample of records we looked at, and evidence obtained from interviews with staff, showed the practice had managed such events consistently and appropriately. For example, following one significant event where an item of medicine was found in the dispensary waste bin, the practice devised a tailored medicines handling policy to help prevent a reoccurrence. All significant events were discussed during practice meetings to promote shared learning.
- The practice's approach to the handling and reporting of significant events ensured that the provider complied with their responsibilities under the Duty of Candour regulation. (The Duty of Candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment.)
- Where relevant, patient safety incidents had been reported to the local clinical commissioning group (CCG) via the Safeguard Incident and Risk Management System (SIRMS). (This system enables GPs to flag up any issues via their surgery computer, to a central monitoring system, so that the local CCG can identify any trends and areas for improvement.)
- The practice had a system which helped ensure that an appropriate response was made to the safety alerts they received. We looked at a recent safety alert that had been received by the practice and saw that an appropriate response had been made.

Overview of safety systems and processes

The practice had a range of clearly defined and embedded systems and processes in place, which helped to keep patients and staff safe and free from harm. These included:

- Arrangements to safeguard children and vulnerable adults. Policies and procedures for safeguarding children and vulnerable adults were in place, and staff had access to local best practice guidance. One of the GPs acted as the safeguarding lead, providing advice and guidance to their colleagues. Staff demonstrated they understood their safeguarding responsibilities and the clinical team worked in collaboration with local health and social care colleagues, to protect vulnerable children and adults. Regular safeguarding meetings, involving health visitor staff, were held to monitor vulnerable patients and share information about risks. Staff had received safeguardingaining relevant to their role. For example, the GPs had completed level three child protection training. Arrangements had been made for new staff to complete appropriate safeguarding training.
- Effective arrangements for managing medicines, including emergency drugs and vaccinations. It was clear that the new provider had been proactive in taking positive action to improve facilities within the dispensary. Also, dispensary staff were very organised, and regularly audited the quality of their work to help promote safe patient care. In particular:
- The practice had standard operating procedures (these are written instructions about how to safely dispense medicines) that were readily accessible and covered all aspects of dispensing.
- The expiry dates of medicines were checked on a quarterly basis and this was recorded appropriately. All the medicines we checked were in date. Expired and unwanted medicines were disposed of in accordance with waste regulations.
- The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had standard procedures in place that set out how they were managed. These were being followed by practice staff. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted. Stock checks of controlled drugs were carried out on a regular basis.
- There was a system in place for monitoring high risk medicines and we saw how staff implemented this to keep patients safe.
- The practice had signed up to the Dispensing Services Quality Scheme, which rewards practices for providing high quality services to patients eligible to use their dispensary. We were shown an electronic spread sheet of near misses (a record of dispensing errors that have been identified before medicines have left the

dispensary) which included evidence of discussions and lessons learnt. These lessons were also shared and discussed with pharmacies in the village. National patient safety alerts and medicines recalls had been appropriately managed.

- All prescriptions were signed by a GP before they were given to patients and there was a robust system in place to support this. We saw evidence of how staff managed the review dates of repeat prescriptions and medicines which had not been collected.
- We checked medicines stored in the medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring medicines were stored at the required temperatures and this was being followed by staff. The lead dispenser also completed monthly audits of the cold chain and discussed any issues at dispensary team meetings. (Maintaining the cold chain ensures that vaccines are stored according the manufacturer's recommended temperature range, until the point of administration.)
- The practice provided a dosette box service for vulnerable patients in the community and we saw how they provided this service in the dispensary. However, they were not following the national guidance in relation to medicines which required special storage conditions in dosettes. The practice addressed this shortfall on the day of the inspection.
- Vaccines were administered by the nurse using directions which had been produced in accordance with legal requirements and national guidance. However, we found several examples where the vaccine directions had not been signed by either the practice nurse or the authorising GP. The practice took immediate steps to address this matter on the day of the inspection.
- Prescription pads were stored securely and there were systems in place to monitor their use.
- The practice engaged with the local community pharmacies by attending whole team dispensary meetings and sharing information to improve working.
- Chaperone arrangements to help protect patients from harm. All the staff who acted as chaperones were trained for the role and had undergone a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record, or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.) The chaperone service was advertised on posters displayed in the waiting area. Staff completed a chaperone checklist to indicate who was present and what procedure had been carried out.
- Maintaining appropriate standards of cleanliness and hygiene. There was an identified infection control lead who maintained an overview of compliance with the practice's infection control standards. There were infection control protocols in place and these could be easily accessed by staff. Staff had completed infection control training appropriate to their roles and responsibilities. An independent infection control audit, using a recognised tool, had been carried out by the local healthcare trust in 2015. Staff had devised an action plan in response, which provided evidence of actions taken to address the issues identified. The most recent in-house infection control audit had been carried out in 2016.
- The carrying out of a range of employment checks to make sure staff were safe to work with vulnerable patients. We looked at a sample of three staff recruitment files, two of which were for clinicians. Appropriate indemnity cover was in place for each clinician. The provider had carried DBS checks for both clinicians, but had decided not to carry out a DBS check for a recently appointed, temporary, non-clinical member of staff. However, they had not completed a recorded risk assessment which identified the reasons why they had considered it unnecessary. Proof of identity had been obtained for two staff, and we were told the identity of the third member of staff had been verified during the DBS application process. Details of employment histories had been obtained for two staff and details for the third member of staff were forwarded to the Commission shortly following the inspection. Written references had been obtained for each person. Copies of professional qualifications were made available to us either on the day of the inspection, or shortly after we completed our visit.

Monitoring risks to patients

Risks to patients were assessed and well managed.

Good

Are services safe?

- There were procedures for monitoring and managing risks to patient and staff safety. For example, the practice had arranged for all clinical equipment to be serviced and, where appropriate, calibrated, to ensure it was safe and in good working order. A range of other routine safety checks had also been carried out. These included checks of fire and electrical systems and equipment. A fire risk assessment had recently been completed, following which a range of improvements had been made. For example, a new fire alarm system and fire panel had been installed, as well as new fire signage. Staff had completed fire safety training and a fire drill had taken place during the previous 12 months. A health and safety risk assessment had been completed, to help keep the building safe and free from hazards.
- The practice had a legionella policy in place, underpinned by a risk assessment that had been carried out in 2015. To help reduce the risks posed by Legionella, the practice had purchased their own testing kit, so they could carry out water temperature checks and sampling. Regular audits were carried out to make sure the practice was following its own legionella policy. (Legionella is a bacterium that can grow in contaminated water and can be potentially fatal.)
- There were suitable arrangements in place for planning and monitoring the number and mix of staff required to meet patients' needs. The practice had taken action to help ensure they had sufficient doctors and nurses to meet patients' needs. Non-clinical staff had allocated roles, but were also able to carry out all duties required of administrative staff. Rotas were in place which helped to make sure sufficient numbers of staff were always on duty to meet patients' needs, and staff covered each other's holiday leave. Locum clinical staff were not used, which helped to promote continuity of patient care.

Arrangements to deal with emergencies and major incidents

The practice had made appropriate arrangements to deal with 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.
- Staff had completed basic life support training, to help them respond effectively in the event of an emergency. The practice manager told us this training would be provided for a temporary, non-clinical member of staff as soon as this was practicable.
- The practice had a business continuity plan in place for major incidents. This was accessible to all staff via the practice's intranet system. A copy of the plan was also kept off site. The plan included emergency contact numbers. There was a supply of oxygen for use in an emergency was available on the premises. Face masks for adults and children were available. Staff also had access to a defibrillator and pads for use with adults. Following advice received from the North East Ambulance Service, the practice had not purchased paediatric pads. They later provided evidence confirming they had purchased appropriate pads for younger children. The GPs had made a clinical decision not to carry emergency medicines when carrying out home visits, for use in an emergency. However, all the GPs had access to an emergency medicines kit, kept on site, which could be taken on a home visit should this be judged clinically necessary. All emergency medicines and equipment we checked were in date, and suitable for use both within and outside of the practice.
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Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Staff carried out assessments and treatment in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice had systems in place to keep clinical staff up-to-date with these.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF), and their performance against national screening programmes, to monitor and improve outcomes for patients. The QOF data, for 2015/16, showed the practice had performed well in obtaining 100% of the total points available to them for providing recommended care and treatment. This was above the local clinical commissioning group (CCG) average of 98.2% and the England average of 95.3%. (QOF is intended to improve the quality of general practice and reward good practice.)

- Performance for the diabetes related indicators was higher than the national averages. For example, the percentage of patients with diabetes, in whom the last blood pressure reading, during the period from 1 April 2015 to 31 March 2016, was 140/80 mmHg or less, was higher when compared to the England average (80.8% compared to 77.6%).
- Performance for the mental health related indicators was higher than the national averages. For example, the percentage of patients with the specified mental health conditions, who had had a comprehensive, agreed care plan documented in their medical record, during the period from 1 April 2015 to 31 March 2016, was higher when compared with the England average (100% compared to 88.8%). Also, the percentage of patients diagnosed with dementia, whose care plan had been reviewed in a face-to-face consultation, during the period from 1 April 2015 to 31 March 2016, was higher when compared with the England average (100% compared to 83.8%). Clinical staff told us that, because their dementia prevalence rate was low, they had carried out case-finding using a recognised tool. This had led to a 60% increase in the number of patients included on the practice's dementia register. (Case-finding is a systematic or opportunistic process that identifies individuals from a larger population for a specific purpose.)
- Performance for the chronic obstructive pulmonary disease (COPD) indicators was higher than the national averages. For example, the percentage of patients with COPD, who had been diagnosed after March 2011, and where the diagnosis had been confirmed by post bronchodilator spirometry between the three months prior to the patient being added to the COPD register, and 12 months after being added, was higher when compared with the England average (100% compared to 88%). Comparative data on COPD diagnosis rates had shown that the practice was below the expected diagnosis rate per patient (a practice value of 43.77 compared to the local CCG value of 63.11). Because of this, the practice had been identified as a 'Level 1' outlier. The practice's performance had been discussed during weekly clinical meetings and an action plan agreed to help address this, resulting in a 42% increase in their COPD diagnosis rate.

The practice's exception reporting rate, at 8.1%, was 2.2% below the local CCG average and 1.7% below the England average. (The QOF scheme includes the concept of 'exception reporting' to ensure that practices are not penalised where, for example, patients do not attend for review, or where a medication cannot be prescribed due to a contraindication or side-effect.)

Staff had been effective in reducing the number of patients who attended the local hospital emergency department. Although the local hospital trust had seen their emergency admissions rate rise by 3.9%, due to winter pressures, the emergency attendances by patients registered with the practice, had reduced by 14% over the same period of time. This included a 20% reduction in emergency attendances by patients aged over 65 years of age and a 50% reduction for children aged under five years of age.

Staff were proactive in carrying out quality improvement activities, including clinical audits. There was a planned programme of audits for the year ahead. This covered activities undertaken by all staff, including those working in the dispensary. During 2015/16 staff had carried out improvement activities in relation to, for example: the use of sodium valproate; the handling of safety alerts; the quality and scanning of patient notes; and compliance with

Good

Are services effective?

(for example, treatment is effective)

the practice's policies and procedures. Two-cycle clinical audits had also been completed and the sample we looked at was relevant and showed learning points. For example, a recent minor surgery audit had led to an improvement in the communication of histology results. There was evidence that clinical audit outcomes had been shared with staff during practice meetings, to help promote shared learning. The practice had a rigorous system for documenting the outcomes of audits and making these easily accessible to staff.

Effective staffing

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

- The practice had an induction programme for newly appointed staff. For example, the practice nurse told us they had received an appropriate induction which they said had met their needs.
- The practice could demonstrate how they ensured role specific training. The practice nurse told us that the GP provider and practice manager had made every effort to ensure that they received the training they needed to take on their new role as a practice nurse. They said that since their appointment, they had completed training in: travel health; immunisations; cervical screening; sexual health; asthma; diabetes and chronic obstructive pulmonary disease. Other staff had also undertaken training that was relevant to their roles and responsibilities. For example, the dispensary staff had completed appropriate vocational training to help them carry out their dispensing duties safely. Staff made use of e-learning training modules, to help them keep up to date with their mandatory training. Most staff had completed training in fire safety, infection control, information governance and safeguarding. The practice manager had made arrangements for a temporary member of staff to undertake as much of their mandatory training as possible, before the end of their temporary contract.
- Staff had received an annual appraisal of their performance during the previous 12 months. Appropriate arrangements were in place to ensure the GPs received support to undergo revalidation with the General Medical Council.

Coordinating patient care and information sharing

The practice's patient clinical record and intranet systems helped to make sure staff had the information they needed to plan and deliver care and treatment.

- The information included patients' medical records and test results. Staff shared NHS patient information leaflets, and other forms of guidance, with patients to help them manage their long-term conditions.
- All relevant information was shared with other services, such as hospitals, in a timely way. Important information about the needs of vulnerable patients was shared with the out-of-hours and emergency services.
- Staff worked well together, and with other health and social care professionals, to meet the range and complexity of patients' needs and to assess and plan on-going care and treatment.

Consent to care and treatment

Patients' consent to care and treatment was sought in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of the legislation and guidance, including the Mental Capacity Act (MCA, 2005).
- When staff provided care and treatment to young people, or adult patients whose mental capacity to consent was unclear, they carried out appropriate assessments of their capacity and recorded the outcome. Relevant staff had completed training in the use of the MCA.

Supporting patients to live healthier lives

Staff were committed to supporting patients to live healthier lives through a targeted and proactive approach to health promotion.

- Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people aged between 40 and 74 years.
- There were suitable arrangements for making sure a clinician followed up any abnormalities or risks identified during these checks.

The practice had a comprehensive screening programme. Their performance was either above, or similar to, the national averages in relation to breast, bowel and cervical screening. Data showed:

Good

Are services effective?

(for example, treatment is effective)

- The uptake of breast screening by females aged between 50 and 70, during the previous 36 months, was above the national average, 83.7% compared to 72.2%.
- The uptake of bowel cancer screening by patients aged between 60 and 69, during the previous 30 months, was above the national average, 71.2% compared to 57.9%.
- The uptake of cervical screening by females aged between 25 and 64, attending during the target period, was in line with the national average, 82.1% compared to 81.8%. The practice had protocols for the management of cervical screening, and for informing women of the results of these tests.
- The practice offered a full range of childhood immunisations and had performed above most of the local CCG averages in delivering these.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Staff were highly motivated to offer care that was kind, promoted patients' dignity and respected cultural differences.

- Throughout the inspection staff were courteous and helpful to patients who attended the practice or contacted it by telephone.
- We saw that patients were treated with dignity and respect. Privacy screens were provided in consulting rooms so that patients' privacy and dignity could be maintained during examinations and treatments.
- Consultation and treatment room doors were closed during consultations, so that conversations could not be overheard. The new provider told us they had made significant changes to the previous layout of the reception area. This included replacing the previous open reception desk with a full height partition and a sliding glass screen, which they said had helped to improve privacy and confidentiality. This positive improvement had been noted by members of the practice's patient participation group. However, conversations taking place behind the screen could still be overheard. We raised this with the practice manager who agreed to give it further consideration.

We spoke with three patients, including a member of the practice's patient participation group. Feedback about the way staff treated patients was positive. Patients were very complimentary about the care and treatment clinical staff provided, and said they received enough time during appointments and felt listened to.

As part of our inspection we asked practice staff to invite patients to complete Care Quality Commission (CQC) comment cards. We received two completed comment cards and these were very positive about the standard of care and treatment provided. One respondent said, 'staff worked closely to plan ahead to create an effective supportive framework and achieve timely interventions' and, the other referred to receiving 'wonderful care.'

Staff had gathered feedback from patients through their Friends and Family Test survey. The most recently analysed figures made available to us were for the previous five months. The practice had received a total of four responses and all the patients had indicated they were 'extremely likely' to recommend the practice to friends and family. Comments made included: 'like the new phone system'; 'friendly service'; 'would recommend'.

Data from the NHS National GP Patient Survey of the practice, published in July 2016, showed patient satisfaction levels regarding the quality of GP and nurse consultations and access to appointments, were overall similar to the local clinical commissioning group (CCG) and national averages. For example, of the patients who responded to the survey:

- 83% said the last GP they saw or spoke to was good at giving them enough time, compared to the local CCG average of 89% and the national average of 87%.
- 94% had confidence and trust in the last GP they saw, compared to the local CCG average of 97% and the national average of 95%.
- 86% said the last GP they saw was good at listening to them, compared to the local CCG average of 91% and the national average of 89%.
- 83% said the last GP they saw or spoke to treated them with care and concern, compared to the local CCG average of 89% and the national average of 85%.
- 95% said the last nurse they saw or spoke to was good at giving them enough time, compared to the local CCG average of 94% and the national average of 92%.
- 98% had confidence and trust in the last nurse they saw or spoke to. This was the same as the local CCG average and above the national average of 97%.
- 90% said the last nurse they saw was good at listening to them, compared to the local CCG of 94% and the national average of 91%.
- 95% said the last nurse they saw or spoke to treated them with care and concern, compared to the local CCG average of 93% and the national average of 91%.
- 92% found receptionists at the practice helpful, compared to the local CCG average of 89% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

The patients we spoke with, and those who completed CQC comment cards, told us clinical staff involved them in

decisions about their care and treatment. The results from the national NHS GP Patient Survey of the practice showed patient satisfaction levels, regarding involvement in decision-making and how clinical staff explained tests and treatments, were similar to, or just below, the local CCG and national averages. Of the patients who responded to the survey:

- 83% said the last GP they saw was good at explaining tests and treatments, compared to the local CCG average of 90% and the national average of 86%.
- 83% said the last GP they saw was good at involving them in decisions about their care, compared to the local CCG average of 86%, and the national average of 82%.
- 84% said the last nurse they saw was good at involving them in decisions about their care, compared to the local CCG average of 92% and the national average of 90%.
- 91% of respondents said the last nurse they saw was good at explaining tests and treatments, compared with the local CCG average of 88% and national average of 85%.

Patient and carer support to cope emotionally with care and treatment

Staff were good at helping patients and their carers to cope emotionally with their care and treatment.

- They understood patients' social needs, supported them to manage their own health and care, and helped them to maintain their independence.
- Notices in the patient waiting room told patients how to access a range of support groups and organisations.
- Where patients had experienced bereavement, staff would send out a letter and a condolence card. Bereavement information leaflets were available in the patient waiting area.

The practice was committed to supporting patients who were also carers.

- Staff maintained a register of these patients, to help make sure they received appropriate support and referral, where appropriate, to the local carers' support group. There were eight patients on this register, which equated to 0.4% of the practice's population. This is considered low in relation to the size of the practice's patient list.
- Following a presentation to the staff team by the local carers' organisation, staff had devised a carers' policy to help them support patients who were also carers. The practice actively encouraged new patients to tell them if they were also carers. The practice actively encouraged new patients to tell them if they were also carers via clinical consultations and their registration process.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Services were tailored to meet the needs of individual people and were delivered in a way that provided flexibility, choice and continuity of care. Examples of the practice being responsive to, and meeting patients' needs included:

- The practice team actively participating in the local High Risk Patient Pathway (HRPP), to help reduce unplanned admissions into hospital. Emergency care plans had been put in place for this at-risk group of patients, most of whom were over 75 years of age, and annual reviews were completed to help ensure their needs were being met. The practice also provided all patients over 75 years of age with a named GP who was responsible for their care.
- The practice taking steps to become 'dementia-friendly.' There was a dedicated GP dementia lead who was able to provide advice and support to colleagues and act as a source of expertise. Two members of staff acted as 'dementia friends', to help improve the quality of care and support patients with dementia received at the practice. T Clinical staff actively carried out opportunistic dementia screening, to help ensure patients were receiving the care and support they needed to stay healthy and safe. The practice's dispensary provided a dosette box service for patients with memory difficulties, to help promote personal safety and improve medicines compliance. Patients experiencing poor mental health had access to information about how to access various support groups and voluntary organisations. Patients were able to access on-site talking-therapies, which enabled them to receive more care and treatment in a local setting.
- The provision of a range of regular clinics focussing on the lifestyle management and monitoring of patients with long-term conditions such as asthma, diabetes, chronic heart disease, chronic obstructive pulmonary disease and hypertension. The practice had a rigorous patient recall system which helped to ensure patients had their needs reviewed on a regular basis. The practice held monthly palliative care meetings, using the Gold Standards Framework guidelines, to help manage the treatment needs of patients requiring end-of-life care. Clinical staff were working towards increasing the number of patients on their palliative care list to include patients with diagnoses other than cancer, to help ensure they received appropriate end-of-life care.
- The practice providing a full programme of childhood immunisations. The practice also offered meningitis vaccinations for patients who were students. Women were able to access midwife-led, ante-natal and post-natal care, with support from the GPs. The Doctor First appointment system meant that children could be seen outside of school hours, to minimise any impact on their school attendance. The practice premises were suitable for children and babies. The practice offered contraceptive services, and sexual health information was available in the reception area.
- Offering a full range of health promotion and screening that reflected the needs of their patients. Extended hours appointments were offered each Tuesday evening until 7:30pm. Patients were able to use on-line services to access appointments and request prescriptions.
- Making reasonable adjustments to help patients with disabilities, and those whose first language was not English, to access the practice. Patients with learning disabilities had access to an annual healthcare appointment where their needs were reviewed to ensure they were being met. Staff told us they had identified that the number of patients assessed as having learning disabilities was below the national average. They had developed an action plan to help them address this.

Access to the service

The practice was open Monday, Wednesday, Thursday and Friday between 8:30am and 6pm, and on Tuesdays between 8:30am and 7:30pm. The practice was closed at weekends.

The practice operated the Doctor First appointment system, which provides patients with same-day access to a GP. Telephone consultations usually commenced at 8:30am and face-to-face consultations took place from 10:30am onwards. Staff told us patients wishing to see a doctor would first be contacted by a GP, who would then assess their needs and invite them for a face-to-face consultation, if this was considered to be the most appropriate clinical response. Patients were able to book nurse appointments by contacting the practice by

Good

Are services responsive to people's needs?

(for example, to feedback?)

telephone or in person. The practice had a system in place to assess whether a home visit was clinically necessary and the urgency of the need for medical attention. We looked at the practice's appointments system in real-time on the afternoon of the inspection. We found appointment slots were still available for patients to see a GP. Nurse appointments were available the following day.

The patients who provided feedback on CQC comment cards raised no concerns about telephone access to the practice or appointment availability. Two patients we spoke with also expressed no concerns about access to appointments, although one of these mentioned that appointments sometimes ran over. They said the doctors always apologised for this. The third patient we spoke to was, in general, positive about the Doctor First appointment system that had recently been adopted by the practice.

Results from the NHS GP Patient Survey of the practice showed that patient satisfaction levels with appointment access were similar to the local clinical commissioning group (CCG) and national averages. In particular, patients showed high levels of satisfaction with telephone access. Of the patients who responded to the survey:

- 94% said the last appointment they got was convenient, compared with the local CCG average of 93% and the national average of 92%.
- 89% were able to get an appointment to see or speak to someone the last time they tried, compared to the local CCG average of 86% and the national average of 85%.
- 97% found it easy to get through to the surgery by telephone, compared to the local CCG average of 77% and the national average of 73%.
- 70% said they usually waited 15 minutes or less after their appointment time, compared to the local CCG average of 73% and the national average of 65%.

Listening and learning from concerns and complaints

The practice had a system in place for managing complaints.

- A designated senior member of staff was responsible for handling any complaints. There was a complaints policy which provided staff with guidance about how to handle them. Information about how to complain was available on the practice's website, including a link to their complaints policy and leaflet. However, there was no information about how to complain on display in the patient waiting area. Two of the three patients we spoke with said they were unclear about how to make a complaint.
- The practice had received seven complaints during the previous 12 months. The practice manager maintained a register which included details of how staff had responded to complaints, whether verbal or written. This showed staff had responded promptly to patients' concerns and treated the issues they raised seriously. There was also evidence which demonstrated that complaints were discussed during clinical governance meetings, to help identify trends and themes and promote shared learning. Regular audits were carried out to help ensure complaints were handled in line with the provider's complaints policy.

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 leadership, governance and culture at the practice actively encouraged and supported the delivery of good-quality, person-centred care.

- The provider had prepared a statement of purpose, as part of their application to register with the Care Quality Commission. This provided a high-level overview of how the practice intended to meet patients' needs. The GP provider had devised a detailed business plan which set out how they intended to ensure continuity of care and treatment in light of the key challenges they faced in continuing to deliver primary care in Northumberland. For example, they had identified they needed to improve the practice's IT system. To do the practice had adopted a web-based information-sharing tool, to help them communicate and engage effectively with their stakeholder partners.
- All of the staff we spoke to understood the practice's commitment to providing good patient care and how they were expected to contribute to this. They were proud to work for the practice and had a clear understanding of their roles and responsibilities.

Governance arrangements

The practice had an effective overarching governance framework which supported the delivery of the GP provider's strategy to provide good quality care. This ensured that:

- There was a clear staffing structure and staff understood their roles and responsibilities.
- Quality improvement activity was undertaken, to help improve patient outcomes.
- Regular planned meetings were held to share information and manage patient risk. These included regular practice, and multi-disciplinary meetings, where the focus was on meeting the needs of venerable patients with complex support and treatment needs. Meetings were well minuted, and copies could be easily accessed by all staff.
- Designated staff held lead clinical and non-clinical roles, to help provide leadership and direction within the practice, and provide patients with the best possible care.
- Staff were supported to learn lessons when things went wrong, and to identify, promote and share good practice.
- Staff had access to a range of policies and procedures, which they were expected to implement.
- Patients were encouraged to provide feedback on how services were delivered and what could be improved.

Leadership, openness and transparency

On the day of the inspection, the GP provider and practice manager demonstrated they had the experience, capacity and capability to run the practice and ensure high quality compassionate care. There was a clear leadership and management structure, underpinned by strong, cohesive teamwork and good levels of staff satisfaction.

The provider had complied with the requirements of the Duty of Candour regulation. (The Duty of Candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment.)

- The GP provider and practice manager encouraged a culture of openness and honesty. Staff we spoke with told us they felt well supported by the leadership at the practice, and regular meetings took place to help promote their participation and involvement.
- A culture had been created which encouraged and sustained learning at all levels.
- There were effective systems which ensured that when things went wrong, lessons were learned to prevent the same thing from happening again.

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

The practice encouraged and valued feedback from patients and staff. They had gathered feedback from patients through their Friends and Family Test survey. In addition to this, they had undertaken a review of the results of the most recent national NHS GP patient survey of the practice and produced an action plan to address the issues raised by their patients, most of which related to appointment availability. The practice had also taken part

Are services well-led?

Good

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

in a demand and capacity exercise led by the local clinical commissioning group (CCG). This had demonstrated that, on a daily basis, the demand for GP appointments exceeded capacity and that, on occasions, appointments were having to be arranged more than two weeks in advance. In response to this, the GP provider looked at options for improving access to appointments and had introduced the Doctor First system in 2016. Data collected during the early phase of implementation showed that, after 24 weeks, the proportion of the practice's patient population who had either a face-to-face appointment, or telephone consultation each week, had risen from 3.5% to 10%. This meant that more patients were receiving care and support following the introduction of the Doctor First system.

The practice also sought feedback from their patient participation group (PPG). Information about how to join the group was available on the practice's website. However, we did not see similar information on display within the practice. We saw that the minutes of some of the PPG meetings had been uploaded onto the practice's website. The PPG member we spoke with told us they met four times a year, in addition to attending an annual general meeting. They said the group had devised their own terms of reference, as well as a set of objectives for 2016. These objectives included, for example, strengthening the practice's arrangements for communicating with patients. The PPG member told us they felt this was important, as the PPG had not been actively involved in discussions about the implementation of the new Dr First System, until after it had been introduced. They said the PPG had been involved in discussions about the possible relocation of the practice and hoped they would continue to be more involved in any future plans for developing the practice.

Continuous improvement

There was a strong focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and actively encouraged improvements in service delivery such as the adoption of the Dr First appointment system. The team demonstrated their commitment to continuous learning and improvement by:

- Actively encouraging and supporting staff to access relevant training including, for example, events run by the local CCG.
- Carrying out a range of clinical and quality improvement audits, to help improve patient outcomes.
- Learning from any significant events that had occurred, to help prevent them from happening again.