Dr C R Dean & Dr M C Jamieson

Quality Report

Cheviot Primary Care Centre
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We inspected the practice on 21 and 22 October 2014. We inspected this service as part of our new comprehensive inspection programme. Overall, we rated the practice as good. Our key findings were as follows:

- Patients received safe care which met their needs;
- Patients reported good access to the practice, including the provision of same day appointments for those with urgent needs;
- Patients reported they were treated with kindness and respect, and received care and treatment which met their needs;
- Patient outcomes were either average, or better than average, when compared to other practices in the local Clinical Commissioning Group (CCG) area;
- The practice was clean and hygienic, and good infection control arrangements were in place;
- The practice was well-led and had good governance arrangements. The practice had an active Patient Participation Group (PPG) that had taken action to improve its own knowledge and the services provided to patients at the practice.

However, there were also areas of practice where the provider could make improvements:

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

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for safe.

The practice had demonstrated that it was safe over time. Staff understood and fulfilled their responsibilities with regards to raising concerns, recording safety incidents and reporting them both internally and externally. The practice management team took action to ensure that lessons were learned and shared these with the team to support improvement. There was evidence of good medicines management. Safe staff recruitment practices were followed and there were enough staff to keep patients safe. Good infection control arrangements were in place and the practice was clean and hygienic. Risks to patients were assessed and well managed.

Are services effective?

Good

The practice is rated as good for effective.

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

Are services caring?

Good

The practice is rated as good for caring.

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

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was respected. Patients had access to health promotion information and advice when needed, and they received support to manage their own health and illness. Staff demonstrated they understood the support patients needed to cope with their care and treatment.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive.

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

Are services well-led?

Good

The practice is rated as good for well-led.

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

Summary of findings

The six population groups and what we found

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

Older people

Good

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

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

People with long term conditions

Good

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

Nationally reported data showed the practice had achieved good outcomes in relation to those patients with commonly found long-term conditions. The practice had taken steps to reduce avoidable hospital admissions by improving services for patients with complex healthcare conditions. All patients on the long-term condition registers received healthcare reviews that reflected the severity and complexity of their needs. Person-centred care plans had been prepared. These included the outcome of any assessments patients had undergone, as well as the support and treatment that would be provided by the practice. The practice nurse had received the training they needed to provide good outcomes for patients with long-term conditions.

Families, children and young people

Good

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

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

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needed. New mothers had access to twice monthly health clinics where child health checks were carried out by a health visitor and nursery nurse. Young people had access to advice and guidance regarding sexual health.

Working age people (including those recently retired and students)

Good

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

The needs of this group of patients had been identified and steps taken to provide accessible and flexible care and treatment. The practice was proactive in offering on-line services to patients. Repeat prescriptions could be ordered, and appointments booked, on-line. Appointments were available until 6.30pm each weekday and an extended hours service was provided once a week. Health promotion information was available both in the waiting area and on the practice web site. The practice provided additional services such as travel vaccinations, smoking cessation and minor surgery.

People whose circumstances may make them vulnerable

Good

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

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

People experiencing poor mental health (including people with dementia)

Good

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

The practice had achieved good outcomes in relation to meeting the needs of patients with mental health needs. The practice held a register which it used to ensure patients received access to relevant checks and tests. 100% of patients with mental health needs had a comprehensive care plan covering the preceding 12 months which

Summary of findings

had been agreed with them, and their carers where necessary. The practice referred patients with alcohol and drugs addictions to appropriate support services. The practice regularly worked with multi-disciplinary teams to help meet the needs of vulnerable patients.

Summary of findings

What people who use the service say

During the inspection we spoke with nine patients and reviewed eight CQC comment cards completed by patients. The feedback we received indicated patients were satisfied with the care and treatment they received. Patients told us they received a good service which met their needs. They said they were treated with dignity and respect and felt their privacy was protected. We received positive feedback about the practice's appointment system and patients told us they found it easy to get through to the practice on the telephone. Patients said they were able to obtain an appointment within a reasonable amount of time. None of the patients expressed any concerns about how the practice operated, and a representative from the PPG spoke positively about the work carried out by the practice.

Findings from the 2013 National GP Patient Survey indicated a high level of satisfaction with the care and treatment provided by the practice. The majority of the above percentages exceeded the CCG regional average. For example, of the patients who responded:

- 93% said they found it easy to get through to the practice by telephone;
- 89% said the GP they saw, or spoke to, was good at listening to them, and they had confidence and trust in them;
- 95% said they were satisfied with the practice's opening hours;
- 95% said they would recommend the surgery to someone new to the area.

This majority of responses were above the CCG regional average. These results were based on 117 surveys that were returned from a total of 239 questionnaires sent out. There was a response rate of 49%.

Information from a practice survey carried out by the practice in 2013 showed the majority of patients were satisfied with the reception area and access to information. An independent survey carried out in 2012 found the practice scored above the national average in most of the areas covered.

Areas for improvement

Action the service SHOULD take to improve

- Introduce a system to track blank prescriptions in accordance with national guidance.

Dr C R Dean & Dr M C Jamieson

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP and an Expert by Experience. An Expert by Experience is somebody who has personal experience of using, or caring for someone who uses, a health, mental health and/or social care service.

Background to Dr C R Dean & Dr M C Jamieson

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

Cheviot Primary Care Centre

Padgepool Place

Wooler

Northumberland

NE71 6BL

The practice is a rural dispensing practice and covers the North Northumberland area. It provides services to 1,937 patients of all ages based on a General Medical Services (GMS) contract agreement for general practice.

The practice occupies part of a large purpose built building. The building also accommodates district nursing, physiotherapy and chiropody staff as well as a 24-hour emergency ambulance service. A range of services and clinics are provided including, for example, clinics for patients with heart disease, hypertension and asthma. The practice consists of two GP partners (one male and one female), a practice manager, a practice nurse (female), and a small team of reception and dispensing staff. The practice is working towards becoming a training practice and hopes to gain the necessary accreditation in February 2015. The practice is part of NHS Northumberland Clinical Commissioning Group (CCG). The practice has a higher percentage of patients in the over 65 age group. It also has lower levels of income deprivation for both children and older people than the England average.

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

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. The practice was chosen at random from the area covered by the Northumberland Clinical Commissioning Group.

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check: whether the provider is meeting the legal requirements and regulations contained within the Health and Social Care Act 2008; the overall quality of the service and to provide a rating for the service as required by the Care Act 2014.

Detailed findings

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

How we carried out this inspection

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

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

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

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

Before visiting we reviewed a range of information we held about the practice and asked other organisations to share what they knew about the services it provided. We carried out an announced inspection on 21 and 22 October 2014. During this we spoke with a range of staff including: a GP partner; the practice manager; the practice nurse and staff who worked in the reception and dispensing teams. We spoke with a member of the practice's Patient Participation Group (PPG), and spoke with nine patients who visited the practice on the day of our inspection. We reviewed eight CQC comment cards where patients had shared their views and experiences of the service with us. We also observed how people were being cared for and looked at some of the records kept by the practice.

Are services safe?

Our findings

Safe Track Record

When we first registered this practice in April 2013, we did not identify any safety concerns that related to how it operated. Also, the information we reviewed as part of our preparation for this inspection did not identify any concerning indicators relating to the safe domain. The CQC had not been informed of any safeguarding or whistle-blowing concerns relating to patients who used the practice. The local CCG told us they had no concerns about how this practice operated.

The practice used a range of information to identify potential risks and to improve quality in relation to patient safety. This information included, for example, significant event reports, national patient safety alerts, and comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. Practice staff told us they had identified and reported that, on one occasion, follow up letters had not been sent to a patient's family regarding missed hospital appointments. We reviewed significant event reports completed by practice staff, and the minutes of meetings where these had been discussed, over the previous 12 months. These showed the practice had dealt with such events consistently over the period concerned, and this provided evidence of a safe track record for the practice.

Learning and improvement from safety incidents

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

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

The practice also reported incidents to the local CCG using a local incident reporting system. We were told that where significant events/incidents had occurred, these would be added to the agenda for discussion at the relevant practice staff meeting. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. For example, we were told a patient had received the wrong treatment during their visit to the practice. We checked to see what learning had taken place following this event. The significant event report for this event stated that staff had been reminded of the importance of checking patients' dates of birth before providing care and treatment

National patient safety alerts were disseminated by the practice manager to relevant members of staff. For example, medicines related safety alerts were forwarded to the medicines manager for action. The practice manager was able to give examples of recent alerts and how these had been responded to. A deputy had been appointed to respond to safety alerts in the practice manager's absence. A record had been kept to indicate when alerts had been reviewed and found not to be relevant to the practice. We were told where safety alerts affected the day-to-day running of the practice, all staff would be advised via an email or in a practice meeting.

Reliable safety systems and processes including safeguarding

The practice had systems in place to manage and review risks to vulnerable children, young people and adults. Practice training records made available to us showed that all staff had received relevant, role specific training on safeguarding. For example, both GPs, one of which was the safeguarding lead for the practice, had completed Level 3 child protection training to enable them to fully carry out their safeguarding duties and responsibilities. Staff we spoke with were aware of which doctor had lead safeguarding responsibilities, but indicated they would always discuss any concerns they had with either the most relevant GP, or the GP on duty. The practice nurse had completed Level 2 child protection training. They told us they knew how to recognise signs of abuse in vulnerable adults and children. They were also aware of their responsibilities regarding reporting safeguarding concerns and sharing information both within the practice and with other relevant professionals. Information about how to report safeguarding concerns and contact the relevant agencies in and out-of-hours, was easily accessible.

A chaperone policy was in place and a notice was on display in the reception area. Chaperone training had been undertaken by all practice staff carrying out chaperone duties. We were told if trained practice staff were not

available to act as a chaperone, district nurses working at the Cheviot Primary Care Centre would be approached about carrying out this role. We noted that there was no mention of this in the practice chaperone policy. The practice manager agreed to update the policy to include this information.

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

Systems were in place which ensured any incoming safeguarding information was scanned to patients' medical records. We were told the GPs attended child protection case conferences when they were given sufficient notice. Where this was not possible, the practice manager said the GPs would complete any information requests sent to them by the local social services staff and return them in advance of the planned meetings. The practice manager confirmed the practice had not been involved in any serious case reviews, but had initiated a child protection alert following concerns they had had for a patient's welfare. A system was in place to follow up children who failed to attend appointments to help ensure they did not miss important immunisations.

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

Medicines Management

We checked medicines stored in the dispensing room and found they were stored securely and were only accessible to authorised staff. Records were kept of all medicines received into the dispensary. Stock control arrangements helped to make sure older batches of medicines were used first. Arrangements had been made to ensure the dispensary maintained sufficient stocks of medicines, especially in advance of foreseeable poor weather.

Processes were in place to check medicines were within their expiry date and suitable for use. Records of these checks had just been introduced. We checked a sample of medicines and found they were within their expiry dates. The records we looked at, and observations made during the inspection, confirmed expired and unwanted medicines were disposed of promptly.

The practice had made arrangements which ensured that the cold chain was maintained for the storage of vaccines and other medicines requiring refrigeration. (A cold chain is an uninterrupted series of storage and distribution activities which ensure and demonstrate that a medicine is always kept at the right temperature). We saw refrigerator temperature checks were carried out daily. However, there was no standard operating procedure for staff to refer to regarding maintenance of the cold chain. The medicines manager told us this would be addressed immediately. Vaccines were administered by the practice nurse. They confirmed they had received appropriate training in how to administer these. The nurse was also qualified as an independent prescriber. They told us they felt well-supported in this role by one of the GPs, who acted as their mentor.

There were appropriate arrangements in place for handling repeat prescriptions. Arrangements had been made for patients on repeat medicines to have a full medication review at least annually. There was a protocol which we saw was followed in practice. We observed a member of the dispensing team taking a telephone request for a repeat prescription. They checked the patient's electronic records to confirm the requested medicines had been placed on repeat by their GP, and that they were within the issue date. Prescriptions were signed before being dispensed. Dispensing staff placed each signed prescription in a small tray into which they then placed the labelled medicines. Each tray was then checked by one of the GPs prior to dispensing. Dispensing staff told us this system worked well. The practice manager told us the practice had agreed to participate in a pilot to look at establishing a service for patients to pick up their dispensed prescriptions at agreed locations.

Are services safe?

The practice held stocks of controlled medicines (these medicines require extra checks and special storage arrangements because of their potential for misuse.) There were written procedures for staff setting out how they were to be managed. These were followed by the dispensing team. Controlled medicines were stored in a secure designated cupboard and access to them was restricted to dispensary staff. There were arrangements in place for the destruction of controlled medicines. A recent concern over an error in disposing of a controlled drug had prompted the medicines manager to seek advice from the local controlled drugs officer. They told us the advice received was implemented.

The practice maintained a dispensing error and near-misses log. This provided details of any concerns that had occurred and what action had been taken in relation to them. The medicines manager told us all errors and near-misses were reported to the local CCG using the Safeguarding Incident and Risk Management System. This system requires practice staff to identify any actions that have been taken to minimise the risk of reoccurrence, and to confirm that the risks identified have been addressed. We were told that following a recent near-miss, the medicines manager had made arrangements to discuss the incident at the forthcoming practice away day and to review what lessons could be learned.

There were arrangements in place to ensure blank prescription forms were stored securely at all times. However, we did identify that clinicians were not keeping a record of the serial numbers of prescription forms issued to them. This is contrary to national guidance. The practice manager agreed to address this matter following the inspection.

The practice had a system in place to assess the quality of its dispensing processes and had signed up to the Dispensing Services Quality Scheme. This Scheme rewards practices for providing high quality services to patients using the dispensing service. For example, ensuring the dispensary has a set of standard operating procedures and dispensing staff have received suitable training. The sample of records we looked at showed that dispensing staff had completed nationally recognised training and had regular checks of their competence carried out.

Cleanliness & Infection Control

The premises were clean and hygienic throughout. An infection control policy was available for staff to refer to. This provided them with guidance about the standards of cleanliness and hygiene expected of them. The practice manager told us they did not have an infection control lead as this was the responsibility of NHS Property Services. A designated infection prevention and control lead will help the practice to manage and monitor the prevention and control of infection.

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

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

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

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

Equipment

Are services safe?

Staff we spoke with told us they had access to the equipment they needed to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw records confirming this. For example, all portable electrical equipment had been tested within the last 12 months. Fire equipment checks were carried out regularly and a fire risk assessment had been completed. Current gas safety and electrical installation certificates were in place. We did identify that there might be a problem with either the internal thermometer in the dispensing fridge, or the handheld thermometer used to provide a back-up reading, given the discrepancy in temperature readings between the two. The practice manager agreed to follow this up after the inspection.

Staffing & Recruitment

The practice had a recruitment policy which provided clear guidance about the pre-employment checks that should be carried out. The sample of records we looked at contained evidence that such checks had been undertaken prior to the appointment of staff. These included, for example, previous work references and criminal records checks via the Disclosure and Barring Service (DBS.) Non-clinical staff working at the practice had not undergone a DBS check. The practice manager told us they had not carried out an assessment to determine which staff were eligible for a DBS check and at what level. We checked the General Medical and Nursing and Midwifery Councils and found all of the clinical staff were licensed to practice. Practice staff carried NHS Smart cards which contained a recent identification photograph. We were told staff's identities had been verified under the NHS Employment Check Standards process.

The practice manager told us about the arrangements for planning and monitoring the number and mix of staff needed to meet patients' needs. Regular locums who knew the patients covered the leave arrangements for both GP partners. The practice nurse told us that, although their clinics were always busy, they had sufficient hours to carry out the chronic disease management, and other clinical work they were contracted to provide. Leave cover was not provided for the practice nurse. We were told patients' needs could be met within their contracted hours.

Monitoring Safety & Responding to Risk

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

Risks had been identified and documented, and actions recorded to reduce and manage these. Staff were able to identify and respond to changing risks to patients, such as deterioration in their health and well-being, or a medical emergency. For example, emergency processes were in place to help reduce hospital admissions for patients with long-term conditions. This included providing a RESCUE pack for patients with breathing difficulties to help them better manage their condition. (RESCUE packs contain medicines for patients with breathing difficulties to use at home in an acute exacerbation as part of their self-management strategy).

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing staff had received training in basic life support. Emergency equipment was available, including oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). The staff we spoke to knew the location of this equipment and records we saw confirmed these were checked regularly.

Emergency medicines were available in an area that only practice staff could access. The practice nurse told us they knew the location of these. Arrangements were in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

The practice had a business continuity plan specifying the action to be taken in relation to a range of potential emergencies that could impact on the daily operation of the practice. Risks identified included incapacity of the GP

Are services safe?

partners and the loss of the computer and telephone systems. The document also contained emergency contact details for staff to refer to. For example, contact details of the company responsible for servicing the building.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GP partner and practice nurse we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance, including guidelines issued by the NICE. We found, from our discussions with the GP partner and the practice nurse, that staff completed thorough assessments of patients' needs, in line with NICE guidelines. Staff told us these were reviewed in line with their clinical judgements.

Lead clinical and non-clinical responsibilities were shared between the GP partners and the practice nurse. The clinical staff we spoke with were very open about asking for, and providing colleagues with, advice and support. For example, the practice nurse told us they received the support they needed to act as a competent nurse prescriber.

Nationally reported data, taken from the Quality Outcomes Framework (QOF) for 2013/14, showed that overall the practice had achieved 99.0% of the total points available to them for delivering best practice clinical care. This achievement was above both the local CCG and the England averages when compared to other practices. We saw that the practice had not achieved full points for one clinical indicator relating to osteoporosis. However, the practice told us that following discussions with the local CCG, they had been awarded maximum points as factors outside of its control meant it was not possible for them to provide the recommended clinical care to one particular patient. (The QOF is a voluntary incentive scheme for GP practices which rewards them for how well they care for patients.)

The practice had a register of patients who they considered might be at risk of an emergency admission into hospital. The practice manager told us they had written to each of these patients to make them aware they were on the register and to invite them to attend for an appointment to review their care and support needs. The practice had also written to each patient aged 75 years and over, explaining that one of the GP partners would act as their named doctor/care coordinator.

The practice had planned for, and made arrangements to deliver, care and treatment to meet the needs of older patients and those with long-term conditions. We were told the practice nurse was responsible for the delivery of chronic disease management. The practice offered patients with long-term conditions, such as hypertension, heart disease and chronic obstructive pulmonary disease, access to appointments of varying lengths depending on the reason for the visit.

The practice had taken steps to ensure its staff had the knowledge, skills and competence to respond to the needs of older people and patients with long-term conditions. For example, the practice nurse had completed training in cervical cytology, smoking cessation, diabetic management, prescribing drugs and administering vaccinations and immunisations. They told us they had also completed training updates in other areas such as infection control and moving and handling. The practice nurse confirmed they had all of the training they currently needed to carry out their role.

The practice made use of information technology to help them with their 'call and recall' system. This ensured patients were invited for their healthcare check at regular intervals determined by the practice nurse. Patients were sent text reminders shortly before their appointment was due, to help reduce non-attendance. A member of the reception team told us arrangements were in place to follow up any non-attenders.

The practice nurse showed us the care plan templates they used to record details of patient assessments, any goals that had been agreed and any advice given. The care plan templates also signposted the practice nurse to tools that could be used to carry out additional assessments of patients' needs where this was needed . The practice nurse told us they carried out dementia screening with patients over a certain age using an assessment tool that was available on the practice IT system.

The practice manager showed us data from recent practice audits carried out in order to improve patient outcomes. For example, the practice had recently completed an audit to check whether patients with diabetes were carrying out the recommended checks at home using the right equipment. The practice had also carried out an audit to identify patients with a certain type of hip replacement had received an orthopaedic follow-up appointment. Other audits had been carried out by the practice, and we saw these had been used to ensure patients were receiving appropriate care and support.

Are services effective?

(for example, treatment is effective)

Interviews with a GP partner and the practice nurse demonstrated that the culture within the practice was to refer patients onto other services on the basis of their assessed needs, and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. For example, dispensary staff monitored the effectiveness of medicines management. The practice manager and a member of the administrative team monitored how well the practice performed against key indicators such as those contained within the QOF. The practice manager told us staff decided, in light of information fed back through various monitoring processes, which areas would be chosen for audit in order to determine what improvements were needed and how these could be actioned. The practice had recently carried out an audit to check that the prescribing of aspirin was in line with current NICE guidance.

The practice manager showed us seven clinical audits that had been undertaken in the previous 12 months. One of these audits had been carried out by an independent organisation. This audit set out to provide a stroke risk profile for all patients with a particular heart condition. The aim had been to assist the practice to provide appropriate management using an effective drug therapy in line with national guidelines. The final report of this audit (including details of a follow-up audit carried out) contained evidence which demonstrated the changes that had been made, following the initial audit, had resulted in improved patient outcomes. Other audits we looked at had also resulted in improvements for the patients involved.

The practice also used the information they collected for the QOF, and information about their performance against national screening programmes, to monitor outcomes for patients. For example, 91.1% of patients on the diabetes register had undergone retinal screening in the preceding 12 months and 96.3% had had a foot examination and a record of the risk to their health and wellbeing documented. These percentages meant the practice had exceeded the standard 80% minimum. We confirmed the practice had provided recommended care and treatment in relation to a range of clinical conditions such as, for example, diabetes, asthma and chronic obstructive pulmonary disease (lung disease.) The information we looked at before we carried out the inspection did not identify this practice as an outlier for any QOF (or other national) clinical targets.

Effective staffing

We reviewed staff training records and saw that most staff were up-to-date with mandatory courses such as annual basic life support and infection control. There was a good skill mix within the clinical team. For example, one of the GP partners had completed training enabling them to train GP speciality registrars. (A GP Registrar is a qualified doctor who is training to become a GP through a period of working and training in a practice). The practice nurse had completed nurse prescribing training and a diploma in asthma management. They confirmed the practice was happy to fund and support staff training to further develop their skills and competencies.

Both GPs were up-to-date with their annual continuing professional development requirements and one GP had recently been revalidated. (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).

All staff received an annual appraisal which identified their learning and development needs and goals that had been agreed. The staff we spoke with confirmed the practice was proactive in providing training and funding for relevant courses.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage complex health conditions. Communications from local hospitals, the out-of-hour service (Northern Doctors) and the 111 service, were received both electronically and by post. The practice staff we spoke with were clear about their responsibilities in relation to dealing with communications from other health and social care providers. All staff we spoke with understood their roles and how systems at the practice worked. We were not told of any instances within the last year where results, or discharge summaries, were not followed up appropriately.

Are services effective?

(for example, treatment is effective)

Satisfactory arrangements were in place to handle blood samples. The practice had equipment which enabled blood samples to be taken from patients throughout the day. This meant that patients who had to provide a sample had more choice as to when they could do this.

Records were kept of minor operations carried out the practice, and of histology (tissue) specimens sent to the pathology laboratory. However, we identified that there was no cross-referencing of histology results with the minor surgery operations carried out. We raised this with the practice manager. They told us they were going to re-instate a procedure that they previously used. The practice made use of the Integrated Clinical Environment (ICE) system which enabled the GP partners to make electronic requests for a variety of tests and to access the test results.

The practice had good arrangements in place for working with other healthcare professionals. The practice held multi-disciplinary, primary health care team meetings every two months to discuss health services in the town of Wooler as a whole. We were told these meetings were attended by all professionals based in the Centre. The practice also held multi-disciplinary team (MDT) meetings with the district nursing team to discuss patients with complex healthcare conditions, including those with end of life care needs. In addition to this, monthly meetings were held with the health visitor, midwife and school nurse to discuss women who were currently pregnant, young mothers and children on the 'at risk' register, as well as those that might require extra help and support. Minutes were kept of each meeting and we were told patients' records were updated following these. The practice manager said all MDT meetings work well.

The practice collaborated with relevant healthcare professionals in North Northumberland and further afield, for example with local hospitals such as the Berwick-upon-Tweed Infirmary and the Royal Victoria Infirmary in Newcastle. The practice nurse was aware of the various health, social care and community based resources and support groups available to them. Until recently, a community psychiatric nurse (CPN) had been based in the Centre. This had facilitated the referral of patients with mental health needs for further assessment and support.

The practice manager told us that, despite the loss of this particular resource, all of the practice clinicians were aware that CPN time could still be accessed during their booked visits to the Centre.

The practice worked well with the other GP practice based at the Centre. Each practice covered for the other when staff meetings and training sessions were held, and when emergency situations occurred. We were told of a recent emergency where staff from both practices worked together to meet the needs of a patient who had collapsed. The practice manager told us they met regularly with their counterpart in the other practice. They said they worked together to ensure the premises were maintained in a safe condition.

Information Sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in, and to book their own out-patient appointments, in discussion with their chosen hospital).

The practice had signed up to the electronic Summary Care Record system and had made plans to have this fully operational by 2015. (Summary Care Records provide healthcare staff treating patients in an emergency, or out-of-hours, with faster access to key clinical information).

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. All staff were fully trained in the use of the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

The practice had a policy which provided clinical staff with guidance about how to obtain patients' consent to care and treatment, and what to do in the event a patient lacked the capacity to make an informed decision. This

Are services effective?

(for example, treatment is effective)

policy also highlighted how patients' consent should be documented in their medical notes, including the recording of what type of consent was required for specific interventions.

Practice staff were aware of the Mental Capacity Act (MCA) (2005) and their duties in complying with it. The GP partner and practice nurse we spoke with confirmed that the MCA had been covered as part of the safeguarding training they had completed. Patients with learning disabilities were supported to make decisions about their care and treatment through the use of care plans which they, and their supporters, were involved in agreeing. The practice had produced a register identifying all patients with learning disabilities. The GP partner we spoke with demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

Health Promotion & Prevention

It was practice policy to offer all new patients registering with the practice a health check with the practice nurse. The practice website provided new patients with access to a patient assessment questionnaire, which they could download and either post to or hand in to the reception team. The practice nurse told us any health concerns identified during a new patient's assessment would be flagged up with the GP partners to be followed-up. The practice offered NHS Health Checks to all its patients aged 40-75 years. This NHS programme aims to keep patients healthier for longer.

The practice was good at identifying patients who needed additional support and were pro-active in offering extra help. For example, there was a register of all patients with learning disabilities. Nationally reported data for 2013/14 showed that patients with Down's Syndrome had received a particular healthcare test in the preceding 12 months.

The practice manager confirmed that all patients with learning disabilities had received an annual health care check during the same period. Steps had been taken to identify the smoking status of patients over the age of 16, who came into contact with the practice. We were told the practice actively offered nurse-led smoking cessation clinics to these patients. The practice nurse told us they were responsible for carrying out cervical smears and had received training to do this. They also said they took every opportunity to offer smear testing to patients who had previously failed to take up the offer.

The practice offered a full range of immunisations for children as well as travel and flu vaccinations. The practice nurse told us they carried out immunisations on babies and children under five during their normal clinics. They also told us the GPs carried out the six-weekly baby checks during normal surgery hours. Routine child health checks were carried out twice a month, in clinics held by a health visitor and nursery nurse. Details of how to contact the health visitor were available on the practice web site. Children in the reception year and year six at school had their weights and heights checked as part of The National Child Measurement Programme. The percentage of patients in the influenza at risk clinical groups, who had received a seasonal influenza vaccination, was higher than the overall average for other practices in the local CCG area.

We did not see any evidence during the inspection of how children and young people were treated. However, patients we spoke to, and those who completed CQC comment cards, did not make us aware of any concerns about how practice staff looked after children and young people. We found the practice was not aware of the Department of Health publication, 'You're Welcome', which contains a set of quality criteria for child friendly health services. The practice manager said they would follow this up after the inspection.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the 2013 National GP Patient Survey, a survey of patients undertaken in 2013 by the practice's PPG and a survey carried out in 2012 by an independent organisation. The evidence from all these sources showed that the majority of patients were satisfied with how they were treated and the quality of the care and treatment they received.

Data from the National GP Patient Survey showed the practice was rated above the regional CCG average in most of the areas covered. For example, of the patients who responded: 90% said the last GP they saw, or spoke to, was good at giving them enough time; 88% said the last nurse they saw, or spoke to, was good at listening to them; 89% and 90% of patients said both the last GP and nurse they saw, or spoke to, was good at treating them with care and concern respectively.

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

All consultations and treatments were carried out in the privacy of a consulting or treatment room. Disposable curtains were provided in these rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and conversations taking place in these rooms could not be overheard.

In the reception area, a barrier had been placed a small distance away from the reception desk. This meant that only one patient approached the reception desk at a time, which provided patients with privacy when speaking to staff. This also helped to prevent patients from overhearing reception staff speaking to patients on the telephone.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients were positive about their involvement in planning and making decisions about their care and treatment, and generally rated the practice well in these areas. For example, data from the 2013 National GP Patient Survey showed: 85% of respondents said their GP involved them in decisions about their care; 88% felt the GP was good at explaining treatment and results. Both of these responses were above the regional CCG average. The results from the 2012 in-practice survey showed that 89% (90) of respondents felt the explanations they received about possible care and treatment options were good. The patients who completed CQC comment cards did not raise any concerns about their involvement in decisions about their care and treatment, and neither did the patients we spoke to on the day of our inspection.

Staff told us translation services were available for patients who did not have English as a first language. However, the practice manager said they only had one or two patients whose first language was not English.

Patient/carer support to cope emotionally with care and treatment

We observed patients in the reception area being treated with kindness and compassion by staff. None of the patients we spoke with, or those who completed CQC comment cards, raised any concerns about the support they received to cope emotionally with their care and treatment. Of the patients who responded to the 2012 in-practice survey: 90% said they were happy with the warmth of the greeting they received from the clinician they visited; 87% said they received the reassurances they were looking for; 88% said they could talk to the clinician about their concerns and fears, and 86% said the clinician they saw showed concern for them. Notices in the waiting room, and on the practice website, signposted patients to a number of relevant support groups and organisations. The practice's computer system alerted clinicians if a patient was also a carer so that this could be taken into consideration when clinical staff assessed their needs for care and treatment.

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Are services caring?

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Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

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

The practice had introduced improvements to the way it delivered services to mothers, babies and children following feedback from the PPG. For example, the PPG had fed back to the practice that the breast feeding area needed to be updated to make it more user friendly, so nursing mothers would make more use of it. The PPG report (2013 -14) contained feedback that the room had been redecorated and child friendly posters/stickers had been placed on the walls. We visited the room as part of the inspection. The room was pleasantly decorated and child friendly. A small number of toys were available for children to access whilst waiting to be seen by a doctor. A comfortable chair was available for mothers wishing to breast feed.

A member of the PPG told us they were in the process of planning a healthcare day with the other practice located in the Centre. We were told leaflets were to be delivered to every household in Wooler and the outlying rural areas inviting local people to attend the seminar. Poster and leaflets were also being prepared to help publicise the event. The focus for the seminar was to cover the wellbeing of men and women, mental health and activities.

The practice had a register which identified all patients in need of palliative care. Multi-disciplinary team (MDT) meetings took place weekly to discuss and review the needs of each patient on this register to help ensure services being provided were effective in meeting their needs. (These meetings also reviewed high risk elderly patients and those at risk of an unplanned hospital admission.) We were told management plans were set up following discussion within the MDT meeting. Each palliative care patient had been given the mobile number of their allocated GP, as well as details of how to contact other relevant healthcare professionals. Each patient had a care plan which healthcare professionals working within the Centre could access at any time. Following the death of a patient on the palliative care register, the practice arranged a multi-disciplinary meeting to review how well the support they offered had worked, and whether there was anything they could have done better.

The practice had taken action to plan its services to meet the needs of the working age population, including those that had recently retired. Of those respondents to the 2013 National GP Survey: 95% said they were satisfied with the practice's opening times, and 100% described their experience of making an appointment as good. The practice provided an extended hours service one evening a week to facilitate better access to appointments for working patients outside of normal surgery times. Reception staff told us they knew their patients well. They said when offering appointments to patients living in outlying rural areas, they would take into account bus arrival times into the village. We were told the practice also had a number of male patients who were long distance lorry drivers, and again, staff would try to offer appointments that fitted in with their availability. The practice website provided working age patients with information about how to book appointments and order repeat prescriptions. It also provided helpful information about how patients could improve their health and wellbeing. For example, there was a link to information about how patients could manage arthritis. Information about how to access carer support groups was available in the reception area.

The practice had identified those patients who were also carers and this was flagged on the computer system to alert clinicians to this so it could be taken into account when assessing these patients' care and treatment needs. Patients were able to access further services within the practice such as midwife appointments and counselling services. Providing these additional services meant that patients were able to access services within their own community rather than travelling to access these services.

Are services responsive to people's needs?

(for example, to feedback?)

The practice worked collaboratively with other agencies and regularly shared patient information to ensure good, timely communication of changes in care and treatment. Out-of-hours care was not provided by the practice. Information on the practice website told patients how to access emergency out-of-hours care and treatment. The practice provided the out-of-hours and emergency care services with access to care plan information, for patients who had palliative care or complex health needs. This enabled these services to access important information about these patients, in the event of an emergency. The practice manager told us the local out-of-hours service updated patients' medical records following any contact they had had with them. They also said a summary record of out-of-hours contact was made available to themselves and both GPs, so that clinical decisions could be made about whether any follow up was required and who would do this.

Advice on the criteria for requesting a home visit was available on the practice website. GP visits to the one residential care home for older people located within the practice boundary were made when requested. We were told longer (double) appointments would be made available if patients requested this.

Turnover of staff at the practice was low. Following recent staff retirements, a new partner and practice nurse had been recruited by the practice. The practice manager told us the staff group was now settled and up to full capacity, and that patients were able to access appointments with their preferred GP.

Tackle inequity and promote equality

The majority of patients who used the practice did not fall into any of the marginalised groups that might be expected to be at risk of experiencing poor access to health care, such as homeless patients and Gypsies and Travellers. We were told the practice took whatever action it could to meet the needs of patients who fell within this population group. For example, homeless patients wishing to register with the practice would be allowed to do so. A member of the reception team said people visiting the area could request to see a GP after registering temporarily. The practice had a small number of patients with learning disabilities. Suitable arrangements had been made to meet the needs of this group of patients.

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

The practice had a very small number of patients whose first language was not English. The practice manager told us the practice had access to a telephone translation service but this was hardly ever used. A member of the reception team confirmed they knew how to access this service if they needed to do so.

Access to the service

Appointments were available from 08:30am to 6:00pm each weekday. Extended hours were provided each Thursday evening up to 7:30pm. Patients were able to book appointments either by telephone, visiting the practice or on-line via the practice web site. The practice remained accessible to patients throughout the working day. The website also provided patients with advice about how to get the best out of their GP appointments so helping them to use the time available more effectively.

Information about how to access urgent appointments was available on the practice website. This included a commitment that all requests for same day urgent care would be met, and that all patients requesting a non-routine appointment would be seen within two working days. Patients were able to book appointments up to three months in advance. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed between 6.30pm and 8.30am which was provided by Northern Doctors. Information about how to access out-of-hours care and treatment was available on the practice website and on the practice leaflet. When the practice was closed there was an answerphone message giving the relevant telephone numbers patients should ring.

Are services responsive to people's needs?

(for example, to feedback?)

Patients were satisfied with the practice's appointments system. Of the patients who participated in the National GP Patient Survey: 95% who had a preferred GP, usually got to see or speak to that GP; 98% said they found it 'easy' to get through on the telephone to someone at the practice; 95% said the practice opened at times that were convenient to them; 93% said they usually waited 15 minutes or less after their appointment time to be seen, and that they didn't normally have to wait too long to be seen. The results of the 2012 in-practice survey showed a similar high level of satisfaction. For example, 88% of respondents reported satisfaction with opening hours. We talked to nine patients about their experience of using the practice. None raised concerns about access to appointments.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and the contractual obligations for GPs in England. The practice manager was the designated responsible person for handling all complaints received by the practice.

Information was available to help patients understand the complaints system. The practice website informed patients of who to contact in the event they had a complaint. It also confirmed the practice operated a complaints procedure as part of the NHS system for dealing with complaints. The website also informed patients that comments about the practice could be made via the NHS Choices website. A comments book was available in the practice waiting area. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had ever needed to make a complaint about the practice.

The practice had received one complaint in the previous 12 months. We looked at the records of this complaint and found it had been handled satisfactorily, dealt with in a timely manner and to the satisfaction of the patient concerned. We saw the practice had offered an apology on behalf of the practice team. We were able to see that improvements had been made following the complaint received.

Are services well-led?

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

Our findings

Vision and Strategy

The practice had a clear vision of how to deliver high quality care and promote good outcomes for patients. The practice development plan and statement of purpose included details of the steps it would take to deliver its vision and improve the quality of care and treatment provided to patients. Information about the practice's vision and values included the following aims: "…the practice is committed to providing high quality and readily available health care to the patients of this practice; we aim to offer continuity of care with the doctor of your choice as much as possible and see this as the key to developing a good doctor/patient relationship." We spoke with some of the staff on duty and they all knew and understood what the practice was committed to providing and knew what their responsibilities were in relation to these aims.

Governance Arrangements

The practice had a number of policies and procedures in place concerning its activities and the services it provided to patients. Staff were able to access these via the practice website. The sample of policies and procedures we looked at had been recently been reviewed. The practice held regular practice management, clinical and multi-disciplinary meetings. Minutes of recent meetings indicated the performance of the practice was reviewed and discussed.

The practice used data from the QOF to measure their performance. This showed the practice was performing in line with practices nationally. We saw that QOF data was discussed at practice management meetings. This helped to ensure all staff were aware of how the practice was performing and to reach consensus about any actions that needed to be taken. In addition to this, the practice manager reviewed the QOF data weekly in order to verify how outcomes for patients could be maintained or improved. They provided the practice management team with up-to-date feedback regarding the performance of the practice. QOF data confirmed the practice participated in an external peer review with other practices in the same CCG group, in order to compare data and agree areas for improvement.

The practice had completed a number of clinical audits. For example, it had carried out an audit of its prescribing practice in relation to the use of a particular medicine with high risk patients. Information made available to us during the inspection regarding the outcome of this audit indicated the practice had made changes to their prescribing practice which had resulted in positive outcomes for this group of patients.

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

Leadership, openness and transparency

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

Regular practice and MDT meetings took place where operational issues and patients' needs were discussed. The practice manager told us they were just about to reinstate more regular staff meetings to ensure they received regular feedback from all team members. Staff told us there was an open culture within the practice and they were happy to raise issues at team meetings. Practice away days took place. These were used to discuss practice based issues and significant events, and to agree ways of working together to improve how the practice operated.

A range of human resource policies and procedures were in place, and these covered harassment and bullying at work. Staff we spoke with said they were able to access all practice policies and procedures via their desktop computers.

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

The practice had arranged for an external organisation to carry out an in-practice patient survey in 2012. The survey covered areas such as patients' satisfaction with the performance of their doctor or nurse, and whether satisfactory systems were in place to ensure good access to

Are services well-led?

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

the practice. The practice manager told us the outcome of the patient survey was discussed at practice meetings to identify what improvements could be made to address the feedback received.

The practice's PPG also carried out a survey of patients in 2013 and this focussed on the practice reception area and waiting room. We were able to confirm that improvements had been made following this survey. The practice website included information about how to express an interest in joining the PPG. The patient participation report for 2013 – 2014 provided details of the composition of the group, and the steps that had been taken to widen the membership to reflect the practice population.

The staff we spoke to felt valued and said they felt they were an important part of the practice team. Staff said team work was really good. They said the whole team worked well together in a positive manner to deliver good patient care. The staff we spoke to said their opinion was sought and confirmed they felt involved in how the practice was managed and services were delivered.

Management lead through learning & improvement

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