Reeth Medical Centre

Quality Report

Reeth Medical 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	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Good ●
Are services caring?	Outstanding ☆
Are services responsive to people's needs?	Outstanding ☆
Are services well-led?	Outstanding ☆

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

This practice is rated as Outstanding overall. (Previous inspection May 2015 - Outstanding

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Outstanding

Are services responsive? – Outstanding

Are services well-led? – Outstanding

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

Older People – Outstanding

People with long-term conditions – Outstanding

Families, children and young people – Outstanding

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

People whose circumstances may make them vulnerable – Outstanding

People experiencing poor mental health (including people with dementia) – Outstanding

At this inspection we found:

- The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.
- The practice was open and transparent, and had systems in place to adhere to the Duty of Candour. When things went wrong, we saw that the practice offered patients an apology and an explanation. Quality improvement was embedded into practice. There was a comprehensive programme of clinical and non-clinical audit that all staff were involved with that was routinely monitored and changes made to practice resulted in measurable improvements to patient care.
- The practice was proactive in identifying new ways of working to streamline services and improve patient experience.
- The practice was strongly committed to multidisciplinary working and could evidence how this had a positive impact on patient care.
- Discussions with staff and feedback from patients demonstrated staff were highly motivated and were inspired to offer care that was kind, caring and supportive and met the needs of the population.
- The practice organised and delivered services to meet patients' needs. The practice had initiated positive service improvements for their patients. There was a proactive approach to understanding the needs of different groups of patients and to deliver care in a way that met their needs and where possible, their preferences.

Summary of findings

- Patients were able to access a wide range of services at the practice, which enabled patients to be treated closer to home.
- The practice improved services where possible in response to unmet needs. They made reasonable adjustments when patients found it hard to access services even if it was only for a small number of patients.
- The practice was passionate about ensuring they always provided their patients with the best care possible. They demonstrated a determined attitude to overcome barriers faced by the practice and the population they served. They focussed on the challenges faced by a rural community and planned their services around this.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.

We saw a wide range of outstanding practice. Examples included:

The practice proactively ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances. Nationally reported data showed the number of patients of Reeth Medical Centre dying in their preferred place was significantly above the national data.

The number of patients on the practice's palliative care register was three times the national average.

The practice funded a local community transport scheme to provide free at the point of use transport for housebound patients so they could attend appointments at the practice. This included using the bus service or someone walking the patient to their appointment. The practice worked closely with the district nursing team hosting their services allowing them to see patients centrally at the practice which after one year, there were 42% fewer district nurse home visits and a high level of satisfaction from the patients using the scheme.

The practice had provided unfunded voluntary support to the Yorkshire Ambulance Service since 2007. This worked by allowing the ambulance service to directly mobilise and inform the practice of incidents in which it was beneficial for the GP to attend (usually the GP could be on scene before the ambulance arrived). On average the practice attended approximately four serious or life threatening incidents a year.

The areas where the provider **should** make improvements are:

Review the practice's home delivery service in relation to maintaining an appropriate audit trail.

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

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

Reeth Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector**.** The team included a GP specialist adviser, a second CQC inspector and a member of the CQC medicines team.

Background to Reeth Medical Centre

Reeth Medical Centre, Back Lane, Reeth, DL11 6SU is situated in a rural village near Richmond serving the two dales of Swaledale and Arkengarthdale, caring for 1600 patients in an area of 200 square miles. The practice is a dispensing practice, dispensing to 1590 of the 1600 registered patients.

The practice has a predominantly British White population, with an above average population aged 65 years plus. There are less people aged zero to 18 years than the England average. Practice data showed slightly more patients than average with a long-standing health condition (58%),

compared to the national average of 53%. Male life expectancy is above the national average at 80 years and female above at 85 years (national average male 79 and female 83). Information published by Public Health England showed the practice scored seven on the deprivation measurement scale; the deprivation scale goes from one to ten, with one being the most deprived. People living in more deprived areas tend to have greater need for health services.

The practice is a partnership made up of a GP partner (male) and non-clinical partner with a second salaried GP (female). There is one practice nurse (female). One GP works at the practice at a time and the nurse is available twenty hours per week. There is a practice manager who is also the non-clinical partner, dispensing staff and a range of administration/secretarial staff.

The practice offers a mixture of open and booked appointments daily. Sit and wait appointments are available every morning from 8.30am with the clinic list closing at 10am, after which the clinic continues until the last patient is seen. Bookable appointments are available from 11.30am. This is usually a single appointment lasting anything between 30 – 60 minutes. This appointment is used for learning disability and dementia patient reviews, memory tests, minor surgery or if the GP wishes to have the option of seeing a patient for longer. This appointment is not time bound. Booked appointments are available from 4pm to 5.30pm (Monday, Wednesday and Friday). On a Tuesday and Thursday a duty arrangement is in place whereby the GP partner or salaried GP is on call and available to see patients if assessed as needed. Emergency appointments are available between the hours of 8am and 6pm daily. Appointments with the nurse are by booked appointment only. The dispensary is open on a Monday, Wednesday and Friday from 8.30am to 1pm and 4pm to 6pm and Tuesday and Thursday from 8.30am to 1pm.

The practice has opted out of providing out-of-hours services to its own patients. The out of hours care is accessed through the 111 service and is provided by Harrogate District Hospital Foundation Trust. The nearest out of hours centre is based at the Harewood Medical Practice, Catterick Garrison.

The practice holds a General Medical Services (GMS) contract to provide GP services which is commissioned by NHS England.

Good

Are services safe?

Our findings

We rated the practice as good for providing safe services.

Safety systems and processes

The practice had clear systems to keep patients safe and safeguarded from abuse.

- The practice conducted safety risk assessments. It had a suite of safety policies which were regularly reviewed and communicated to staff. Staff received safety information for the practice as part of their induction and refresher training. The practice had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance.
- The practice worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check.
- There was an effective system to manage infection prevention and control. The practice completed an audit against Part 3 of The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections. They had reviewed each criterion within the Code of Practice and rated its performance against this.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.

Risks to patients

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

- There were arrangements for planning and monitoring the number and mix of staff needed. The practice had a minimum staffing level policy in place which was followed at all times.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections, for example, sepsis. There was no information in the practice reception area in respect of sepsis. Shortly after the inspection the practice added information about sepsis to their social media platform.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

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

Safe and appropriate use of medicines

The practice had reliable systems for the appropriate and safe handling of medicines.

- The practice had standard operating procedures (these are written instructions about how to safely dispense medicines) that were readily accessible and covered all aspects of the dispensing process.
- The practice had signed up to the Dispensing Services Quality Scheme, which rewards practices for providing high quality services to patients of their dispensary. We were shown a log of near misses (a record of dispensing errors that have been identified before medicines have

left the dispensary) which included evidence of discussions and lessons learnt. These lessons were discussed at the monthly dispensary meetings but minutes of these were not recorded.

- The expiry dates of medicines were checked on a monthly basis and this was recorded appropriately. All medicines we checked were in date. Expired and unwanted medicines were disposed of in accordance with waste regulations.
- The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by practice staff.
- All prescriptions were signed by a GP before they were given to patients and there was a robust system in place to support this. Staff told us how the lead GP managed review dates within the practice. We looked at 10 records and found all patients were reviewed.
- There was a system in place for the monitoring of high risk medicines and we saw how this kept patients safe. For example dispensary staff had undertaken audits of high risk medication to ensure patient's records had the appropriate doses on repeat medication.
- The practice told us how they managed medicines alerts and we saw how this worked on the day of the inspection.
- The practice provided a dosette box service for patients. (These are plastic boxes with small compartments that show clearly which pills need to be taken at what time of the day). The practice did not follow good practice in relation to placing medicines in dosettes which put patients at risk of harm. However, the national guidance document had not been received by this provider as it related to dispensing pharmacies and not dispensing doctors. We received confirmation shortly after the inspection to confirm the current arrangement had ceased and new arrangements were being put in place.
- The practice offered a home delivery service to patients. Whilst the practice kept a daily record of what medicines left and were returned to the practice each day they did not keep an audit trail of this over time for them to refer to. No arrangements were in place for patients or the delivery driver to sign for receipt/delivery of the medicines.
- We checked medicines stored in the medicines refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring medicines were stored at the required temperatures and this was being followed by practice staff.
- PGDs had been adopted by the practice to allow nurses to administer vaccines in line with legislation and these had been appropriately signed and authorised.
- Blank prescription forms were stored in accordance with requirements set out in national guidance. Blank prescriptions were stored in a locked cupboard within a locked area and only accessible to authorised personnel.

Track record on safety

The practice had a good safety record.

- There were comprehensive risk assessments in relation to safety issues.
- The practice closely monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were effective systems in place for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice. For example it had been identified that a patient sample had been sent to pathology but not processed. Following this a weekly reconciliation of pathology tests against results received was put in place. The effectiveness of this system was demonstrated by capturing a recent missing laboratory result which was immediately flagged with secondary care and rectified.
- There was a system for receiving and acting on safety alerts. We saw evidence that the two most recent alerts received by the practice had been acted on immediately. The practice learned from external safety events as well as patient and medicine safety alerts.

Good

Are services effective?

(for example, treatment is effective)

Our findings

We rated the practice as good for providing effective services overall and across all population groups.

Effective needs assessment, care and treatment

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

- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- The practice used information technology systems to monitor and improve the quality of care. For example the practice had identified that patients' blood pressure results could potentially be more accurate if taken in the home environment where they were more relaxed. Patients had the facility to e-mail their readings to the practice or bring them in in person and if needed, a review with the GP would then be arranged. Similar arrangements were in place for the management of diabetes and feedback to patients on test results including high risk medicines and prostate cancer monitoring.
- Staff advised patients what to do if their condition got worse and where to seek further help and support. Following a recent incident in the community the practice had used various media sources to promote the importance of considering whether to call the emergency services first rather than the practice.
- Staff and patients had access to a wide range of equipment that staff had been trained to use to assist in improving diagnosis and ongoing treatment. For example, blood pressure monitors for use at home, a dermatoscope to assist in the diagnosis of skin conditions and an electrocardiogram (ECG) machine. Also we saw evidence that the practice was raising funds along with the local community to purchase a nitric oxide monitor (FeNO monitor) in line with the most recent NICE guidance on the diagnosis of asthma.

Older people:

- 31% of patients were older people. Patients aged over 75 were invited for a health check. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan. Over a 12 month period the practice had offered 113 older patients a health check and 79 checks had been carried out.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.

People with long-term conditions:

- 10% of the practice population had a long term condition. Patients with long-term conditions had a structured review to check their health and medicines needs were being met. The practice used a one-stop-shop approach to reduce the number of visits a patient had to make to the practice. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Personalised care plans were in place for patients with diabetes, chronic obstructive pulmonary disease (COPD), asthma and heart failure.
- The practice used information technology systems to monitor and improve the quality of care. For example the practice had identified that patients' blood pressure results could potentially be more accurate if taken in the home environment where they were more relaxed. Patients had the facility to e-mail their readings to the practice or bring them in in person and if needed, a review with the GP arranged. Similar arrangements were in place for diabetes management and feedback to patients on test results including amber drugs and prostate cancer monitoring.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- Patient's medicines were reconciled by the GP when they were discharged after admission to secondary care.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were above CCG/national averages. Childhood immunisation rates for the vaccinations given up to age two were above the 90% national target at 100% scoring 10 out of 10 compared to the national average of 9.1.

Good

Are services effective?

(for example, treatment is effective)

- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. We saw evidence that patients of child bearing age who were taking a certain medicine were written to and notified to contact the practice if, in the future they became pregnant.

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

- The practice's uptake for cervical screening was 79%, which was in line with the 80% coverage target for the national screening programme.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time. The practice carried out regular meningitis vaccination proactive case finding for young people eligible for vaccination and recall. 100% coverage had been achieved in the last catch up.
- Patients had access to appropriate health assessments and checks including NHS health checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified. 100% of eligible patients had been invited for a NHS health check in the last five years. 53% had taken up this check.

People whose circumstances make them vulnerable:

- Older patients who were frail or may be vulnerable received a full assessment of their physical, mental and social needs. Those identified as being frail had a clinical review including a review of medication and their social status.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. The GP partner was appointed National Clinical Support Fellow for End of Life care at The Royal College of General Practitioners (RCGP). They had developed the RCGP End of Life toolkit which the practice used. Nationally reported data showed that the number of patients of Reeth dying in their own home was significantly above actual reported national data. Data sourced from Sue Ryder's A Time and a Place report and Practice mortality data 2015-2017 showed:

63% of people wanted to die at home (national); 21% actually died at home (national); and 58% of Reeth patients died at home.

8% of people wanted to die in hospital (national); 55% actually died in hospital (national); and 23% of Reeth patients died in hospital (which included the local community hospital where patients continued to receive end of life care from their own GP).

28% of people wanted to die in a hospice (national); 5% actually died in a hospice (national); and 18% of Reeth patients died in a hospice.

1% of people wanted to die in a care home; 18% actually died in a care home (national); and 0% of Reeth patients died in a care home (there were no care homes in the practice area).

- The practice held a register of patients living in vulnerable circumstances including veterans, housebound and those with a learning disability.
- Records showed patients on the learning disability register had all received a comprehensive annual review.
- The practice linked in with the local community transport scheme to provide free at the point of use transport for relatively housebound patients so they could attend appointments at the practice. The practice worked closely with the district nursing team hosting their services and using the transport service allowing the district nurses to see patients centrally at the practice.
- The practice had run a successful hepatitis B campaign resulting in five potentially at risk patients being immunised.

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

- Published data showed 90% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This is comparable to the national average. The practice provided evidence that they had now reviewed 100% of the patients.
- 90% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This is comparable to the national average.

Good

Are services effective?

(for example, treatment is effective)

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. The practice had identified the audits for 2016 – 2017 and also had a programme of rolling audits each year. Examples of these included quarterly prostate cancer monitoring, meningitis vaccination proactive case finding for young people eligible for vaccination and recall and overdue International normalized ratio checks (INR). If you take blood thinning medicines, also called anti-clotting medicines or anticoagulants, it is especially important to check the patients INR.

The most recent published Quality and Outcomes Framework (QOF) results were 99% of the total number of points available compared with the clinical commissioning group (CCG) average of 99% and national average of 97%. The overall exception reporting rate was 5% compared with a national average of 10%. We discussed the small number of areas that showed higher than average exception reporting and was satisfied with the explanation, notably which as the practice population size was small, excepting a small number of patients impacted on the overall exception result. (QOF is a system intended to improve the quality of general practice and reward good practice. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.)

- The practice used information about care and treatment to make improvements. The practice had carried out sixteen completed clinical audits, all of which showed improvements identified were acted on and monitored. Two specific examples included the use of opiates in non-cancer patients and the suitability of adrenaline pens kept in patient's homes.
- The practice was actively involved in quality improvement activity. The practice had a programme of targeted clinical audits and a rolling programme of others areas for audit. For example, high risk medicines and prostate cancer monitoring. They also used clinical data, targeted reviews such as medicines reviews and external data from the local CCG to monitor their performance and to take action where needed.
- Staff had the skills, knowledge and experience to carry out their roles. Practice staffing included medical, nursing, dispensing, managerial and administrative staff. We noted a good skill mix among the clinical staff; both male and female. GPs had additional qualifications in a range of areas; examples of which were Diploma in Mountain Medicine, Certificate in Pain Management, Pre-hospital Emergency Care Certificate (Advanced), Certificate in Practical Palliative Care for General Practitioners and Certificate in Diabetes Management and appointed National Clinical Support Fellow for End of Life care at the RCGP. Staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.
- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained.
- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, six monthly appraisals, coaching and mentoring, clinical supervision and support for revalidation.
- There was a strong focus on staff development and training. For example staff had been supported and funded to undertake additional qualifications to support them in their career development. For example a member of the administration team was being supported to under NVQ Level three in Clinical Health Care whilst the dispenser was undertaking a Diploma in Management so they could move into a supervisory role in the practice.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- The practice proactively worked with other health and social care professionals to deliver effective care and treatment to help patients remain at home.

Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant

Good

Are services effective?

(for example, treatment is effective)

agencies. The practice had access to beds for patients at a local community hospital. This was a part funded service. The GP looked after any of their patients who were admitted to this hospital. The frequency of the visits to the hospital depended on the patients' reason for admission. If a person was receiving end of life care then the GP visited daily resulting in continuity of care for these patients. The hospital was a thirty mile round trip.

The practice proactively ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances. Nationally reported data showed the number of patients of Reeth Medical Centre dying in their preferred place was significantly above the national data. The number of patients on their palliative care register was three times the national average. 2.3% of patients had a care plan, do not attempt cardiopulmonary resuscitation (DNACPR) decision or advance directive in place.

Helping patients to live healthier lives

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

- The practice identified patients who may be in need of extra support. They worked closely with such patients, provided care and treatment, assisted them to access services and support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition, patients with a learning disability and carers. For example the GP had sought to find dental services for a patient with a learning disability who had experienced difficulty accessing services.
- Staff encouraged and supported patients to be involved in monitoring and managing their health.

Staff discussed changes to care or treatment with patients and their carers as necessary.

- The practice supported national priorities and initiatives to improve the population's health. For example the practice nurse offered smoking cessation advice, the practice co-ordinated access for patients to ensure they could obtain their flu vaccination and they monitored patient alcohol intake.
- The practice used social media platforms for health promotion as well as regular articles in the local newspaper.
- The practice utilised every opportunity to assist in managing social isolation. For example the practice offered tea/coffee, cakes and tombola at flu clinics. They had also delivered books to a socially isolated patient.

Consent to care and treatment

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

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately. For example an audit of consent obtained for minor surgery had been carried out.

Outstanding ☆

Are services caring?

Our findings

We rated the practice as outstanding for providing caring services.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion. Discussions with staff and feedback from patients' demonstrated staff were highly motivated and were inspired to offer care that was kind, caring and supportive and that met the needs of the population.

- Staff demonstrated a clear understanding of patients' personal, cultural, social and religious needs. They took action to provide care and support to the person and not just their condition.
- The practice gave patients timely support and information.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs. If patients felt unwell they were immediately moved to a spare clinical room where they were monitored and seen by the GP.
- All of the 54 patient Care Quality Commission comment cards we received were extremely positive about the service experienced. This was in line with the results of the NHS Friends and Family Test and other feedback received by the practice such as compliments received which the practice shared with staff.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. 209 surveys were sent out and 135 were returned. This represented about 8% of the practice population. The practice was significantly above average for its satisfaction scores on consultations with GPs and nurses achieving 100% in five out of the 9 related questions. For example:

- 100% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 93% and the national average of 89%.
- 100% of patients who responded said the GP gave them enough time; CCG - 91%; national average - 86%.
- 99% of patients who responded said they had confidence and trust in the last GP they saw; CCG - 97%; national average - 95%.
- 100% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG– 91%; national average - 86%.
- 100% of patients who responded said the nurse was good at listening to them; (CCG) - 95%; national average - 91%.
- 98% of patients who responded said the nurse gave them enough time; CCG - 95%; national average - 92%.
- 100% of patients who responded said they had confidence and trust in the last nurse they saw; CCG - 99%; national average - 97%.
- 99% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG - 95%; national average - 91%.
- 99% of patients who responded said they found the receptionists at the practice helpful; CCG - 91%; national average - 87%.

Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care. The practice had an action plan in place to adhere to the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given). All action points in the plan had been addressed:

- Interpretation services were available for patients who did not have English as a first language and when needed a signer was also used.
- Staff communicated with patients in a way that they could understand, for example, communication aids and easy read materials were available. Correspondence sent to patients had been amended to ask patients if they required any information in a different format.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.

The practice proactively identified patients who were carers. The practice had identified 67 patients as carers (4% of the practice list). They worked with the local Carers Association. The Association had last visited the practice to promote carers' services at the flu vaccination clinic in October 2017. The practice also had a carers resource file

available for patients to view in the reception area. Patients were also asked opportunistically whether they were a carer or were cared for. The dementia assessment questionnaire had been amended to ask about carers and how they were managing.

We were told that most deaths in the practice area were planned deaths which meant the practice was already actively involved in the patients' end of life care. Staff told us that if families had experienced bereavement a sympathy card was sent. Their usual GP contacted them and this call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. When a death was not planned the same approach was applied. We were provided with a number of examples where unplanned deaths had occurred and the action the GP had taken. One example had been where the GP had responded to an emergency incident in the community and had then driven to find the relative to inform them of the incident and spending time talking through the event with them following their bereavement which we were told they found comforting.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were above local and national averages achieving 100% in three out of the four related questions.

- 100% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the local clinical commissioning group (CCG) average of 92% and the national average of 86%.
- 100% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG - 90%; national average - 82%.
- 100% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG - 93%; national average - 90%.
- 98% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG - 90%; national average - 85%.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The practice complied with the Data Protection Act 1998. They had set out an action plan and actioned all points in relation to the new Department of Health requirements in relation to data protection.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We rated the practice as outstanding for providing responsive services. We rated all of the population groups as outstanding.

Responding to and meeting people's needs

The practice had initiated positive service improvements for their patients. There was a proactive approach to understanding the needs of different groups of patients and to deliver care in a way that met their needs and where possible, their preferences. Patients were able to access a wide range of services at the practice, which enabled patients to be treated nearer to their home.

The practice understood the needs of its population and tailored services in response to those needs. Two specific examples were:

- The practice funded a local community transport scheme to provide free at the point of use transport for relatively housebound patients so they could attend appointments at the practice. Reported benefits included patients accessing care in a clinical environment, reduced social isolation, supporting a local voluntary scheme, reduced district nurse home visits, optimised clinicians' time seeing patients rather than travelling in a practice area of approximately 200 square miles and patients being able to use return transport to visit Post Office, luncheon clubs etc. to maintain social contact and independence. The practice worked closely with the district nursing team hosting their services allowing them to see patients centrally at the practice which after one year, there were 42% fewer district nurse visits and a high level of satisfaction from the patients using the scheme. This joint working had also provided the benefit of mutual training opportunities and skill development with the practice nurse and district nurse. This scheme was now fully funded by the practice. As a result of the project, other practices in the locality had set up similar schemes.
- Annual reviews for patients with a learning disability were planned at the end of each clinic so that the review was not time limited. We were told that this meant the review could be undertaken at a pace to suit the patient.

A wide range of services were available to patients at the practice.

- The practice hosted a range of services at the practice. For examples Physiotherapist, Chiropodist, Primary Care Mental Health worker and McMillan nurse. These services (with the exception of the private Chiropodist) were accessed via GP referral.
- A range of services were offered which meant patients could be treated closer to home and this was of significant benefit due to the rurality of the practice. For example, in house blood tests for warfarin monitoring, ring pessary fitting, acute retention catheterisation and DVT diagnosis management.
- Minor surgery and minor injury services were offered which was again particularly useful as the practice saw transient patients due to its location on the Coast to Coast cycle route.
- An open surgery was available daily along with pre-bookable appointments.

The practice made reasonable adjustments when patients found it hard to access services even if it was only for a small number of patients. For example:

- The practice had run an unfunded pilot for administering intravenous antibiotics at the practice and in the community for patients requiring long term antibiotics. The practice arranged training for their nurse and community nurses to administer the antibiotics overseen by the GP and in consultation with the relevant consultant. Whilst only two patients had used the service so far it had saved them up to 10 weeks of hospital stay or daily visits to the medical assessment ward which was a 60 mile round trip.

The practice improved services where possible in response to unmet needs. For example:

- The practice had provided unfunded voluntary support to the Yorkshire Ambulance Service since 2007. This worked by allowing the ambulance service to directly mobilise and inform the practice of incidents in which it was beneficial for the GP to attend (usually the GP can be on scene before the ambulance arrives). On average the practice attended approximately four serious or life threatening incidents a year.

The practice had its own all weather vehicle for use in difficult terrains/inclement weather which meant every effort was made to visit patients in hard to reach areas. For example fell walkers.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

- The facilities and premises were appropriate for the services delivered.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services. For example the practice held 6-weekly palliative and supportive care meetings with community and specialist nurses with a summary record shared with the out-of-hours service. The practice had been approached to work with Macmillan and South Tees Hospital Trust to develop a pilot site for a Community Macmillan nurse to support recently diagnosed cancer patients. This nurse was currently hosted at the practice on an as and when needed basis.

Older people:

- The practice was responsive to the needs of older patients. 31% of the practice population was over the age of 65 years. Patients who found it difficult to attend the practice and who may also be socially isolated were offered use of the transport service to attend the practice for appointments. This included routine appointments with the GP or nurse, attendance at flu clinics and also to see the district nurse who the practice hosted twice a month. Patients were either returned home using the transport service or dropped off at various locations of their choice.
- All patients had a named GP who supported them.
- After hospital discharge, the GP performed medicines reconciliation and a follow up visit/appointment arranged as appropriate.

People with long-term conditions:

- Patients with a long-term condition received a minimum annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.

Families, children and young people:

- There were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.
- The practice had, in 2016, provided first aid training in partnership with British Red Cross for parents with young children and expectant mothers. Further training was planned for early 2018 to coincide with planned births.
- The practice had set up a specific nasal flu vaccination clinic to coincide with school pickup times to try and improve uptake.
- The practice had approached the local CCG as they were keen to start working towards the PACE setter award for the practice (Primary and Community Care Quality Mark for Children and Young People's NHS service) after the proposed closure of the local paediatric day unit due later in 2018.

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

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, a sit and wait service as well as fixed appointments were offered daily.
- Telephone and email GP consultations were available which supported patients who were unable to attend the practice during normal working hours. The practice had been running a campaign to improve the uptake of online services (up from 17.6% in 2015 to 31.7% currently). The practice was increasingly using e-mail consultation to liaise with patients to follow up on consultations, reviews and to share test results.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including veterans, housebound patients and those with a learning disability.
- 100% of patients with a learning disability had received an annual review. These reviews were planned at the end of each clinic so that the review was not time limited.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

- 1.3% of the practice population were identified as veterans. The practice provided a Veterans' Health Kite mark service to these patients.
- The practice had its own response vehicle for use in difficult terrains.
- The practice provided unfunded voluntary support to the Yorkshire Ambulance Service since 2007. This worked by allowing the ambulance service to directly mobilise and inform the practice of incidents in which it was beneficial for the GP to attend (usually the GP can be on scene before the ambulance arrives).

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

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia. For example staff were aware of patients who may need to be offered consultations outside of the normal clinic times.
- Staff provided a reminder service before appointments and followed up missed appointments
- Information was made available to patients about mental health services available to them.
- A mental health care worker was available at the practice two days a month for patients to see.
- A representative from a local mental health service had recently visited the practice to talk to patients about their services.

Timely access to the service

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- The appointment system was easy to use.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was significantly above national averages in all related questions and above local CCG averages in four out of the six related questions and comparable in the other two. This was supported by observations on the day of inspection and completed comment cards. 209 surveys were sent out and 135 were returned. This represented about 8% of the practice population.

- 89% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 83% and the national average of 76%.
- 99% of patients who responded said they could get through easily to the practice by phone; CCG – 89%; national average - 71%.
- 96% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment; CCG - 91%; national average - 84%.
- 94% of patients who responded said their last appointment was convenient; CCG - 91%; national average - 81%.
- 98% of patients who responded described their experience of making an appointment as good; CCG - 86%; national average - 73%.
- 67% of patients who responded said they don't normally have to wait too long to be seen; CCG - 66%; national average - 58%.

Listening and learning from concerns and complaints

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

- Information about how to make a complaint or raise concerns was available and it was easy to do. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. The practice had not received any complaints in the last year. There was evidence that where concerns or complaints had been raised through other avenues other than direct to the practice that action was taken in respect of this. For example in response to being made aware of concerns regarding opening times the practice produced an article in the Reeth Gazette about their opening times. Opening times were also supplied to the Parish Council. Other examples included responding to negative feedback from the Friends and Family test.

Are services well-led?

Outstanding ☆

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

Our findings

We rated the practice as outstanding for providing a well-led service.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- A clear leadership structure was in place. The partners at the practice demonstrated a commitment to driving improvement in the quality of care and patient experience. We were told there was an open and transparent culture at the practice and all staff were engaged in the direction of the practice.
- Leaders had the experience, capacity and skills to deliver the practice strategy and address risks to it.
- Partners were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them. There was evidence that future changes/ requirements were acted on immediately or a plan put in place in readiness for changes. For example the change of coding on the electronic patient record system.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

• Staff told us they had the opportunity and were happy and encouraged to raise issues.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.

- There was a clear vision and set of values. The practice had a realistic strategy and supporting business plans to achieve priorities.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The practice planned its services to meet the needs of the practice population. They demonstrated a determined attitude to overcome the barriers the practice and the population faced.
- The practice closely monitored progress against delivery of the strategy.

Culture

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

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- The practice focused on the needs of patients. Patients' health needs were not viewed in isolation. Patients were viewed as a person and not just as their condition. Patient's social needs were very much at the forefront of the practices consideration.
- Evidence showed the partners acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they needed. This included appraisal, career development and financing of external courses. All staff received six monthly appraisals. Staff were supported to meet the requirements of professional revalidation where necessary.
- All staff were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical and non-clinical work.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

Governance arrangements

Are services well-led?

Outstanding ☆

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

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

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care. Staff were clear on their roles and accountabilities.
- Practice leaders had established appropriate policies, procedures and activities to ensure safety and assured themselves that they were operating as intended. The governance and performance management arrangements were proactively reviewed and reflected best practice. The practice held regular governance meetings where matters such as performance, quality and risks were discussed. The practice demonstrated how they took a systematic, proactive and innovative approach to working with other organisations to improve care outcomes for patients, how they worked to tackle health inequalities and how they also considered the financial aspects for the practice and the NHS. For example the practice had calculated the cost saving to secondary care that had been made by the practice providing two patients with long term antibiotics in the practice rather than attending secondary care.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

- There were processes to identify, understand, monitor and address current and future risks including risks to patient safety. The practice had comprehensive systems in place for reporting, recording and monitoring significant events, incidents and accidents. For example the practice had raised concerns with the CCG in respect of a CCG commissioned service which resulted in a CCG investigation and changes to the private contractor's policies to improve patient safety.
- The practice had a range of action plans in place to ensure compliance with future changes and requirements. For example data protection, accessible information standards and the coding changes on the electronic patient record used that was shortly taking place.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions.
- Practice partners reviewed all MHRA alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality. All staff were involved in audits. For example the dispensing staff had undertaken an audit of epi pens. The practice had plans in place and had trained staff for major incidents.
- The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The practice used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care. Electronic communication was available for patients to contact the practice direct. This line of communication was open to patients to ask advice, raise concerns, and receive test results and for sharing information such as blood pressure results. Emails were reviewed daily by the GP and responded to (when routine) within 48 hours. Any information of concern was acted on immediately.
- The practice submitted data or notifications to external organisations such The National Reporting and Learning System (NRLS). This is a central database of patient safety incident reports.

Are services well-led?

Outstanding ☆

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

- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

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

- The practice did not have a stand-alone PPG in place. Their attempts at setting up a group had been unsuccessful due to a lack of interest. In 2012 the practice joined the Upper Dales Area Partnership (UDAP) as they felt this was an ideal way of engaging and working with patients and the wider community. The group met five times a year and was made up of County, District and Parish Councillors, public sector representatives such as the Police, voluntary sector, business people and members of the public living and working in the Upper Dales.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There was clear evidence that staff at the practice drove continuous improvement using a wide range of information as well as their own knowledge and skills. The practice was passionate about ensuring they always provided their patients with the best care possible. For example the practice closely monitored the effectiveness of helping to ensure patients died in their preferred place. Evidence showed there was a clear proactive approach to seeking out and embedding new ways of providing care and treatment to improve outcomes for their patients. For example the implementation of the transport service.

The practice had become an accredited research practice. The three recent projects the practice had been involved with had reached out to 25% of the practice list. The practice was clear that being part of accredited research allowed patients to maybe have the chance to try medicines/interventions they would not ordinarily have been given, which may turn out to improve their condition or reduce the chance of disease progression or death. For example use of allopurinol in the All Heart study to reduce the chance of heart attacks in at-risk people.

There were systems and processes for learning, continuous improvement and innovation. There was a focus on continuous learning and improvement at all levels within the practice. Examples included:

- The GP partner at the practice developed the concept of Veterans' Health kite mark for GP practices to develop and recognise standards of care for Veterans. This had been taken up by NHS England, Ministry of Defence (MOD), Cabinet Office and The RCGP. To date, 52 practices had signed up to the pilot phase which was due to start 2018 in the West Midlands.
- The GP partner was appointed National Clinical Support Fellow for End of Life care at The Royal College of General Practitioners (RCGP). They had developed the RCGP End of Life toolkit which the practice used.
- The continuation of the transport service after funding from the local CCG had ceased.
- Inviting a practice from another CCG area to share learning and best practice.
- The practice was raising funds along with the local community to purchase a nitric oxide monitor (FeNO monitor) in line with the most recent NICE guidance on the diagnosis of asthma.

Staff knew about improvement methods and had the skills to use them. There was evidence that all staff were involved in methods of improvement within the practice. The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements. Partners at the practice encouraged staff to take time out to review individual and team objectives, processes and performance.

The GP partner at the practice had been awarded a Fellowship of the Royal College of General Practitioners (FRCGP) for his work in rural general practice. He was due to receive their award in May 2018. The team had also been a finalist in a professional journals practice team of the year award in recognition of the transport project they initiated.