The Bondgate Practice

Quality Report

The Bondgate Practice, Seahouses Health Centre, James Street, Seahouses, Northumberland, NE68 7XZ

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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?	Requires improvement
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 a planned comprehensive inspection of The Bondgate Practices on 6 October 2014. We inspected all four locations registered with the Care Quality Commission. These were the Alnwick main surgery and the Seahouses, Embleton and Longhoughton branches.

We rated the practice overall as good.

Our key findings were as follows:

- The practice covered a large geographical and rural area; services had been designed to meet the needs of the local population.
- Feedback from patients was positive; they told us staff treated them with respect and kindness.
- Staff reported feeling supported and able to voice any concerns or make suggestions for improvement.
- The practices were clean and further work was planned to improve the approach to infection control.

However, there were also areas of practice where the provider needs to make improvements.

Importantly, the provider must:

- Ensure that prescriptions are checked and signed by GPs before medicines are dispensed and issued to patients.

In addition the provider should:

- Ensure that blank prescriptions are stored and recorded in accordance with national guidance to reduce the risk of theft or misuse.

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?

Requires improvement

The practice was rated as requires improvement for safe as there were areas where improvements should be made. Staff understood and fulfilled their responsibilities to raise concerns, report incidents and near misses. Lessons were learnt and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed in most cases. However, the practice must improve the way they manage medicines.

Are services effective?

Good

The practice was rated as good for effective. Data showed patient outcomes were at or above average for the locality. NICE guidance was referenced and used routinely. Patients' needs were assessed and care was considered in line with current legislation. This included assessment of capacity and the promotion of good health. Staff had received training appropriate to their roles and further training needs had been identified and planned. The practice worked with other healthcare professionals to share information.

Are services caring?

Good

The practice was rated as good for caring. Data showed patients rated the practice higher than others for several aspects of care. Patients were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was available for most patients to help them understand the care available to them. We also saw staff treated patients with kindness and respect ensuring confidentiality was maintained.

Are services responsive to people's needs?

Good

The practice was rated as good for responsive. The practice reviewed the needs of their local population and engaged with the NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) to secure service improvements where these were identified.

Some patients reported difficulty in accessing appointments, but we saw the practice had implemented improvements to address these concerns and was still in the process of evaluating this. Patients reported that they had access to a named GP and continuity of care, particularly at branch surgeries. Urgent appointments were

Summary of findings

available the same day. The practice made the best use of the facilities they had available to enable continued service in rural locations. The practice was well equipped to treat patients and meet their needs.

There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of learning from complaints with staff and other stakeholders. The practice had implemented suggestions for improvement and made changes to the way it delivered services as a consequence of feedback from the Patient Participation Group (PPG).

Are services well-led?

Good

The practice was rated as good for well-led. The practice had a clear vision which had quality and safety as its top priority. The strategy to deliver this vision had been promoted with stakeholders and was regularly reviewed and discussed with staff. High standards were promoted and owned by all practice staff with evidence of team working across all roles. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. The practice carried out proactive succession planning. We found there was a high level of constructive staff engagement and a high level of staff satisfaction. The practice sought feedback from patients. There was an active patient participation group (PPG).

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 was rated as good for the care of older people. Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older people. The practice offered proactive, personalised care to meet the needs of the older people in its population. Older patients confirmed with us how they valued the care and treatment provided by the practice, particularly in relation to end of life care. There were care plans in place for the frailest older patients. All patients over the age of 75 had a named GP.

The practice was responsive to the needs of older people, including offering home visits for the most old and frail patients. There were good communication mechanisms with other providers of care and treatment for frail older patients, such as district nurses.

People with long term conditions

Good

The practice was rated as good for the population group of people with long term conditions. Emergency processes were in place and referrals made for patients in this group that had sudden deterioration in health. This was supported by care plans for those patients whose long term conditions put them most at risk of deteriorating health and whose conditions were less well controlled.

When needed longer appointments and home visits were available. All patients had a named clinician and structured annual reviews to check their health and medication needs were being met. For those people with the most complex needs the named GP worked with relevant health care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice was rated as good for the population group of families, children and young people. Systems were in place for identifying and following up children living in disadvantaged circumstances and who were at risk. For example, for children who failed to attend for routine childhood immunisations. Immunisation rates were relatively high for all standard childhood immunisations. Appointments were available outside of school hours and premises were suitable for children and babies. We were provided with good examples of joint working with paediatricians, midwives and health visitors.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice was rated as good for the population group of the working -age people (including those recently retired and students). The needs of the working –age, recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering a full range of health promotion and screening, which reflected the needs of this age group.

People whose circumstances may make them vulnerable

Good

The practice was rated as good for the population group of people whose circumstances may make them vulnerable. The practice held a register of patients who may be more vulnerable, such as people with learning disabilities. The practice had carried out annual health checks and offered longer appointments for people with learning disabilities.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice was rated as good for the population group of people experiencing poor mental health (including people with dementia).Data about the practice as a whole, in the Quality and Outcomes Framework (QOF) demonstrated that 93.8% of people with physical or mental health conditions had received an offer of support and treatment within the last 15 months. 82.1% of patients with dementia had their care reviewed within the preceding 15 months. The practice worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.

The practice had signposted patients experiencing poor mental health to support groups, including Mind. The practice had a system in place to follow up on patients who had attended accident and emergency where there may have been mental health needs.

Summary of findings

What people who use the service say

We spoke with two members of the practice Patient Participation Group (PPG) in advance of the inspection. During the inspection we spoke with 31 patients. This included 25 at the main Alnwick practice, one patient at the Embleton Branch and five patients at the Longhoughton Branch. The majority of patients were complementary about the services they received at the practice. The patients we spoke with reported they felt safe and had no concerns when using the service. They told us that all staff treated them with dignity and respect. Some patients raised concerns with us about how quickly they could book a routine appointment. However they told us that they could normally get an emergency appointment on the same day. A number of patients told us that they had got an appointment on the same day they had contacted the surgery to make it.

We reviewed 45 CQC comment cards completed by patients prior to the inspection. This included six cards from patients at the Alnwick main surgery, six from the Embleton branch, 16 from the Seahouses branch and 17 from the Longhoughton branch. All were complimentary about the practices, staff who worked there and the quality of service and care provided. Words used to describe the practice were excellent, friendly, helpful and second to none.

Patients commented how clean the Embleton branch surgery was. Two patients at the Seahouses branch commented that sometimes it was inconvenient that the branch was closed one day a week. However, patients said they felt that staff genuinely had time for them. Patients at the Longhoughton branch said they appreciated having a regular GP at the branch.

The latest GP Patient Survey completed in 2013/14 showed the large majority of patients were satisfied with the services the practice offered. The data related to the main practice and all three branch surgeries. The results were:

- Contact practice by phone – 92%
- Surgery opening hours – 70.5%
- Overall satisfaction – 90.8%
- Patients who would recommend the practice: 83.8%

Areas for improvement

Action the service MUST take to improve

- Ensure that prescriptions are checked and signed by GPs before medicines are dispensed and issued to patients.

Action the service SHOULD take to improve

- Ensure that blank prescriptions are stored and recorded in accordance with national guidance to reduce the risk of theft or misuse.

The Bondgate Practice

Detailed findings

Our inspection team

Our inspection team was led by:

A **CQC Lead Inspector.** The team included a GP, CQC inspectors and a variety of specialists:

- A specialist advisor with experience of GP practice management
- Two CQC pharmacy inspectors.
- An additional CQC inspector
- An expert by experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

Background to The Bondgate Practice

The Bondgate Practice covers a largely rural area. The main surgery is based in the centre of Alnwick, with branch surgeries in Seahouses, Embleton and Longhoughton. The three branches are dispensing practices. This means under certain criteria they can supply eligible patients with medicines directly.

The surgery in Alnwick is located alongside the local community hospital and another GP practice. All patient services are delivered from the ground floor and there are 18 consultation / treatment rooms. There are good access facilities for patients with disabilities.

The Seahouses branch is a purpose built facility shared with another practice. Some consultation and treatment rooms are shared with the other practice. There is a shared baby clinic, podiatry and physiotherapy clinic. There are good access facilities for patients with disabilities and services are delivered from the ground floor.

The Embleton branch is purpose built and based in a residential area, all facilities are on the ground floor. It has two consulting rooms, two treatment rooms and a large waiting area. There are good access facilities for patients with disabilities.

The Longhoughton Surgery is based in a residential area of Longhoughton where the families of those serving at the local RAF base live. Medical services are provided to local people and to the families of those serving at the RAF base. The premises is rented from the RAF and the rental agreement means that the practice are unable to make any changes to this property to make it more suitable as a location for delivering primary healthcare. There is limited access for patients with disabilities, but the practice has made reasonable adjustments to allow patients to access this service.

The practices provide primary medical care services to patients within a 220 square mile area, living in the area including Alnwick, Glanton, and Alnmouth. The practice boundaries go from Bamburgh, Warren Mill, Ingram and Swarland to Warkworth.

The provider is a partnership of six doctors. The practice provides services to approximately 8,900 patients of all ages. All patients registered can access services at the main surgery or any of the three branches. The practice is commissioned to provide services within a Personal Medical Services (PMS) Agreement with NHS England.

The practice also has a medicines manager, three practice nurses, three healthcare assistants, a practice manager, a reception manager, seven dispensers and 18 reception and administrative staff. The practice is a teaching practice. They have a foundation doctor and a GP registrar working at the practice. They also train and support final year medical students.

Detailed findings

The service for patients requiring urgent medical attention out of hours is provided by Northern Doctors Urgent Care Ltd and the 111 service.

The addresses of the main surgery and branches are

- Main - Alnwick, Infirmary Close, Alnwick, Northumberland, NE66 2NL
- Branch - Seahouses Surgery, The Health Centre, James Street, Seahouses, Northumberland, NE68 7XZ
- Branch - Embleton Surgery, West View, Embleton, Northumberland, NE66 3XZ
- Branch - Longhoughton Surgery, 4-6 Portal Place, Longhoughton, Northumberland, NE66 3JN

We inspected the main surgery and all three branches.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the 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.

This provider had not been inspected before and that was why we included them.

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. This included the local Clinical Commissioning Group (CCG) and the NHS Local Area Team (LAT). We spoke with two members of the practice's Patient Participation Group (PPG).

We carried out an announced visit on 6 October 2014. During our visit we spoke with a range of staff. These included GPs, Practice Nurses, Healthcare Assistants, Dispensers, Reception and Administrative staff. We also spoke with 33 patients who used the service. We reviewed 45 comment cards where patients and members of the public shared their views and experiences of the service. Six were collected at Alnwick, 16 from Seahouses, six from Embleton and 17 from Longhoughton.

Requires improvement

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example they used reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses. We saw the practice had improved processes as a result of incidents.

We reviewed safety records and incident reports, and the minutes of meetings where these had been discussed, These demonstrated that the practice had processes in place to identify and take action where incidents happened or risks were identified. The practice had managed safety incidents consistently over time and so could demonstrate a safe track record.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. All staff had responsibility for reporting significant or critical events. Records were kept of significant events, and these were made available to us. We looked at four significant or critical events records. We found details of the event, key risk issues, specific action required and learning outcomes and action points were noted. There was evidence that significant events were discussed at clinical and governance meetings, to ensure learning was disseminated and implemented. The practice recorded significant events electronically in a number of places, which made it difficult for them to easily identify trends and numbers.

We discussed the process for dealing with safety alerts with the GPs. Safety alerts inform the practice of problems with equipment or medicines or give guidance on clinical practice. There was a practice Medicines Manager, who identified any alerts and sent these via email to staff across the surgery and branches. The GP who led on medicines prescribing for the practice gave an example of the action taken following a drug safety alert on the medicine Domperidone. We saw the practice had processes in place to ensure patient safety alerts were identified and acted upon.

Reliable safety systems and processes including safeguarding

All staff had received relevant training on safeguarding and we saw evidence of this on staff files. Staff knew their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Contact details were easily accessible on a shared drive. Practice staff were able to tell us who the GP lead for safeguarding was in the Northumberland area, from whom they could access further information and advice.

The practice had good arrangements for the safeguarding of children. The lead GP and a senior nurse attended multi-agency safeguarding meetings, along with the consultant paediatrician who worked from the Alnwick Surgery. There were good systems for recording and following up where action was needed and sharing information with other team members. Where children did not attend for vaccinations, there were appropriate processes in place to follow up these and take further action where needed. This allowed the practice to monitor and plan for the needs of the most vulnerable families within the practice population.

The GP lead for children was actively involved with the local paediatric service, assisting one day a week in a clinic. This increased awareness and information sharing, which helped support the practice within children's safeguarding systems.

A chaperone policy was in place. Chaperone training had been provided to all staff during a whole team half day event in September 2012. Normally nursing staff would act as a chaperone, however administrative and reception staff had also been trained to undertake this role where required and understood their responsibilities when acting as chaperones. Clinicians documented that a chaperone had been offered and either accepted (with name of chaperone) or declined by the patient, in the patient record. However, we noted that this service was not advertised in all of the branches.

Medicines Management

Arrangements for managing medicines were checked at the main surgery, and at the three branch surgeries where medicines were dispensed for patients who did not live near a pharmacy. The branch practices must improve the way they manage medicines.

Requires improvement

Are services safe?

The management of repeat prescription records for patients who took medicines for long term conditions was assessed at the main surgery. Staff said that only GPs were authorised to make alterations to patients' repeat prescription records. The practice had a safe system for reviewing hospital discharge and clinic letters. Where changes to medicines were recommended or made, these were highlighted promptly to GPs who made the necessary changes to patients' records. Staff who dealt with the day-to-day issue of repeat prescriptions were knowledgeable and understood their roles and limitations.

Systems for dispensing medicines were assessed at all three branch surgeries. Staff said that eligible patients had the choice of having their medicines dispensed by the surgery or by a pharmacy. Staff had written procedures for the safe dispensing of medicines and these were recently reviewed. Some procedures for other aspects of medicines management needed review to reflect actual practice, such as systems for medication review.

Arrangements were in place to minimise dispensing errors. Errors affecting dispensed medicines were recorded and reviewed at dispensary and practice meetings to reduce the risk of them happening again. This helped to ensure patients received their medicines correctly. However, the records of these meetings and the agreed actions to improve patient safety were not available at the time of the inspection.

There was no robust system in place to regulate the issue of medicines where the annual medicines review was out-of-date. There was also no system in place to ensure that GPs checked and signed repeat prescriptions before the medicines were dispensed and issued to patients at branch surgeries.

The arrangements for the review of medicines for patients with long term conditions were checked. Regular medicines reviews are necessary to make sure that patients' medicines are up to date, relevant and safe. Staff said that overall the GPs were responsible for these reviews. The practice had recently introduced a new system of recall of patients for medicines review. This was yet to be fully implemented to ensure that the majority of patients on long term medicines received an annual review.

We checked the storage of medicines, including emergency medicines and vaccines, at all surgeries. These were stored at appropriate temperatures and stock was rotated to ensure that older medicines were dispensed first. There was a system in place for monitoring the expiry dates of medicines and this was clearly recorded. All medicines were in date with the exception of four injections that expired two months previously.

The storage and recording of blank prescriptions was not managed well. They were stored in unsecured areas and were not in locked cabinets at the main surgery and all branches. Guidance from NHS Protect states as a minimum, prescription forms should be kept in a locked cabinet within a lockable room or area. There was no audit in place to record and monitor stock. The recording and audit trail of blank prescriptions was poor and this could lead to theft or misuse of prescriptions that could go undetected.

The storage of medicines at the main surgery was not secure. The storage of oxygen cylinders was checked. There were no warning signs and the practice manager told us that building plans did not identify where these were kept. This could be a hazard in the event of a fire.

Appropriate records relating to the use of medicines that were liable to misuse, called controlled drugs, were kept. Audits of these were completed monthly to ensure that medication was managed safely and could be accounted for at all times.

Records showed staff who managed the dispensary had received appropriate training. Staff said they had regular appraisals.

We saw a system in place for managing national alerts about the safety of medicines. Records showed that the alerts were distributed by the medicines manager to relevant staff for implementation. Alerts were discussed and action plans were produced and implemented to promote patient safety. Dispensers working in the branch surgeries implemented actions as necessary, such as removing defective medicines from stock, to protect people from harm.

Cleanliness & Infection Control

We saw that all four practices were visibly clean and tidy. There was a daily cleaning schedule for all four premises and some tasks were to be completed on a weekly basis. Patients we spoke with told us they were happy with the

cleanliness of the facilities. Comments from patients who completed CQC comment cards reflected this. The practice had a range of policies and procedures relating to infection control.

The practice had identified that the chairs and carpets in the treatment room at the Embleton Branch were not easy to wash and keep clean. They recognised that action needed to be taken in relation to this, but had not yet identified resources to allow remedial work to be undertaken.

Staff used single use instruments to reduce the risk of the spread of infections. We saw that personal protective equipment, such as gloves and aprons were available in clinical areas. Cleaning kits for dealing with spillage of bodily fluids were available in the reception area. There were also sufficient supplies of hand sanitising gel and hands soaps available in clinical areas.

There were arrangements in place for the safe disposal of clinical waste and sharps, such as needles. There were also contracts in place for the collection of both general and clinical waste. There were sharps disposal boxes in all the clinical areas of the practice. It was noted that not all of the sharps boxes within the practices had been dated or signed on commencing use. It is best practice that sharps boxes are signed on commencing and collection to provide an audit trail.

The practice had started an audit process to improve infection control procedures. This had resulted in an action plan to address those areas where change could be easily implemented. This had included changing the privacy curtains in treatment rooms to disposable ones that were changed every six months. The practice manager told us that work on infection control was on going and they were plans to phase improvements over a number of months.

Equipment

The practice had a range of equipment in place that was appropriate to the service. We saw regular checks took place to ensure it was in working condition. We saw that where required, equipment was calibrated (adjusted for accuracy) in line with manufacturer's guidelines.

The practice had recently purchased a centrifuge to enable more flexibility in the taking and processing of blood samples. This meant greater flexibility of appointments could be offered to patients as the practice no longer needed to arrange appointments based on when the courier picked up blood samples. The courier service for samples was operated by the hospital laboratory. In the past, the practice had explored whether collection times could be later in the day. However, the courier service could not collect at a later time due to the rural nature of the practice and the distance from the hospital.

Staffing & Recruitment

We saw the practice had recruitment policies in place that outlined the process for appointing staff. These included processes to follow before and after a member of staff was appointed. For example, applicants would be invited to attend an interview and satisfactory references would be sought prior to a firm job offer and start date being agreed.

The practice had a well-established staff team, where the majority of staff had worked for the practice for a number of years. We reviewed the records for a number of staff and found the appropriate checks had been completed. The practice was in the process of applying for a Disclosure and Barring Service (DBS) check for all clinical staff members that did not already have one and showed us evidence this was in progress. Only those non-clinical staff that had been recruited since the practice had changed its recruitment policy had a DBS check carried out. The practice manager told us he was considering the application of a DBS check for other existing non-clinical staff.

The practice employed sufficient numbers of suitably qualified, skilled and experienced staff for the purposes of carrying on the regulated activities. There were arrangements in place to ensure cover for staff absences.

Monitoring Safety & Responding to Risk

Feedback from patients we spoke with and those who completed CQC comment cards indicated they would always be seen by a clinician on the day if their need was urgent.

Appropriate staffing levels and skill-mix were provided by the practice during the hours the service was open. Clinical staff worked at the main surgery and across the three branch surgeries. Staff included six partner GPs, three practice nurses, three healthcare assistants, a practice manager, a reception manager, seven dispensing staff and 18 reception and administration staff.

Requires improvement

Are services safe?

Staff we spoke with were flexible in the tasks they carried out. This meant they were able to respond to areas in the practice that were particularly busy. For example, within the reception on the front desk receiving patients or on the telephones.

We found that the practice ensured that the clinical staff received annual cardiopulmonary resuscitation (CPR) training and training associated with the treatment of anaphylaxis. Staff trained to use the defibrillator received regular update training to ensure they remained competent in its use.

Staff had access to a defibrillator for use in a medical emergency. All of the staff we spoke with knew how to react in urgent or emergency situations. We also found the practice had a supply of medicines for use in the event of an emergency.

The practice had not conducted a health and safety risk assessment. The practice planned to carry out this risk assessment in 2015. However, risk assessments for legionella, asbestos, and access to building under the Disability Discrimination Act had been completed. Risk assessments of this type make sure the practice was aware of any potential risks to patients, staff and visitors and planned mitigating action to reduce the probability of harm.

Arrangements to deal with emergencies and major incidents

The practice had emergency response plans in place. These identified the action to take during disruption due to unforeseen changes in staffing levels or loss of essential supplies or facilities. At the Alnwick site the practice had buddy arrangements with the local community hospital and another practice based on site. There were also arrangements to use the branch surgeries to ensure continued access to services in the event of any of the practice premises being unavailable due to an emergency.

We saw there was equipment for dealing with medical emergencies available within the practice, including emergency medicines, oxygen and a defibrillator. There were appropriate arrangements in place to ensure that staff knew what to do in the event of a fire in the practice.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

All clinical staff we spoke with were able to describe and demonstrate how they accessed both guidelines from the National Institute for Health and Care Excellence (NICE) and from the local health commissioners. They told us these were discussed in clinical meetings, and we saw evidence of this in the most recent notes.

We spoke with staff about how the practice helped people with long term conditions manage their health. They told us that there were regular clinics where people were booked in for recall appointments. This ensured people had routine tests, such as blood or spirometry (lung function) tests to monitor their condition.

A number of the GPs in the practice had specialist interests and delivered clinics within the practice. For example, one GP had an interest in Endoscopy. Patients could be referred to them to check on the appropriateness of a referral to a consultant or for advice and guidance. This reduced the need for some patients to be referred unnecessarily to other services, some of which were delivered some miles from the practice itself.

We reviewed the most recent Quality and Outcomes Framework (QOF) results for the practice for the year 2012 / 2013. The QOF is part of the General Medical Services (GMS) contract for general practices. Practices are rewarded for the provision of quality care. We saw the practice and branches had scored high on clinical indicators within the QOF. They achieved 86.92%, which was in line with the England average of 86.91%.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. Examples of clinical audits included an audit of minor surgical procedures, a review of calcium and vitamin D therapy and stroke prevention in atrial fibrillation. These were completed clinical audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, the audit on stroke prevention in atrial fibrillation led to an increase in the number of relevant patients who were assessed as at risk and receiving relevant treatment.

Doctors in the surgery undertook minor surgical procedures in line with their registration and NICE guidance. The staff were appropriately trained and kept up to date. They also regularly did clinical audits on their results and used that in their learning.

We reviewed a range of data available to us prior to the inspection relating to health outcomes for patients. This demonstrated that the practice was performing the same as, or better than, average when compared to other practices in England. There were no areas of risk identified from available data.

The practice told us they were in the process of developing care plans for those identified at most risk of poor or deteriorating health. This was delivered as part of an enhanced service provided by the practice. This included care plans for patients with long term conditions who were most at risk of deteriorating health and whose conditions were less well controlled. Care plans were also being developed for the most elderly and frail patients. These patients all had a named GP or clinical lead for their care. All patients over the age of 75 had been informed who their named GP was and had been given the opportunity to request another doctor if that was their preference.

The most recent QOF data demonstrated that across the main practice and branches 93.8% of people with physical or mental health conditions had received an offer of support and treatment within the last 15 months. 82.1% of patients with dementia had their care reviewed within the preceding 15 months.

The practice had processes in place that covered child health and family support. This included a programme of health and development reviews. These were to allow them to assess growth and development of young children, identify risk factors and opportunities for improving health. It also gave parents the opportunity to routinely discuss any concerns they had with their children. The programme ran from an initial neo-natal examination within the first 72 hours of birth through to vaccinations up to the age of 18 years.

The practice had systems in place to identify patients, families and children who were most at risk or vulnerable. For example, practice staff told us that they had a register of patients who had a learning disability and also those with poor mental health. They also told us that annual

Good

Are services effective?

(for example, treatment is effective)

health checks were carried out for patients on these registers. QOF data demonstrated that registers were in place and that patients were having their health needs assessed on a regular basis.

The practice reported that they had access to services provided by the local crisis team if a patient presented at the surgery with a mental health crisis.

The practice worked in partnership with an independent health company commissioned locally to monitor the needs of patients on warfarin. Patients on warfarin need to have their blood tested on a regular basis. This partnership working enabled patients to get their results by undergoing a finger prick test in the testing suite. The independent health company delivered this once a week at the Seahouses branch. This gave patients in a rural location more choice about how they monitor their condition. This service was also available to house-bound patients to carry out this test for those who were unable to travel.

Effective staffing

Staff employed to work within the practice were appropriately qualified and competent to carry out their roles safely and effectively. This included the clinical and non-clinical staff.

We reviewed staff training records for a selection of staff, and we saw that they had attended mandatory training, such as annual basic life support. Staff had their training needs assessed and were supported to update their skills and knowledge, The staff we spoke with confirmed this. The nurses in the practice were registered with the Nursing and Midwifery Council (NMC). To maintain their registration they must undertake regular training and updating of their skills. The GPs in the practice were registered with the General Medical Council (GMC) and were also required to undertake regular training and updating of their skills.

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

The practice had processes in place for managing the performance of staff. The practice manager told us they used team and one-to-one meetings to discuss these matters where appropriate. We found that there were clear mechanisms for communicating with staff and between different staff groups to ensure that all staff remained up to date with changes made as a result of identified learning.

Working with colleagues and other services

We saw evidence the practice staff worked with other services and professionals to meet patients' needs and manage complex cases. There were regular monthly meetings with the multi-disciplinary team within the locality. This usually included district nurses, social workers and health visitors. There were also regular informal discussions with these staff. These meetings are important as they help to share important information about patients, including those who were most vulnerable and high risk. There were a range of secondary health services located at the practice provided by other organisations. This included District and Macmillan Nurses, community psychiatry, Improving Access to Psychological Therapies (IAPT) counselling, paediatricians and school health, diabetic nurses and dieticians. Staff told us this helped the communication between different organisations.

Staff told us that all test results and patient letters from consultants and specialists were first seen by the doctor. Necessary actions from these were identified and carried out. The letters were then administratively coded and scanned onto the clinical records. The GP who reviewed the correspondence was responsible for any action required. They recorded the action required, and where appropriate arranged for the patient to be contacted and seen clinically.

Information Sharing

The practice had systems in place for recording information from other health care providers. This included out of hours services and secondary care providers, such as hospitals.

We spoke with clinical staff about the how information was shared with the Out of Hours services in the local area, 111 and Northern Doctors Urgent Care Ltd. Staff told us that patient information received from the out of hours service was of good quality and received on time in the morning. The practice manager confirmed that all faxed information from the out of hours provider, was passed to the GP to review. The GP then identified any action needed and passed the information to the administrator to scan and attach to the electronic clinical patient notes. Staff told us that this normally happened on the same day the information was received.

Good

Are services effective?

(for example, treatment is effective)

Consent to care and treatment

We found before patients received any care or treatment they were asked for their consent and the practice acted in accordance with their wishes. We asked staff how they ensured they obtained patients' consent to treatment. Staff were all able to give examples of how they obtained verbal or implied consent. Staff told us that when patients underwent minor surgery, written consent to the procedure was obtained before the procedure took place and this was recorded in the patients' notes.

A GP we spoke with showed they were knowledgeable of Gillick competency assessments of children and young people. Gillick competence is a term used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

Decisions about or on behalf of people who lacked mental capacity to consent to what was proposed were made in the person's best interests and in line with the Mental Capacity Act 2005 (MCA). We found the doctors were aware of the MCA and used it appropriately. The doctors described the procedures they would follow where people lacked capacity to make an informed decision about their treatment. They gave us a copy of the consent form they used to record their assessment. The doctors told us an assessment of the person's capacity would be carried out first. If the person was assessed as lacking capacity then a "best interest" discussion needed to be held. They knew these discussions needed to include people who knew and understood the patient, or had legal powers to act on their behalf.

Health Promotion & Prevention

The practice offered all new patients a consultation to assess their past medical and social histories, care needs and assessment of risk. These were completed by the GP or nursing staff employed by the practice. We found patients with long term conditions were recalled at regular intervals, to check on their health and review their medications for effectiveness. Processes were also in place to ensure that regular screening of patients was completed, for example, cervical screening.

We saw a number of leaflets were displayed in the waiting room for patients to access. This included information about common conditions and their symptoms, promotion of healthy lifestyles and prevention of ill health.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

The majority of patients we spoke with said they were treated with respect and dignity by the practice staff. Comments left by patients on CQC comment cards we received reflected this. We received six comment cards from the Alnwick practice, 16 from Seahouses, six from the Embleton and 17 from the Longhoughton branches. Therefore there were 45 CQC comment cards completed by patients in total. None of the CQC comment cards completed raised any concerns in this area.

We observed staff who worked in reception and other staff as they received and interacted with patients. Their approach was seen to be considerate, understanding and caring, while remaining respectful and professional. The reception desks were based near to the patient waiting areas. We saw staff who worked in these areas made every effort to maintain people's privacy and confidentiality. We saw voices were lowered and personal information was only discussed when absolutely necessary.

We reviewed the most recent data available for the practice overall on patient satisfaction from the national patient survey. This demonstrated that patients were satisfied with how they were treated and that this was with compassion, dignity and respect. Results on the NHS patient survey were all similar or better than expected when compared with other practices.

People's privacy, dignity and right to confidentiality were maintained. For example, the practice offered a chaperone service for patients who wanted to be accompanied during their consultation or examination. However, we noted this was not always highlighted to patients as some of branch surgeries did not have a notice placed in the reception areas to offer patients this service. We were told that some staff had completed chaperone training. A private room or area was also made available when people wanted to talk in confidence with the reception staff.

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

Staff were aware of the need to keep records secure. We saw patient records were mainly computerised and systems were in place to keep them safe in line with data protection legislation.

The practice had policies in place to ensure patients and other people were protected from disrespectful, discriminatory or abusive behaviour. The staff we spoke with were able to describe how they put this into practice.

Care planning and involvement in decisions about care and treatment

Patients told us they felt they had been involved in decisions about their care and treatment. They said the clinical staff gave them plenty of time to ask questions and responded in a way they could understand. They were satisfied with the level of information they had been given. Information provided by patients who filled in CQC comment cards reflected this. The staff we spoke with said consent to treatment was always sought and documented within the patients' records.

The results of the national GP survey from July 2014 showed 93% of patients surveyed rated the question 'Rating of GP involving you in decisions about your care' as good or very good. This was higher than both the national and local averages.

We asked staff how they made sure that people who spoke a different language were kept informed about their treatment. Staff told us they had access to an interpretation service.

They told us that information was made available in large print for patients with visual impairments. The practice did not provide information in an easy read format for children or people with a learning disability. When we asked about this, the practice manager said they would consider how they could meet the needs of those patients groups going forward.

Patient/carer support to cope emotionally with care and treatment

We saw there was a variety of patient information on display throughout the practice. This included information on health conditions, health promotion and support

Good

Are services caring?

groups. The practice manager told us that rather than overwhelm patients with lots of different information when they visited the practice, information on notice boards was changed frequently and based around themes. We saw there was a current theme of local services available for families, babies and young children. This ensured that it was easy for patients to find the information they were looking for, that notice boards were visually pleasant and information was appropriate and of interest to patients.

Support was provided to patients during times of bereavement. There was evidence of sharing information for those patients who were reaching the end of their life with other healthcare professionals. Support was tailored to the needs of individuals, with consideration given to their preferences at all times. Staff we spoke with in the practice recognised the importance of being sensitive to people's wishes at these times. We saw that there was a range of leaflets and information available in the waiting area relating to bereavement and end of life services, such as hospices. These directed patients to support agencies and others sources of advice and support. The patients we spoke with commented on the exceptional end of life care and support provided by the practice.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to people's needs and had sustainable systems in place to maintain the level of service provided.

As part of our pre-inspection preparation we looked at the latest demographic population data available for the practice overall from Public Health England, published in 2013. The average male life expectancy for the practice population was 78.96 and female life expectancy was 82.42. The majority of patients registered with the practice were between the ages of 40 and 74, with the percentage of patients within this age group higher than the England average for practices. For the patient group 54.8% had a long standing health condition and 56.5% reported they had health-related problems in daily life. There were 40.8 per 1000 people in the area claiming disability allowance.

There were also 17.4% of patients reported having caring responsibilities. There were slightly more patients in the area who lived in nursing homes when compared to the England average.

The practice told us that the biggest challenge in terms of patient demographics was the rural nature of the practice boundaries and the availability of public transport locally. Some of the outlying villages had only infrequent bus services, which made travelling by public transport difficult.

They told us that the practices, in particular Alnwick and Seahouses, experienced increased demand during tourist season from visitors to the area. The practice registered these visitors as temporary patients to ensure they got the care and treatment they needed in a timely way.

The Longhoughton branch was based in a residential area of Longhoughton where the families of those serving at the local RAF base live. The practice manager told us that due to RAF tours of duty, this patient group changed frequently as families changed bases. Some families experienced isolation, as a result of moving away from family and friends. The practice was able to deliver services close to home for these families by using a house rented from the RAF as practice premises.

The practice manager told us that they kept abreast of changes in the local population to plan the future delivery of services. This included planning for new housing estates and care homes in the local area, which may have an impact on the demands for healthcare locally.

Practice staff told us that because they delivered services in rural areas, they felt they could get to know their practice population well. When we asked about those most at risk of poor access to primary care, the practice were able to tell us who these patients were and what action they had taken to reduce the barriers for them to access care and treatment. There had been little turnover of staff over the last few years, particularly in the branch surgeries. This enabled good continuity of care and accessibility of appointments with a GP of choice. All patients who needed to be seen urgently were offered same-day appointments and there was an effective triage system in place. Staff told us that double appointments could be booked for those who requested them. They told us where patients were identified as needing more flexibility with appointments, such as always having double appointments booked; this was noted on their medical records so staff could make suitable arrangements when an appointment was requested.

We found that the practice understood the needs of the practice population and systems were in place to address identified need.

The practice worked collaboratively with other agencies, regularly sharing information (such as special patient notes) to ensure good, timely communication of changes in care and treatment.

Tackling inequity and promoting equality

The practice had recognised the needs of the different groups in the planning of its services.

The practice had made arrangements so that people with physical disabilities were able to access the service. At the main surgery in Alnwick there was a bell at the front door, and a sign telling patients to ring it if they needed assistance to access the building. All the consultation and treatment rooms were on the ground floor. There was ample parking near to the surgery.

Good

Are services responsive to people's needs?

(for example, to feedback?)

At the branch surgeries there was car parking close to all of the buildings. At Embleton and Seahouses branch surgeries there was access to the building for patients with physical disabilities and all of the treatment rooms were on the ground floor.

At the Longhoughton branch the nature of the building made adjustments for wheelchair users difficult. Staff told us they had one wheelchair user who would contact them by telephone if they needed to access the surgery and there was a specially made ramp which they could put out to assist access. There was also a bell at the front door for patients to ring if they needed assistance to access the building. The treatment room was upstairs. Most treatment was carried out at the Alnwick branch; however, there were handrails on both sides of the stairs for access to the room if it needed to be used. If patients with mobility difficulties could not access the stairs and they needed bloods taken this was carried out behind a screen in the corridor if no treatment room was available.

Only a small minority of patients did not speak English as their first language. There were arrangements in place to access interpretation services. Reception staff had a sheet which they could show patients, which had a list of the most common languages to help identify which interpretation service was most appropriate.

The practice had access to large print information for patients who were visually impaired, and gave us examples of how they had met the needs of visually impaired patients. However this was not advertised within the waiting room area or on their website. The practice had a hearing loop available for those with a hearing impairment.

There was a wooden play area in the Alnwick Surgery with a selection of plastic and easy to clean toys. We saw that this facility was well liked and used by children visiting the surgery.

Access to the service

Patients could make appointments and order repeat prescriptions by calling into the practice, by telephone or online via the internet. The practice website outlined how patients could book appointments and organise repeat prescriptions. Patients could choose which of the four locations they wished to book an appointment at. If there were no appointments left at their preferred location, they were also able to book into any of the other locations to get access to a medical appointment more quickly.

The Alnwick practice was open Monday to Friday and the opening hours were clearly displayed, both within the practice and on the practice's website and practice leaflet. The practice normally opened between 8am and 6:30pm. There were also late night surgeries on a Monday and Wednesday until 7:30pm. This allowed people who worked or were at school during the day or were unable to get to the practice a choice of when they wanted to see the GP.

The Seahouses branch was open four weekdays during the week. Monday, Tuesday and Thursday they were open 8:30am to 5:30am and Friday was open from 8:30am till 12noon.

The Longhoughton Branch was open three weekdays a week. Monday between 2 and 5-30pm and, Wednesday and Thursday between 8:30am and 1pm and 2pm and 5:30pm.

The Embleton Branch was open four weekdays a week. Monday between 8:30 and 12:30pm, Tuesday and Wednesday between 8:30am and 5pm. On Friday the Embleton branch was open between 8:30am to 1pm. This gave patients a range of appointment times across all four branches.

Patients were not as satisfied with the opening times of the practice, with only 70.5% saying they were very or fairly satisfied with the opening times. This compared with the England average of 79.8%. Two patients we spoke with and two of the comment cards returned to CQC raised the issue of the branch surgeries not being open every weekday. We discussed this with one of the GP partners who told us that in order to provide a service across all three branches it was necessary to have the opening times there were to maintain staffing levels.

Out of hours enquiries were redirected to the provider's contracted out of hour's provider, North Doctors Urgent Care Ltd.

Consultations were provided face to face at the practice, advice given over the telephone, or by means of a home visit by the GP. This helped to ensure people had access to the right care at the right time. There were both male and female GPs in the practice; therefore patients had choice over the gender of doctor they wished to see.

We looked at the information we had received prior to the inspection about patient satisfaction with the appointment system. We noted there were a number of patient comments on the NHS Choices website relating to

Good

Are services responsive to people's needs?

(for example, to feedback?)

dissatisfaction with availability of appointments. However we did note that the practice manager had responded to these patients directly on the NHS Choices website and there was evidence that action had been taken to follow up and address the concerns. A number of patients also told us that although they could get urgent appointments on the day, they sometimes struggled to get a routine appointment at the surgery of their choice. We spoke with the practice manager about this. They showed us evidence that the practice had further investigated these concerns to identify solutions for improvements. We saw this issue had been discussed with the practice Patient Participation Group (PPG). As a result the process for requesting appointments had been changed. Patients were now asked why they wanted to see the doctor, to identify if another healthcare professional, such as a practice nurse or healthcare assistant could meet their needs or to make sure that patients who required a more urgent appointment were able to access one. We noted the change was advertised when people phoned to make an appointment, on the practice website and within the practice. The practice manager told us if patients were uncomfortable with giving this information to reception staff, they did not have to say why they would like an appointment. However, this information helped the reception team to understand how best they could help.

The most recent GP Survey 2013/14 showed that most patients surveyed were satisfied with how easy it was to contact the practices by phone. 92% said it was easy to get through, which compared with an England average of 75%.

Older patients and those identified as most at risk were offered pneumococcal and flu vaccination to help them stay healthy and well. Take up rates for these were in line with national averages.

Listening and learning from concerns & complaints

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

Staff we spoke with were aware of the practice's policy and knew how to respond in the event of a patient raising a complaint or concern with them directly.

We asked to see a summary of all the complaints the practice and branches had received this year. Since January 2014 there had been 10 complaints received. We reviewed these and found the complaints had been recorded and fully investigated. We found the practice listened and learned from the complaints. For example, GPs had considered their communication skills and discussed learning as a practice team following a complaint. The GPs and the practice manager told us that all complaints were considered through the significant events process, to ensure they were fully investigated and any learning was identified for the practice as a whole. We saw that complaints were referred to other agencies where needed. For example the General Medical Council or the Public Health Services Ombudsman.

Are services well-led?

Good

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

Our findings

Vision and Strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The practice had a mission statement, 'We aim to provide high quality care in a rural setting', which featured in the practice leaflet and was displayed in the practice reception area.

We found that there was strong leadership and strategic vision within the practice. Staff were able to demonstrate their understanding and commitment to providing high quality patient centred care. There was a strong focus on improvement and learning shared by all staff.

The staff we spoke with across the four surgeries were clear on their roles and responsibilities. All of them demonstrated an understanding of their area of responsibility and each took an active role in ensuring a high level of service was provided on a daily basis. We found that managers in the practice understood their role in leading the organisation and enabling staff to provide good quality care.

Governance Arrangements

We found there were clear processes for governance, which were well embedded across all four surgeries.

The practice had a number of policies and procedures in place to govern activity. These were available to all staff electronically on a shared drive. We looked at a range of these policies and procedures and found most covered the relevant areas in sufficient detail and incorporated national guidance and legislation. We found that most had been regularly reviewed and updated, however some had not been reviewed as planned within the last twelve months.

The practice held regular meetings where governance, quality and risk were discussed. We saw the most recent notes of these meetings to confirm this.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for the practice and branch surgeries showed they were performing in line with national standards. We saw that the clinical team regularly discussed QOF data and the quality of service delivered at team meetings.

The practice had systems in place to monitor and improve quality. We saw evidence of audit activity within the practice during the last 12 months.

The practice ensured risks to the delivery of care were identified and mitigated before they became issues. The practice had a system in place for monitoring all aspects of the service.

Leadership, openness and transparency

There was a well-established management structure with clear allocation of responsibilities. The GPs all had individual lead roles and responsibilities, for example, safeguarding and prescribing. We spoke with a number of staff, both clinical and non-clinical, and they were all clear about their own roles and responsibilities. They were able to tell us what was expected of them in their role and how they kept up to date.

Staff told us there was an open culture in the practice and they could report any incidents or concerns about the practice. This ensured honesty and transparency was at a high level. We saw evidence of incidents that had been reported by staff, and these had been investigated and actions identified to prevent a recurrence.

Staff told us they felt confident about raising any issues and felt that if incidents did occur these would be investigated and dealt with in a proportionate manner. The staff we spoke with were clear about how to report incidents. Staff told us they felt supported by the practice manager and the clinical staff and they worked well together as a team.

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

The practice had an active patient participation group (PPG) to help it engage with a cross-section of the practice population and obtain patient views. We spoke with two representatives of the PPG who explained their role and how they worked with the practice. They told us that the group was on the cusp of moving to be a patient led group. Previously the group had been led by practice staff. They told us now members of the group were keen to take on more responsibility and ownership for the group. They told us that practice staff were keen to support them to do this. They also said that the practice were open to listening to their feedback and ideas for improvement.

The group met quarterly. The PPG members we spoke with gave examples of the areas the group had been asked to comment and provide ideas for. This included use of the appointment system and the accessibility of the practice.

We spoke with the practice manager about how the practice had used feedback from patients to improve the

Are services well-led?

Good

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

service offered. They told us that they had analysed a range of feedback received through complaints and on the NHS choices website and had identified an area for improvement relating to availability of appointments. The practice also carried out a survey across all sites in 2013 to determine if patients were satisfied with the availability of appointment times and their understanding and use of appointment times with different healthcare professionals. Of the 92 patients surveyed 60% said they were satisfied with the current level of availability for appointments. We saw evidence these were discussed with the PPG to explore the issue and identify possible solutions and improvements. We saw that changes had been implemented as a result. The practice had communicated the changes made and the reason for these changes to patients. This was by means of a recorded message when patients phoned the practice, on the practices website and in the reception areas within the practices. We saw that following implementation the practice gave feedback to the PPG on how the changes had impacted positively on appointment availability.

We saw that a practice newsletter was produced on a regular basis to keep patients informed and updated. We saw the newsletter for the Alnwick surgery. This covered news items such as fundraising for a local charity, the availability of flu clinics, the practices responsibilities relating to data protection, warfarin clinics and the PPG.

Staff we spoke with told us they regularly attended staff meetings. They said these provided them with the opportunity to discuss the service being delivered, feedback from patients and to raise any concerns they had. Staff gave us example of where things had changed as a result of their feedback. For example, at the Seahouses branch patient records had been moved to give more room for the dispensing team.

Management lead through learning & improvement

We saw practice staff met on a regular basis. Minutes from the meetings showed the team discussed clinical care, audit results, significant events and areas for improvement. Staff from the practice also attended the CCG protected learning time (PLT) initiative. This provided staff with dedicated time for learning and development.

We saw an example of how the practice had changed the way it did things as a result of a partner GP attending a protected learning time session. This related to medicines optimization in prescribing benzodiazepines. Where appropriate an evidence based letter was sent to patients who were prescribed these drugs. A laminated withdrawal guide was also produced for doctors to use to assist with drug reduction and discussion with the patient. The success of this approach was reviewed in January 2014 and it found that the impact of this approach had been greater than anticipated. The letter and withdrawal guide were shared and adopted by another practice.

The team met monthly to discuss any significant incidents that had occurred. The practice had a robust approach to incident reporting in that it reviewed all incidents. Staff we spoke with discussed how action and learning plans were shared with all relevant staff and meeting minutes we reviewed confirmed that this occurred. Staff we spoke with could describe how they had improved the service following learning from incidents and reflection on their practice. We were told this was done in an open, supportive and constructive way.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines Patients who used the service and others were not protected against the risks associated with the unsafe use and management of medicines because of inadequate arrangements for authorising of prescription forms. Regulation 13