Cheviot Medical Group

Quality Report

Cheviot Primary Care Centre
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Date of inspection visit: 16 January 2018
Date of publication: 11/05/2018

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?	Outstanding

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

At our previous inspection on 23 and 24 October 2014, we rated the practice as good overall and outstanding for people with long-term conditions. At this inspection, we have also rated the practice as good.

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? - Outstanding

As part of our inspection process, we also look at the quality of care for specific population groups. The population groups are rated as:

Older People – Good

People with long-term conditions – Good

Families, children and young people – Good

Working age people (including those recently retired and students – Good

People whose circumstances may make them vulnerable – Good

People experiencing poor mental health (including people with dementia) - Good

We carried out an announced comprehensive inspection at Cheviot Medical Group on 16 January 2018 to check that the provider continues to meet the legal requirements and regulations associated with the Health and Social Care Act 2008.

At this inspection we found:

- The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and made improvements.
- The practice routinely reviewed the effectiveness and appropriateness of the care and treatment they provided. Staff ensured that care and treatment was delivered in line with evidence- based guidelines.
- Quality Outcomes Framework (QOF) data, for 2016/17 showed the practice had performed well in achieving 100% of the points available to them for providing recommended treatments for the most commonly found key clinical conditions.
- Patients found the appointment system easy to use and reported that they were able to access care when they needed it.
- Feedback from patients about access to appointments, the practice's opening hours and the

Summary of findings

quality of their care and treatment was continuously very positive. The results of the NHS National GP Patient Survey, published in July 2017, showed patients rated the practice higher for almost all aspects of care, when compared to the local clinical commissioning group (CCG) and national averages. This high level of achievement had been sustained over a number of years.

- Leadership at the practice was compassionate, inclusive and effective at all levels. Leaders were able to demonstrate they had the high levels of experience, capacity, capability and skills needed to deliver very high-quality, sustainable care.
- The culture of the practice was to deliver person-centred care and treatment. All the staff were highly committed to delivering a quality service.
- There was a very strong focus on continuous learning and improvement at all levels of the organisation. The practice proactively used performance information to drive improvement.
- There were rigorous systems and processes in place that supported learning, continuous improvement and innovation. Safe innovation was celebrated and there was a clear and proactive approach to seeking out and embedding more effective ways of working.
- The practice had a clear vision and credible strategy to deliver high-quality care and promote good outcomes for patients, and leaders demonstrated a clear commitment to system-wide collaboration and leadership.

We also saw areas of outstanding practice:

- People can access services and appointments in a way and at a time that suits them. The practice had a very responsive appointment system. They used a 'patient-decided' consultation approach that actively encouraged patients to choose the length of their appointments. This had resulted in a high level of patient satisfaction as demonstrated by the results of the most recent national GP Patient Survey. Leaders had reviewed the effectiveness of this approach and had published their findings so learning could be shared nationally to promote improvement.
- There was an innovative approach to providing responsive, integrated person-centred care, particularly for older people and people with complex needs. The practice understood that these patients were at more risk, if emergency services were delayed because of their rural location. To address this, the practice had collaborated with the local ambulance service to set up a rural community paramedic service. Clinical staff had provided training and clinical support to the paramedic team for which they received no extra funding. There was also a telephone 'hot-line' which paramedics could use to obtain clinical advice and support from the GPs. This had helped to significantly reduce the number of accident and emergency attendances. For example, in 2014/15, there had been 726 attendances. In 2017/18, this had reduced to 453 attendances.

The areas where the provider should make improvements are:

- In addition to the routine environmental audits carried out by the local trust, carry out regular infection control audits.
- Review the arrangements for using non-clinical staff as chaperones so that they are in line with the guidance issued by the General Medical Council.
- Carry out a risk assessment to determine whether non-clinical staff carrying out chaperone duties should undergo a Disclosure and Barring Service check.
- Record refrigerator temperatures in line with the practice's standard operating procedure.

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

Summary of findings

Areas for improvement

Action the service SHOULD take to improve

- In addition to the routine environmental audits carried out by the local trust, carry out regular infection control audits.
- Review the arrangements for using non-clinical staff as chaperones so that they are in line with the guidance issued by the General Medical Council.
- Carry out a risk assessment to determine whether non-clinical staff carrying out chaperone duties should undergo a Disclosure and Barring Service check.
- Record refrigerator temperatures in line with the practice's standard operating procedure.

Outstanding practice

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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 included a second inspector, a GP specialist adviser and an expert by experience.

Background to Cheviot Medical Group

The Cheviot Medical Group is located in the Wooler area of Northumberland and provides care and treatment to 2448 patients of all ages, based on a General Medical Services (GMS) contract. The practice is part of the NHS Northumberland clinical commissioning group (CCG). A dispensing service was provided for those patients who were eligible to be on the practice's dispensing list, i.e. those who lived further than one mile away from the surgery. We visited the following location as part of the inspection:

Cheviot Primary Care Centre, Padgepool Place, Wooler, Northumberland, NE71 6BL.

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. Cheviot Medical Group has fewer patients aged under 18 years of age, and more patients over 65 years, than the England averages. The percentage of patients with a long-standing health condition, and patients with caring responsibilities, are above the England average. Life expectancy for women and men is similar to the England averages. National data showed that 0.6% of the population are from non-white ethnic groups.

The practice occupies part of a large purpose built building. All consultation and treatment rooms are on the ground floor. Disabled access is provided via a ramp at the front of the premises, for patients with disabilities. The building also accommodates district nursing, physiotherapy and chiropody staff, as well as a 24-hour emergency paramedic ambulance service. The practice provides a range of services and clinics 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 open Monday to Friday between 8:30am and 6pm. Extended hours appointments are provided in collaboration with other local GP practices. As part of their contribution to the new local out-of-hours scheme, the practice provides appointments between 6pm and 8pm on Tuesdays. On other weekdays and Saturday mornings, patients are able to access out-of-hours appointments at the other GP practices involved in the scheme.

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

Good

Are services safe?

Our findings

We rated the practice, and all of the population groups, as good for providing safe services.

Safety systems and processes

The practice had systems and processes in place which helped to keep patients safe and protected from abuse. However, the practice manager acknowledged they needed to improve the arrangements for maintaining an oversight of the health and safety checks carried out by the landlord of the premises, so they knew they were completed as and when required.

- Health and safety risk assessments had been completed by the practice and the building's owner, to help keep patients and staff safe. For example, legionella and fire risk assessments were in place. Health and safety policies were in place and staff were able to easily access them.
- The practice had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. They clearly outlined who to go to for further guidance. The practice worked with other agencies to support patients and protect them from neglect and abuse. Regular multi-disciplinary meetings were held to help manage patient risk and share information. Children identified as being at risk of potential harm were highlighted on the practice's medical records system, to make sure this could be taken into account when meeting their needs and providing information to other agencies.
- The practice carried out (DBS
- All staff had received training in safeguarding children that was appropriate to their role and up-to-date. Staff we spoke with knew how to identify and report concerns. Most staff had recently updated their adult safeguarding training. Arrangements were being been made to provide the two non-clinical staff who had missed the session with same training.
- The practice had a chaperone policy which stated that non-clinical staff carrying out this role should stay outside of the screened-off area, when a patient was being examined. By doing this, the non-clinical chaperones are not The practice manager had provided staff with chaperone training. However, there was no record of this. The practice manager told us they would address this shortfall by ensuring that all staff updated their chaperone training, using the practice's new training package.
- Systems and processes were in place for managing infection prevention and control. This included, for example, providing staff with appropriate mandatory training in infection control. The local care trust carried out periodic environmental audits, to make sure suitable standards of cleanliness were being maintained by the domestic services team responsible for cleaning the premises. However, the practice had not carried out their own infection control audit. The practice had recently appointed a new nurse who acted as the practice's infection control lead. Although they confirmed they had completed their mandatory infection control training, they had not yet completed more advanced training, to help them carry out this role. The practice manager told us they would source appropriate training to address this training need.
- The practice ensured equipment, including clinical equipment used to treat patients, was safe to use. The practice manager confirmed all equipment was maintained according to the manufacturers' instructions. There were systems in place for safely managing healthcare waste.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

- There were effective arrangements in place for planning and monitoring the number and mix of staff required to meet patients' needs.
- When new GP locums were used by the practice, the practice manager completed an induction checklist with them to make sure they were able to work in a safe manner. A GP locum induction pack was available and easy to access.
- Staff understood their responsibilities to manage emergencies occurring on the premises and knew how to identify those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections such as sepsis. Both GP partners had completed training in sepsis.

Good

Are services safe?

- When there were changes to how services were provided or changes to staff, the practice assessed and monitored the impact on safety. For example, following feedback from dispensing staff that they were not always involved in the dispensing process from end-to-end during a shift, the rotas were adjusted to provide them with a working pattern which helped them to manage the dispensing process more safely and consistently. The practice manager told us she, and the dispensing team, continued to monitor the effectiveness of the new rota arrangements, to identify whether any further improvements were needed.
- The practice had an up-to-date business continuity plan, to help them respond in the event of an emergency. This was available to key personnel when the practice was closed.

Information to deliver safe care and treatment

- Individual care records were recorded and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff and easily accessible.
- The practice had systems for sharing information with staff and other agencies, to enable them to deliver safe care and treatment.
- The sample of letters we checked referring patients to other services included all of the necessary information.

Safe and appropriate use of medicines

Most of the practice's systems and processes helped ensure appropriate and safe handling of medicines. However, staff had not always followed the practice's procedure for checking that medicines requiring cold storage were stored at the right temperature.

- The practice's standard operating procedure (SOP) for checking refrigerator temperatures stated that checks should be carried out twice a day. Two refrigerators were used to store medicines that required cold storage. Both refrigerators had internal thermometers (data loggers) which logged temperatures at frequent intervals during each 24-hour period.

  Each week staff downloaded the e-data collected, so they could check medicines requiring cold storage had not been stored outside of the recommended temperature range. In addition, each refrigerator also had an external digital thermometer and an alarm, which sounded when temperatures were outside of the recommended range. Both data loggers had an alarm to alert staff to potential problems with refrigeration temperatures. However, although the practice nurse told us they carried out regular checks of the refrigerator temperatures, they had not always kept a written record of these. Also, on the occasions when the temperature had been recorded as being slightly higher than the maximum recommended temperature, staff had not always recorded the reasons for this. The practice manager explained that on the occasions when the temperature was slightly higher, this was because the thermometer had to be removed from the refrigeration in order to download the data logger information.

Other systems and processes for handling medicines were safe.

- Appropriate arrangements were in place to monitor the health of patients prescribed high-risk medicines. These included the carrying out of regular reviews to help to avoid these patients developing illnesses caused by their treatment. Following a significant event involving a failure by an external agency, the practice had reviewed their systems and processes for keeping patients who are prescribed high-risk medicines safe. They shared what they had learnt with other services in the locality, including with the emergency services, to help promote learning.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date.
- There was evidence of actions taken to support good antimicrobial stewardship. For example, both GP partners had completed antimicrobial training. Information supporting good antimicrobial use was available at the health centre.
- Systems were in place to ensure prescriptions were signed before the medicines were dispensed to patients.
- At our last inspection, in October 2014, we found the practice's arrangements for ensuring prescription

security were not fully satisfactory. During this inspection we found blank prescription forms and pads were securely stored and there were systems in place to monitor their use.

- The practice had taken steps to assure the quality of service provided to patients on their dispensing list, by participating in the Dispensary Standards Quality Scheme, and having a named GP who took overall responsibility for the day-to-day management of the dispensary.
- There were standard procedures in place which covered all aspects of the dispensing process (these are written instructions about how to safely dispense medicines). These were up-to-date, and had been signed and dated.
- The practice nurse and GPs routinely completed 'Dispensing Reviews of the Use of Medicines' (DRUMs) with each patient. This meant discussion about prescribed medicines could take place within a confidential setting, which respected patients' privacy.
- The three staff who delivered the dispensing service had recently started a recognised professional training course in dispensing. The lead GP for dispensing provided mentoring support and had assessed their competency, to help make sure they were safe to work in the dispensary. Competency assessments were completed each year.
- Systems were in place to ensure prescriptions were signed before the medicines were dispensed to patients.
- Appropriate arrangements were in place to monitor dispensary stock and dispose of waste medicines belonging to the dispensing service.
- The practice held stocks of controlled drugs (medicines that require extra checks and special storage because of their potential misuse) and had procedures in place to manage them safely.
- We saw a positive culture in the practice for reporting and learning from medicines incidents and errors. Incidents were logged efficiently and then reviewed promptly.
- Systems were in place to deal with any medicines alerts or recalls, and records were kept of any actions taken.
- Appropriate arrangements had been made to assure the safety of medicines delivered to agreed drop-off points, including the practice manager visiting each location to assess safety.
- A number of dispensary audits had been completed. For example, following a concern raised by a patient, an audit of out-of-stock medicines was carried out. This resulted in a change of supplier, to help ensure a more consistent supply of medicines. Monthly audits of the 'near-miss' log were carried out and learning was shared at team meetings, to promote improvement.

Record on safety

The practice had a good safety record.

- There were comprehensive risk assessments in relation to safety issues.
- The practice continually monitored and reviewed their safety practices. This helped the practice to understand potential risks to patient safety, and provided a clear, accurate overview which staff were able to use to make improvements. For example, following an incident where an urgent blood test result had not been communicated to the practice by their local laboratory, staff reviewed their processes and systems and introduced improvements. These included clinical staff putting an IT task in place, to remind them to check whether urgent blood tests had been returned. This was also monitored by administrative staff, to help ensure none were overlooked. The practice had also set up a system to share information about outstanding urgent blood tests with the local out-of-hours service, to promote patient safety and continuity of care. Staff had shared details of the incident and the action they had taken, with other local practices to help promote learning.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and 'near-misses'. Leaders and managers supported them when they did so.

Good

Are services safe?

- There were effective systems for reviewing and investigating when things went wrong. The practice learned from incidents and took action to improve safety. For example, the practice identified that some patients had not been prescribed the correct dose of statin therapy. As a consequence, the practice decided to increase the length of appointments for people with long-term conditions to allow more time for checking that their prescriptions were correct. The practice had also developed a template to prompt clinical staff to consider whether the correct dose of this medicine had been prescribed.
- Significant events were discussed at practice meetings and then reviewed at the next one, to ensure that the lessons learned had led to improvements. Where judged relevant, staff had shared significant events outside of the practice, to help promote shared learning and improvement with other services.
- There was a system for receiving and acting on safety alerts. All safety alerts received were logged, shared with staff and actions taken were recorded.

Good

Are services effective?

(for example, treatment is effective)

Our findings

We rated the practice, and all of the population groups, as good for providing effective services.

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance, supported by clear clinical pathways and protocols.

- Clinicians carried out full assessments of each patient's needs including their mental health and social needs.
- We saw no evidence of discrimination when care and treatment decisions were made.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.
- Staff used technology to help them provide a better service to their patients. For example, mobile blood pressure monitors had been purchased so patients could undergo monitoring in their own home, rather than having to go to hospital. Voice recognition software had been purchased to help clinicians more accurately and efficiently record patient consultation outcomes.

Older people:

- Older patients who were frail and vulnerable received a full assessment of their physical, mental and social needs. Staff made use of the electronic frailty index facility on their clinical IT system, to help them identify and predict adverse outcomes for their older patients. As a result, frail patients assessed as being at increased risk received a clinical assessment, including a review of their medication and susceptibility to falling.
- The practice did not routinely carry out health care checks for patients who were aged over 75 years of age because these patients were able to access longer appointments which clinicians used to assess and meet their individual needs.
- There were suitable arrangements in place to ensure that, when older patients were discharged from hospital, their care plans and prescriptions were updated, to reflect any extra or changed needs.

People with long-term conditions:

- Patients with long-term conditions (LTCs) had an annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GPs worked with other health and social care professionals to deliver a coordinated package of care.
- Staff who were responsible for the reviews of patients with LTCs had received relevant training.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme and uptake rates were above the target of 90%.

Working age people (including those recently retired and students):

- The uptake of cervical screening by patients was 72.4%, which was above the 71.9% target of the national screening programme. (Public Health England Cervical Screening Indicator.)
- The practice had arrangements for advising eligible patients, such as students attending university for the first time, to have a meningitis vaccination.
- Patients had access to appropriate health assessments and checks, including NHS checks for patients aged 40-74. There were arrangements for following up the outcomes of health assessments and checks, where abnormalities or risk factors were identified. Over a 12 month period the practice had offered 127 patients a health check and53 had taken up the offer. Of the 127 invited, the practice had contacted 12 by telephone, to see if this would help improve take-up rates.
- < >local clinical commissioning group (CCG) average of 80.7% and the national average of 78%.< >local CCG of 81.3% and the national average of 80%.
  87.1% of patients with asthma, had had an asthma review that included an assessment of asthma control using the three Royal College of Physician questions, during the period April 2016 to March 2017. This was above the local CCG of 75.7% and the national average of 76.4%.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way, which took into account the needs of those whose circumstances may make them vulnerable.

Good

Are services effective?

(for example, treatment is effective)

- The practice held a register of patients living in vulnerable circumstances, including those who had a learning disability or other mental health needs.

People experiencing poor mental health (including people with dementia):

Overall, the QOF data, for 2016/17, showed the practice had obtained 100% of the total points available to them for providing targeted care and treatment to this group of patients. This was 2.3% above the local CCG average and 6.4% above the England average.

- 87.5% of patients diagnosed with dementia had their care reviewed, in a face-to-face meeting, during the period April 2016 to March 2017. This was above the local clinical commissioning group (CCG) and national averages of 83.7%.
- 100% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses, had a comprehensive, agreed care plan documented, during the period April 2016 to March 2017. This was above the local CCG average of 92.6% and the national average of 90.3%.

The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example:

- 100% of patients who experienced poor mental health had their level of alcohol consumption recorded in their medical records, during the period April 2016 to March 2017. This was above the local CCG average of 94.4% and the national average of 90.7%.
- 100% of patients experiencing poor mental health, who had a record of blood pressure, during the period April 2016 to March 2017. This was above the local CCG average of 92.7% and the national average of 90.4%.

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care they provided.

- The practice had carried out clinical audits, to help them improve outcomes for their patients. The sample of clinical audits we looked at were relevant, showed learning points and evidence of planned changes to practice. They were clearly linked to areas where staff had identified potential risks to their patients. For example, a clinical audit had been carried out to check staff's compliance with NICE guidance on Lipid modification (lowering cholesterol levels with the use of a statin), following an issue identified during a tutorial with a GP registrar. The first audit showed that not all patients with raised lipids were receiving appropriate statin therapy. The second part of the audit showed that as a result of changes introduced after the first one, more patients had had their needs reassessed and were receiving appropriate statin therapy. In addition, following the second audit, further interventions to improve patient care were identified and shared with staff during a practice meeting. Other audits completed included monitoring the side-effects of new anticoagulants and whether the prescribing of Calcium and Vitamin D3 to at-risk groups was appropriate.
- Clinical staff took part in local and national improvement initiatives. For example, the practice participated in the local CCG's medicines optimisation programme and had performed well. During 2017, using a toolkit provided by the Royal College of General Practitioners, the practice had participated in a review of antibiotic prescribing, for the local medicines optimisation team. The practice also contributed to a demand and access review carried out by their local CCG, to help improve appointment availability in and outside of normal surgery hours. Staff had also participated in other local audits including ones on stroke prevention, atrial fibrillation, Osteoporosis and bone health. Staff were taking steps to improve the care and treatment they provided to patients who had cancer. This included meeting with Cancer Research UK to help them improve their systems and processes in relation to, for example, recalling patients for screening. Also, the practice had provided the practice nurse and administrative staff with additional training in how to better meet the needs of these patients.

The most recent published Quality Outcome Framework (QOF) results for the practice, showed they had obtained 100% of the total number of points available, compared to the local CCG average of 99% and the national average of 95.5%. The overall exception reporting rate was 11.4% compared to the national average of 10%. However, two of the clinical indicators had higher than average exception reporting rates. We shared this with the practice manager who took immediate action to review the reasons for this

Good

Are services effective?

(for example, treatment is effective)

and provide us with feedback. (QOF is a system intended to improve the quality of general practice and reward good practice. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline, or do not respond to, invitations to attend a review of their condition, or when a medicine is not appropriate.)

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included administering immunisations, and taking samples for the cervical screening programme, had received relevant training.

- The practice understood the learning needs of staff and provided protected time and appropriate training to meet them. This included providing staff with a range of appropriate training including fire safety, cardiopulmonary resuscitation and adult safeguarding. The practice manager had been proactive in sourcing safeguarding training for their staff. Other local clinical staff, including locums who had worked at the practice, had been invited to attend. The practice manager had recently completed a leadership in management course, which they felt had helped them to improve how they managed the practice.
- Up-to-date records of staff's skills, qualifications and training were usually maintained. However, with regards to some training for non-clinical staff, the practice had found it difficult to obtain evidence that staff had actually completed this training. Because of this, the practice had just purchased access to a new on-line training system. At the time of the inspection, staff were just about to start their e-learning mandatory training for 2018/19, using the new training package.
- The practice provided staff with ongoing support. This included providing effective inductions, appraisals, mentoring for staff carrying out extended roles, and clinical supervision and support for revalidation. The induction process for the healthcare assistant included the requirements of the Care Certificate.
- There was a clear approach for supporting and managing staff who were underperforming.

Coordinating care and treatment

Staff worked together and with other health and social care professionals, to deliver effective care and treatment.

- Clinical staff were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services, for example, when they were referred to, and discharged from, hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies. Clinicians completed a standard information sharing template for high-risk patients, which was shared with out-of-hours services, to promote better care when the practice was closed.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances. The QOF data, for 2016/17, confirmed that the practice kept a register of all patients in need of palliative care. Staff held a weekly meeting with the community nursing team to discuss patients at risk, including those patients on the palliative care register.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in need of palliative care, patients at risk of developing a long-term condition and patients who were also carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their health.
- Staff ensured any changes to care or treatment were discussed with patients and their carers.
- The practice supported initiatives to improve the health of their patient population. These included, for example, the promotion of smoking cessation and initiatives to tackle weight management.

Consent to care and treatment

The practice obtained consent to care and treatment in line with current legislation and guidance.

- Clinicians understood and followed the requirements of legislation and guidance, when considering consent and decision making.

Good

Are services effective?

(for example, treatment is effective)

- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice had a clear protocol for seeking consent. Staff's compliance with the practice's consent process was regularly monitored.

Good

Are services caring?

Our findings

We rated the practice, and all of the population groups, as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs.
- Staff gave patients timely support and information.
- Reception staff knew that if patients wanted to discuss sensitive issues, or appeared distressed, they could offer them a private room to discuss their needs.
- Both of the patient Care Quality Commission comment cards we received contained positive comments about the care and treatment patients received. This was in line with the results of the NHS Friends and Family Test (FFT) and other feedback received by the practice. Recent results showed 95.7% of patients would recommend the service to family and friends.

Results from the annual National GP Patient Survey of the practice, published in July 2017, showed patients felt they were treated with compassion, dignity and respect. (214 surveys were sent out and 130 were returned. This represented approximately 5.3% of the practice population.) Satisfaction scores relating to consultations with GPs and nurses were either above, or comparable with, local clinical commissioning group (CCG) and national averages. Of the patients who responded to the survey:

- 87% said the last GP they saw or spoke to was good at listening to them, compared to the CCG average of 93% and the national average of 89%.
- 96% said they had confidence and trust in the last GP they saw or spoke to, compared to the local CCG average of 97% and the national average of 95%.
- 92% said the last GP they spoke to was good at treating them with care and concern, compared to the local CCG average of 90% and the national average of 86%.
- 99% said the nurse was good at listening to them, compared to the local CCG average of 94% and the national average of 91%.
- 99% said the last nurse they saw or spoke to was good at treating them with care and concern, compared to the local CCG average of 93% and the national average of 91%.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about their care and treatment. Evidence obtained during the inspection indicated the practice had systems and processes in place to meet the needs of patients who have a disability, impairment or sensory loss. Although staff were not familiar with the Accessible Information Standard (AIS), the practice manager told us they would take action to review how the practice operated against this standard, to ensure they were fully compliant. (The AIS is a requirement to make sure that patients and their carers can access and understand the information they are given.)

Interpretation services were available for patients who did not have English as a first language. However, there was no information in the reception area informing patients that this service was available.

- Staff communicated with patients in a way that they could understand. For example, they had obtained easy to read materials from the local learning disability service, to help them communicate effectively with patients who have a learning disability.

The practice had taken steps to identify patients who were carers. The new patient information form asked patients to indicate if they were also carers. The practice's computer system alerted clinicians if a patient was also a carer. The practice had identified 38 patients who were carers (1.5% of the practice list).

- One of the GP partners acted as the carers' lead, to help ensure that the various services supporting carers were coordinated and effective. The practice's website signposted patients to various carers' guides, to help ensure they knew how to access care and support. Arrangements were in place to offer carers a health check.
- Staff told us that if families had experienced bereavement, their usual GP contacted them by telephone, and visited where this was appropriate.

Results from the National GP Patient Survey showed patients responded very positively to questions about their involvement in planning and making decisions about their

Good

Are services caring?

care and treatment. Results were above all of the local CCG and national averages, and patients' satisfaction with how the practice nurse involved them in making decisions about their care, was significantly above the national average. Of the patients who responded:

- 92% 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%.
- 89% said the last GP they saw was good at involving them in decisions about their care; compared to the local CCG average of 87% and the national average of 82%.
- 97% said the last nurse they saw was good at explaining tests and treatments, compared to the local CCG average of 91% and the national average 90%.
- 96% said the last nurse they saw was good at involving them in decisions about their care, compared to the local CCG average of 88% and the national average of 85%.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of respecting patients' dignity and right to privacy.
- The practice complied with the Data Protection Act 1998. Patient information leaving the surgery was stored securely and all computers were password protected.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We rated the practice, and all of the population groups, as good for providing responsive services across all population groups.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. They took account of patients' needs and preferences.

- The practice understood the needs of their patient population and tailored services in response to those needs. For example, by providing online services which enabled patients to request repeat prescriptions and book appointments in advance. Extended opening hours were provided to offer patients greater flexibility when booking appointments. The practice improved services where possible, in response to unmet needs. For example:
- There was an innovative approach to providing responsive, integrated person-centred care, particularly for older people and people with complex needs. The practice understood that these patients were at more risk, if emergency services were delayed because of their rural location. To address this, the practice had collaborated with the local ambulance service to set up a rural community paramedic service. Clinical staff had provided training and clinical support to the paramedic team for which they received no extra funding. There was also a telephone 'hot-line' which paramedics could use to obtain clinical advice and support from the GPs. This had helped to significantly reduce the number of accident and emergency attendances. For example, in 2014/15, there had been 726 attendances. In 2017/18, this had reduced to 453 attendances.
- Following difficulties experienced by some patients visiting the dispensary to collect their medicines, arrangements were put in place to deliver medicines to agreed drop-off points and shops in outlying rural areas.
- The provision of 'patient-decided' consultation lengths for any patient requesting a consultation with a GP.
- The facilities and premises were appropriate for the services the practice delivered.
- The practice made reasonable adjustments when patients found it hard to access services.
- Care and treatment for patients with multiple long-term conditions, and patients approaching the end-of-their lives, was coordinated with other services.

Older people:

- All patients aged 75 and over had a named GP who supported them in whatever setting they lived.
- The practice offered home visits and urgent appointments for those with enhanced needs. However, the practice had a low home visit rate as, wherever possible, older patients were encouraged to attend the surgery, so clinicians could access their full medical records and carry out an appropriate assessment of each patient.
- There was a dedicated emergency option on the practice's telephone line, so patients with a medical emergency could access urgent care.
- The appointment system took into account local bus timetables, so those patients living in outlying rural areas could get to the practice more easily.
- The practice planned for bad weather so vulnerable older patients were not left without appropriate care. Following recent bouts of bad weather, the practice had coordinated travel arrangements with the community health team to help them to continue providing care and treatment to patients with end-of-life and complex needs, who lived in remote rural areas. Other arrangements included identifying which vulnerable patients would need their prescriptions prepared in advance of predicted bad weather and also delivering medicines to vulnerable patients during heavy snowfalls.

People with long-term conditions:

- Patients with a long-term condition (LTC) received an annual review to check their health and medicines needs were being appropriately met. These were arranged at times to suit the needs of each patient. This made it easier for patients with LTCs living in rural areas, to access the care and treatment they needed.
- The practice actively participated in research projects. They had used findings from their participation to improve how they met the needs of patients with LTCs

such as asthma, diabetes and chronic obstructive pulmonary disease (COPD). For example, as a result of their involvement in an asthma-related research project, the practice had developed their own in-house system for identifying patients at risk of an asthma exacerbation, to help ensure they received immediate triage.

- Since the last inspection, the practice had introduced a new and innovative approach to recording the outcome of GP consultations and long-term care planning, which had, in particular, helped to improve continuity of care for patients with LTCs. This involved the use of voice recognition software and an audit carried out by the practice had demonstrated that the use of the software had led to significant improvements in the quality of information recorded by the GPs, following consultations. For one of the GP partners, the audit showed: a 30% improvement in care plan recording; a 74% improvement in diagnosis recording; and a 24% improvement in recording the details of the examinations they had carried out.
- Clinical staff provided holistic, community-based care and support to patients with long-term conditions and those with palliative care needs. We saw a number of examples where staff had provided very good care and treatment to patients over and above what we would normally encounter.
- A range of healthcare specialists provided clinics in the health centre in which the practice was located. This helped patients to access care and treatment closer to home. These clinics included chiropody, physiotherapy, counselling and psychological services.
- The practice held regular meetings with local community health staff, to discuss and manage the needs of patients with complex medical needs.

Families, children and young people:

- Systems were in place which helped to identify and follow up children living in disadvantaged circumstances who were at risk. For example, multi-disciplinary team meetings were held to discuss the needs of vulnerable children and families. These meetings were used, for example, to follow up children and young people who failed to attend for planned appointments or for routine immunisations.
- Parents calling with concerns about a child under the age of 18 were able to access clinical advice and support, and were offered a same-day appointment when necessary.
- A twice-monthly, health visitor led, drop-in clinic, also provided opportunities for parents to access advice and support in relation to the health of their child.
- Weekly post-natal clinics
- Clinical staff provided young people with access to appointments where they were able to see their doctor alone. Staff demonstrated they were sensitive to the difficulties younger patients can face in a rural community when accessing a confidential appointment. The practice operated the 'C card' system, which enabled young people to receive condoms confidentially.
- Patients were able to access contraceptive services at the practice, including contraceptive implants and emergency contraception.
- The premises were suitable for mothers and babies, with baby-changing, breast feeding and quiet room facilities provided.

Working age people (including those recently retired and students):

- The needs of this population group had been identified and the practice had adjusted the services they offered to ensure these were accessible, flexible and offered continuity of care. For example, patients were able to access extended hours appointments with a GP one evening a week, as well as a long-term conditions surgery provided by the practice nurse. Telephone consultations were provided to make it easier for working patients to access clinical advice during normal working hours.
- Patients were able to access NHS Health Checks. The practice was trialling a new system, which involved telephoning patients beforehand, to help improve uptake rates in response to offering this service.
- Communication with patients was good. Regular newsletters were provided for patients and work was currently underway to update the practice's website, to make it more interactive with new technology such as smart phones.

Good

Are services responsive to people's needs?

(for example, to feedback?)

People whose circumstances make them vulnerable:

- The practice held registers of patients living in vulnerable circumstances, including those with learning disabilities, 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 review of their needs to help ensure they were receiving the support they needed.
- In collaboration with the wider healthcare team, the practice actively participated in the local High Risk Patient Programme, to help manage the needs of their most vulnerable patients.
- Patients whose circumstances made them vulnerable were able to benefit from the practice's easy to use appointments and the good access provided to appointments.
- 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 in normal working hours and out-of-hours.
- The practice had information available for vulnerable patients about how to access various support groups and voluntary organisations.
- Where clinicians judged that patients had complex needs, an emergency healthcare plan was put in place. Concerns about the wellbeing of vulnerable patients were identified prior to, and discussed at, the practice's multi-disciplinary meeting, to help ensure they were receiving appropriate care from the right professionals. Paramedics based at the health centre also attended these meetings.

People experiencing poor mental health (including people with dementia):

- Staff had a good understanding of how to support patients with mental health needs, including patients living with dementia. Staff had completed dementia awareness training and some acted as dementia friends, to help improve how patients with dementia experienced the service.
- Patients with mental health needs, including those with dementia, were offered an annual review and, where appropriate, referred to mental health services.
- Information about how to access mental health services was available in the practice. Patients were also able to access mental health information via the practice's website. In addition, patients were able to access psychological treatment and support at the practice.

Timely access to the service

Patients were able to access care and treatment from the practice in a very timely manner.

- The appointment system was easy to use. The practice had introduced 'patient-decided consultation lengths' where patients were able to routinely choose the appointment length they felt would best meet their needs, i.e. ten or twenty minute appointments.
- Patients had timely access to initial assessments, test results, diagnosis and treatment. All patients received a personal call from one of the GPs, to inform them of the results of their tests.
- Waiting times, delays and cancellations were minimal and managed appropriately. Emergency appointment slots were available each morning and afternoon clinic session. We looked at the practice's appointments system in real-time on the afternoon of the inspection. We found there was capacity for patients to be seen by a doctor later that day. A routine nurse appointment was available within 48 hours. This was reflected in the very good feedback we received from patients about access to care and treatment.
- Patients with the most urgent needs had their care and treatment prioritised.

Results from the annual National GP Patient Survey of the practice, published in July 2017, showed that patients' satisfaction with how they could access care and treatment, was above all of the local and national averages. In particular, patients' satisfaction with the ease of getting through to the practice on the telephone and their experience of making an appointment, was significantly above the local and Clinical Commissioning Group (CCG) averages. (214 surveys were sent out and 130 were returned. This represented approximately 5.3% of the practice population.) The feedback was also consistent

Good

Are services responsive to people's needs?

(for example, to feedback?)

with feedback given in Care Quality Commission comment cards that had been completed and by our observations on the day of the inspection. Of the patients who responded to the survey:

- 85% were satisfied with the practice's opening hours, compared to the local CCG average of 75% and the national average of 76%.
- 99% said they could get through easily to the practice by telephone, compared to the local CCG average of 76% and the national average of 71%.
- 93% said that the last time they wanted to speak to a GP or nurse they were able to get an appointment, compared to the local CCG average of 86% and the national average of 84%.
- 92% described their experience of making an appointment as good, compared to the local CCG average of 74% and the national average of 73%.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately, to improve the quality of care.

- Information on the practice's website informed patients they should make their complaint directly to the practice manager. However, we did not see any complaint related information in the practice's waiting area. We were told should a patient wish to make a complaint, an information leaflet would be printed off and they would be signposted to the practice manager.
- The practice's complaint policy and procedures were in line with recognised guidance, although it did not include the contact details for the Parliamentary and Health Service Ombudsman office. One complaint had been received during the previous 10 months. We reviewed this complaint with the practice manager and found it had been satisfactorily handled in a timely way. The complainant was offered an apology, an explanation of the circumstances that had led to their concerns and a solution to address the problem. We noted that the complainant was very satisfied with how the practice had handled their complaint.

Are services well-led?

Outstanding ☆

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

Our findings

We rated the practice, and all of the population groups, as outstanding for providing well-led services.

Leadership capacity and capability

Leadership at the practice was compassionate, inclusive and effective at all levels.

- Leaders were able to demonstrate the high levels of experience, capacity, capability and skills needed to deliver very high-quality, sustainable care.
- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. In particular, they had a deep understanding of the issues, challenges and priorities, for their own service, as well as those relating to delivering general practice within a rural setting.
- Leaders were visible and approachable. They worked closely with staff to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high-quality care and promote good outcomes for patients, and leaders demonstrated a clear commitment to system-wide collaboration and leadership.

- Leaders had a clear vision of what they wanted to achieve at the practice and there was a systematic and integrated approach to monitoring and reviewing their progress. Following a recent leadership meeting, held at the end of 2017, the practice manager told us they were in the process of devising a business plan, to set out how the practice's vision would be delivered. A second meeting was planned for March 2018 to agree the new business plan and their strategy for the next three years. The practice manager told us the future development of the practice and strategies to drive improvements, were regularly discussed during management meetings.
- Staff were aware of and understood the practice's vision and values, and their role in achieving them.
- Clinical staff worked collaboratively with others, both locally and nationally, to help promote a better understanding of the issues affecting their own practice, as well as that of rural GP practices in general. One of the GP partners was the chair of the Royal College of General Practitioners (RCGPs) Rural Forum. The work they did in this role had helped to raise the profile of rural general practice, locally and nationally, and had led to the creation of a rural GP Registrar integrated training post at the practice.

Culture

The practice had a very strong culture of high-quality sustainable care.

- Leaders had an inspiring shared purpose and strove to deliver and motivate staff to succeed. Staff said they felt respected, supported and valued and they were proud of the service they provided. There was strong collaboration and team-working and a common focus on improving quality and patients' experience of using the practice.
- The practice focused on the needs of patients and demonstrated this through their good Quality and Outcomes Framework (QOF) performance.
- The practice manager took action in relation to performance that was not consistent with the practice's vision and values.
- The provider was aware of, and had systems to ensure compliance with, the requirements of the duty of candour.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that their concerns would be addressed.
- There were processes for providing all staff with opportunities for development. All staff had received an appraisal in the last year. Where relevant, staff were supported to meet the requirements of professional revalidation.
- Clinical staff were considered valued members of the practice team and were given protected time for professional development and evaluation of their clinical work.

Are services well-led?

Outstanding ☆

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

- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity, with some staff having completed training in this area.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Leaders had a systematic approach to working with other organisations to improve patient outcomes.
- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. For example, the practice had an agreed programme of meetings for staff at all levels within the organisation. This helped to ensure staff were clear about their roles and responsibilities and were supported to carry these out. In addition, a daily thirty minute meeting was held for clinical staff to discuss issues of concern relating to patient care and sign prescriptions. Regular GP partner and practice manager meetings were held, to ensure the practice was continuing to operate safely and effectively.
- Staff were clear about their roles and accountabilities, including those in relation to safeguarding vulnerable patients and infection prevention and control.
- Practice leaders had put in place effective policies, procedures and activities to ensure safety and they monitored these to make sure they were operating as intended.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance. Leaders ensured that staff at all levels had the skills and knowledge to manage risks and performance. Any problems were identified and addressed quickly and openly.

- There was an effective process to identify, understand, monitor and address current and -future risks, including risks to patient safety.
- The practice had processes to manage current and future performance. They could demonstrate the effective performance of their clinical staff by, for example, the results of the audits of prescribing practice they had carried out.
- The practice manager had effective oversight of MHRA alerts, incidents, and complaints, and ensured appropriate actions were undertaken by the relevant staff.
- The practice's clinical audits had a positive impact on the quality of care and outcomes for patients. There was evidence of action to change practice to improve quality.
- The practice had plans in place to help them deal with a range of emergencies.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to improve performance. For example, the practice had systems in place to help them identify any areas of QOF under-performance. The GP partners and practice manager used this information to help them manage resources, direct staff activity and deliver improved care and treatment to their patients.
- Staff meetings were used to discuss the quality and sustainability of the services the practice provided. All staff were encouraged to be involved in these discussions.
- Information used by staff to monitor the practice's performance and the delivery of quality care, was accurate and useful. Where staff identified weaknesses, they took action to address these.
- The practice used information technology (IT) systems to monitor and improve the quality of care. For example, the practice's IT systems enabled patients to request repeat prescriptions online or book appointments.
- The practice submitted data or notifications to external organisations as required. For example, staff submitted prescribing data to the local clinical commissioning group (CCG), to provide evidence of compliance with locally agreed targets.

Are services well-led?

Outstanding ☆

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

- There were effective arrangements in place for managing the availability, integrity and confidentiality of patient identifiable data, and these were in line with data security standards.

Engagement with patients, the public, staff and external partners

The practice involved patients, staff and external partners, to support high-quality sustainable services.

- Patients were encouraged to express their views and these were listened to. There was an active 'virtual' patient participation group (PPG) which had 144 members, who were consulted from time-to-time about matters relating to the running of the practice. In addition, a small number of members met every two to three months. Staff's views and opinions were obtained via staff meetings and through the practice's appraisal system. Staff said their feedback was encouraged, valued and acted on.
- Leaders were proactive in helping patients understand plans for developments in their locality. For example, information about the re-development of the local hospital had been uploaded onto the practice's website, to help patients participate in local decision-making. The practice also supported patients to understand how national improvement initiatives affected patients at the practice. A representative from the Northumberland cancer bowel screening programme had recently attended a PPG meeting to share information about a local project to promote screening for bowel cancer amongst the population.
- The practice supported the work of the local carers' group, to help them provide more responsive services to their patients who were also carers. Patients had told the practice they would benefit from having access to one-to-one support from a member of the group. The practice shared this feedback with the organisers of the group who then appointed a member of staff to provide this service. Staff had also actively worked with the group to help secure extra funding so they could hold a monthly carers' meeting.
- The practice worked in a transparent and collaborative way with the local CCG and they made sure their systems provided the data they needed to monitor their performance against local and national standards.

Continuous improvement and innovation

There were rigorous systems and processes in place that supported learning, continuous improvement and innovation.

- Safe innovation was celebrated and there was a clear and proactive approach to seeking out and embedding more effective ways of working. For example, the practice had collaborated with the local ambulance service to set up a rural community paramedic service. Clinical staff had provided training and clinical support to the paramedic team. Leaders had introduced used a 'patient-decided' consultation approach that actively encouraged patients to choose the length of their appointments, to help provide them with a better appointment experience.
- There was a strong focus on continuous learning and improvement at all levels within the practice. Cheviot Medical Group is an accredited research and training practice. Staff undertook research which they judged would benefit their patients and used outcomes from this to improve the care and treatment they provided to patients. Clinical staff had helped form a local research alliance, which provided increased opportunities for sharing expertise and learning outside of the practice.
- The practice actively supported a successful bid for a development grant to help set up a local GP locum agency. This was to help improve access to locum staff in rural practices within the locality. The practice also offered locum GP staff access to their in-house training programme and both GP partners provided support to help locums achieve revalidation.
- The GP partners and the practice manager encouraged staff to attend, and provided opportunities for, internal and external training.
- The clinical team provided opportunities for GP registrars and medical students to learn about general practice and for young people interested in a medical career to participate in work experience placements. There was evidence the practice used feedback from their GP Registrars (GPR) to improve patient care. For example, following an audit carried out by a GPR, the practice introduced a new system for testing samples and provided relevant staff with the training they needed to implement it.

Are services well-led?

Outstanding ☆

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

- Staff knew about improvement methods and had the skills to use them. For example, since the last inspection, the practice had carried out an audit of the quality of their patient records, to help improve the continuity and quality of care their patients received.
- During the last 12 months, the practice had collaborated with other local GP practices in North Northumberland to identify, and then purchase, a training software programme that better met their needs.
- Learning was shared and used to make improvements. Where patients had received less-than-good care and treatment internally and from other services, the practice shared these incidents externally, to promote learning across the whole healthcare system. Following a significant event involving the care and treatment provided by external agencies to patients with mental health needs, clinical staff had actively collaborated with the local mental health trust to bring about improvements. These included the provision of urgent consultant/community psychiatric nurse appointments and improved co-coordination between key organisations providing mental health care. Feedback about the improvements was shared within the locality, to help promote learning.