Dr Rina Miah

Quality Report

The Harbottle Surgery
The Village Hall
Harbottle
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NE65 7DG
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Rina Miah (Harbottle surgery) on 28 July 2015. Overall the practice is rated as good.

Our key findings across all the areas we inspected were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. However, assessments had not been carried out in relation to all risks to the safety of patients and staff;
- Overall, the main practice and its branch surgeries had good facilities and were well equipped to treat patients and meet their needs. However, the absence of a defibrillator and oxygen supply at the Otterburn surgery could make it difficult to provide emergency treatment to patients should they become seriously ill at the surgery;
- Most systems and processes for managing medicines were satisfactory. However, the practice had failed to make sure that prescription forms were always stored at the Otterburn surgery in accordance with national guidance;
- Information about how to complain was available and easy to understand;
- Most patients told us they were treated with compassion, dignity and respect and were involved in making decisions about their care and treatment. Information was provided to help patients understand the care available to them;
- The practice worked closely with other organisations to help deliver a wider range of services so they could better meet the needs of patients who lived in a rural, isolated setting and who were dispersed over a large geographical area;
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received most of the training appropriate to their roles, although we did identify some gaps;
- Results from the National GP Patient Survey of the practice, published in July 2015, showed that patient satisfaction with access to care and treatment was

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higher when compared to local and national averages. The majority of patients we spoke to on the day of the inspection, as well as those who completed Care Quality Commission (CQC) comment cards and contacted us before the inspection, were satisfied with access to appointments.

The areas where the provider should make improvements are:

- Ensure prescription forms are always stored in accordance with the national guidance;
- Carry out a risk assessment to assess any potential risks to staff when they are working by themselves, and take action to put appropriate support systems in place where these are needed;
- Carry out a review of the systems for delivering medicines to designated 'pick up' points to ensure they are safe and secure, including the carrying out of a risk assessment to identify and manage areas of risk associated with this.

We saw an area of outstanding practice:

Results from the National GP Patient Survey showed most patients were happy with how they were treated and the quality of the care and treatment they received. Patient satisfaction scores for GP and nurse consultations were above the local CCG and national averages. For example:

- 99% of patients said the GP was good at listening to them, compared to the local CCG average of 91% and the national average of 89%;
- 100% said the GP gave them enough time, compared to the local CCG average of 89% and the national average of 87%;
- 100% said they had confidence and trust in the last GP they saw, compared to the local CCG average of 96% and the national average of 95%;
- 99% said the last GP they spoke to was good at treating them with care and concern, compared to the local CCG average of 88% and the national average of 85%.

We are aware that since the inspection NHS England have terminated the contract and surgery has been closed. Had the surgery continue to function it may have been subject to a requirement notice with respect to the security arrangements for blank prescription pads at the branch surgery at Otterburn.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services as there are areas where it should make improvements. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned when things went wrong and shared with the practice team to support improvement. There was an effective system for dealing with safety alerts and sharing these with staff. Individual risks to patients had been assessed and were well managed. For example, the arrangements for protecting patients from abuse were satisfactory and staff knew what to do if they had concerns about a patient's safety. However, there was no documented evidence the practice had assessed, and put contingency arrangements in place to deal with, the potential health and safety risks faced by staff who worked at times by themselves. Blank prescriptions forms had not been stored at the Otterburn surgery in accordance with national guidance. This meant the arrangements for preventing prescription fraud and misuse were not fully satisfactory. The written procedure regarding the delivery of dispensed medicines to designated 'pick-up' points did not contain sufficient detail to ensure the system was safe and secure. We also found that a risk assessment had not been carried to identify and manage areas of risk associated with this system.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were, in most areas, above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included promoting good health, and providing advice and support to patients to manage their health and wellbeing within a rural setting. Staff worked with multidisciplinary teams to help ensure patients' needs were met. Although clinical staff had completed the training they needed to meet patients' health needs, there were gaps in some staff's training. There was evidence clinical audit cycles had been completed and that these had been used to improve patient outcomes. The management team recognised the benefits of having an appraisal process for staff.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than other local

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practices for most aspects of the care and treatment provided. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand, although some patients told us the practice could do more to make this more accessible. During the inspection we saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. They had recently reviewed the needs of their local population to ensure capacity matched patient demand. They were also working with the local NHS England Area Team to ensure continuity of the services they provided. Results from the National GP Patient Survey of the practice, published in July 2015, showed that patient satisfaction with access to care and treatment was higher when compared to local and national averages. The majority of patients we spoke to on the day of the inspection, as well as those who completed CQC comment cards, were satisfied with access to appointments. Overall, the practice and its branch surgeries had good facilities and were well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised.

Are services well-led?

Good

The practice is rated as good for being well-led. The GP provider had taken steps over the previous five years to develop a range of services that would meet the needs of their rural patient population. Practice staff had carefully considered the future demands likely to be placed on the service, and the potential threats to the continuing operation of the practice. The GP provider was working with NHS England to ensure the practice could continue to offer the range of services it was providing. At the time of our visit, steps were being taken to secure a long-term locum GP for the practice, to replace the current locum who was shortly due to leave.

The practice had policies and procedures to govern their activity and there were systems in place to monitor and improve quality and identify risk. However, we did identify that there were areas where the practice could make improvements. For example, carrying out risk assessments to reduce risks to staff who at times worked by themselves, and to ensure that dispensed medicines were delivered to patients in the safest possible manner. Regular practice and

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multi-disciplinary team meetings took place which helped to ensure that patients received effective and safe clinical care. The practice proactively sought feedback from patients and had an active, virtual patient participation group (PPG).

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The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed the practice had performed well in providing recommended care and treatment for the majority of the clinical conditions commonly associated with this population group. For example, the data showed the practice had achieved 100% of the total points available to them for providing the recommended care and treatment to patients with heart failure. (This was 0.1% above the local Clinical Commissioning Group (CCG) average and 2.9% above the England average). Staff offered proactive, personalised care to meet the needs of the older people. They were responsive to the needs of older people, and offered home visits and longer appointment times. Patient feedback about the quality of care and treatment provided was mostly very positive.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nationally reported data showed the practice had performed well in providing recommended care and treatment for most of the clinical conditions commonly associated with this population group. For example, the data showed the practice had achieved 100% of the total points available to them for providing the recommended care and treatment to patients with asthma. (This was 0.4% above the local CCG average and 2.8% above the England average). Where data showed the practice had performed less well with regards to some clinical indicators, we were provided with reasonable explanations for this. The practice nurse had a lead role in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All patients who had long-term conditions had a named GP and the practice nurse undertook regular reviews of their health to ensure any long-term conditions they had were being satisfactorily managed. The GP provider and their team worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children who were at risk. For example, the practice maintained a register of vulnerable children and contacted families where children had failed to attend planned appointments. Where

comparative data was available to us, this showed immunisation rates were relatively high for all standard childhood immunisations. Appointments were available outside of school hours and the Harbottle surgery site was suitable for children and babies. The practice offered sexual health screening and family planning services, which included the fitting of implants and coils. Safeguarding issues were discussed at monthly practice meetings. The practice had prepared a healthcare information leaflet aimed at younger people and had recently set up a Facebook page.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs of this age group. A SMS text service was used to remind patients of any planned appointments. Practice staff used a number of mechanisms to communicate with patients. For example, the practice had a website, a Facebook page and produced quarterly newsletters. However, some patients told us staff could be better at communicating what was happening at the practice. The practice offered combined longer appointments for patients with multiple conditions to reduce the number of visits they required for their annual health reviews to be completed. The practice delivered a range of services so that patients could access them locally, rather than having to travel long distances. For example, the practice provided: Cryotherapy (use of low temperatures to treat benign and malignant tissue damage), a minor injury and minor surgery clinic, wound care, warfarin monitoring and diabetic eye and foot screening.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice maintained a register of vulnerable adults, (including those patients with learning disabilities) and discussed these patients at the monthly practice meetings. Staff maintained a register of patients who were also carers, and offered these patients an annual healthcare check and, where appropriate, signposted them to other services that might be able to offer extra help. Nationally reported data showed the practice had obtained 100% of the points available to them for providing recommended care and treatment to patients with learning disabilities. (This achievement was 8.7% above the local CCG average and 15.9% above the England average.) Staff knew how

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to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, the recording of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Nationally reported data showed the practice had achieved 100% of the total points available to them for providing recommended care and treatment to patients with dementia. (This achievement was 3.1 % above the local CCG average and 6.6% above the England average.) Dementia screening and assessment was offered to patients at risk of Dementia. In August 2014, the practice dementia diagnosis rate was very low compared to the national target of 67%. By March 2015, this had increased significantly to 62.3%. Patients experiencing poor mental health had a care plan documented in their medical records. Patients experiencing poor mental health were provided with advice about how to access various support groups and voluntary organisations.

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What people who use the service say

The National GP Patient Survey of the practice, published in July 2015, showed it was performing above the local Clinical Commissioning Group (CCG) and national averages. There were 113 responses which was a response rate of 50%. Of the patients who responded to the survey:

- 97% found it easy to get through to this surgery by telephone compared with the local Clinical Commissioning Group (CCG) average of 77% and the national average of 73%;
- 94% found the receptionists at this surgery helpful compared with the local CCG average of 89% and the national average of 87%;
- 93% were able to get an appointment to see or speak to someone the last time they tried compared with the local CCG average of 86% and the national average of 85%;
- 100% said the last appointment they got was convenient compared with the CCG average of 93% and the national average of 92%;
- 97% described their experience of making an appointment as good compared with the local CCG average of 76% and the national average of 73%;
- 99% found the GP they last saw treated them with care and concern compared with the CCG average of 88% and the national average of 85%;
- 100% had confidence in the last GP they saw compared with the CCG average of 96% and the national average of 95%;
- 99% described their overall experience of the surgery as good compared to the CCG average of 87% and the national average of 85%;
- 91% said they would recommend the surgery to someone new in the area compared to the local CCG average of 81% and the national average of 78%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 27 completed comment cards and these were all positive about the standard of care received. Words used to describe the service included: excellent; brilliant; exceptionally accommodating; and warm, friendly and professional. A small number of patients expressed concern at the imminent departure of the long-term GP locum and what this might mean for the future of the practice.

Areas for improvement

Action the service SHOULD take to improve

- Ensure prescription forms are always stored in accordance with the national guidance;
- Carry out a risk assessment to assess any potential risks to staff when they are working by themselves, and take action to put appropriate support systems in place where these are needed;
- Carry out a review of the systems for delivering medicines to designated 'pick up' points to ensure they are safe and secure, including the carrying out of a risk assessment to identify and manage areas of risk associated with this.

Dr Rina Miah

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 who was undergoing induction training, and a practice nurse specialist adviser.

Background to Dr Rina Miah

Dr Rina Miah is a busy rural practice providing care and treatment to 815 patients of all ages, based on a Personal Medical Services (PMS) contract agreement for general practice. The practice is part of NHS Northumberland Clinical Commissioning Group (CCG) and provides care and treatment to patients living in the Upper Rede and Coquet Valleys of central Northumberland, including the Powburn, Harbottle, Longhorsley and Otterburn areas. The practice serves an area where deprivation is lower than the England average, but 18.2% of children live in poverty. Life expectancy for both men and women is lower than the England average.

The main surgery was based in Harbottle village hall and there were small branches located in the Rothbury and Otterburn areas. We visited the following locations as part of inspection:

The Harbottle surgery, The Village Hall, Harbottle, Morpeth, Northumberland, NE65 7DG.

The Rothbury branch surgery, The Community Hospital, Whitton Bank Road, Rothbury, Morpeth, Northumberland, NE65 7RW.

The Otterburn branch surgery, The Otterburn Village Hall, Otterburn, Northumberland, NE19 1NR.

The main premises are located in the Harbottle Village Hall and these have been adapted to provide fully accessible treatment and consultation rooms for patients with mobility needs. Both branch surgeries also provided disabled access.

Dr Rina Miah provides a range of services and clinics including, for example, services for patients with asthma, diabetes and coronary heart disease. The practice consists of two GPs (one male and one female), a practice manager, a practice nurse, a dispenser and a trainee dispenser, and a small team of administrative and reception staff. The male GP was a locum doctor who had worked for the practice for a considerable number of years. However, they were shortly due to leave the practice. The GP provider held some sessions at the Harbottle surgery, but also worked at another practice in the Durham area for which they were registered with the Care Quality Commission. When the practice is closed patients can access out-of-hours care via Northern Doctors, and the NHS 111 service.

The Harbottle surgery opening hours were: Monday: 8:30am to 5pm; Tuesday: 8:30am to 6pm; Wednesday: 8:30am to 12:30pm; Thursday: 8:30am to 12:30pm and Friday: 8:30am to 5pm.

The Harbottle surgery GP appointment times were:

Monday: 2pm to 4.15pm, and nurse appointment times ran from 8:30am to 11am;

Tuesday: 2pm to 6pm, and nurse appointment times ran from 8:30am to 11am and between 3pm to 5pm;

Wednesday: 9am to 11:15am;

Friday: 9am to 11:15am, and nurse appointment times ran from 10:15am to 11:15am and between 3pm to 5pm.

The Otterburn branch surgery appointment times were:

Monday: 9am to 10:45am;

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Friday: 2:45pm to 4:30pm.

The Rothbury branch surgery appointment times were:

Thursday : 9am to 10am: following an agreement reached with the former primary care trust, staff attended a weekly multi-disciplinary meeting at this time which also involved staff from another local practice as well as community based health staff;

Thursday: 10am to 12:15pm.

Friday: the nurse appointment times ran from 7:30am to 9:30am.

The practice manager told us emergency telephone triage was provided by Northern Doctors each Wednesday and Thursday between 12:30pm and 6:30pm so patients could access the care and treatment they needed. Although extended hours surgeries were not offered, staff told us every effort would be made to offer patients an appointment time which met their needs, even if this meant seeing them before or after a planned surgery session.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

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

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 Care Quality Commission (CQC) at that time.

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visits on 28 and 31 July 2015. During our visits we spoke with a range of staff, including the GP provider, the practice manager, the practice nurse, the dispenser and staff working in the administrative and reception team. We also spoke with two patients who used the service. We observed how people were being cared for and reviewed a sample of the records kept by practice staff. We reviewed 27 comment cards where patients and members of the public shared their views and experiences of the service. We also spoke with patients who contacted us before the inspection.

Requires improvement

Are services safe?

Our findings

Safe track record and learning

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 and complaints. The practice manager told us any safety alerts they received were forwarded to the relevant staff so they could, where necessary, take appropriate action. The practice had a system which staff followed when reporting safety incidents relating to medicines. The practice manager monitored those reported to identify any common themes where improvements might be needed, as well as staff training needs. Dispensary staff were able to describe how the practice expected them to respond to national safety alerts relating to medicines. For example, when medicines have to be removed from use due to manufacturing quality issues. The practice manager showed us evidence which confirmed how she checked that these had been addressed. Relevant patient safety incidents were reported to NHS England using the National Reporting and Learning System (NRLS). This provided evidence of a safe track record for the practice.

Staff we spoke to were aware of their responsibilities to raise concerns and knew how to report incidents and near misses. The patients we spoke with raised no concerns about safety at the practice. There was a structured system in place for reporting and recording significant events. We found evidence that significant events were discussed as and when they happened and copies of significant event reports could be accessed by all staff on the practice intranet. All staff had received training regarding what constituted a significant event and there was an agreed template which staff could use to record them. The practice had carried out an analysis of the significant events that had occurred over the previous 12 months. Records of these significant events were made available to us. The sample of records we looked at, and evidence obtained from interviews with staff, showed the practice had managed such events consistently and appropriately. However, we identified that a recorded risk assessment had not been completed for staff who occasionally worked by themselves. This meant that there was no documented evidence the practice had assessed, and put contingency arrangements in place to deal with, any potential health and safety risks faced by staff working alone, such as intermittent mobile phone coverage. We discussed this with the practice manager and the GP provider who both agreed this risk assessment needed to be completed as a matter of urgency.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices which helped to keep patients safe. These included:

- Arrangements to safeguard adults and children from abuse that reflected relevant legislation and local requirements. The practice had safeguarding policies and procedures which were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding who provided leadership in this area. Staff demonstrated they understood their responsibilities in relation to safeguarding patients, and they all had received training relevant to their role. Systems were in place which ensured that staff contacted the families of any children who missed their planned appointments;
- Notices were displayed in the consultation rooms advising patients they could request a chaperone if they wanted one. All staff who acted as chaperones were trained for the role, with the exception of the practice nurse, and had received a disclosure and barring check (DBS). The practice manager told us this shortfall would be addressed following the inspection. (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);
- There were systems which helped to ensure the main practice building and its branch surgery sites were well maintained and the equipment used by staff was safe to use. For example, the practice had an up-to-date fire risk assessment and the majority of staff, with the exception of the GP provider, had recently completed fire training. All electrical and clinical equipment had been checked and, where appropriate, serviced to ensure it was safe to use. None of the patients we spoke to, or those who completed Care Quality Commission (CQC) comment cards, raised concerns about their safety whilst visiting the main practice or the branch surgeries. Practice staff

had completed some risk assessments in relation to the safety of the premises. For example, there was an assessment regarding the appropriate storage of substances hazardous to health.

Infection control:

Appropriate standards of cleanliness and hygiene were followed. We observed the premises at all three sites were clean and tidy. However, we did identify that a privacy screen at the Otterburn branch surgery was rusty which would make it difficult to clean. The practice had infection control policies and procedures which provided staff with guidance about the standards of practice expected. Staff were easily able to access these. The training matrix we looked at confirmed all staff had completed basic training in infection control. In addition, the provider told us the practice nurse, who was the infection control lead for the practice, had completed more advanced training to enable them to carry out this role.

Infection control audits had been carried out at the main and branch surgeries. Following a recent audit carried out at the branch surgery located in the Otterburn Village Hall, the practice manager had identified a number of concerns. For example, it had been identified that the consultation room was fitted with a carpet rather than a surface which was easier to clean. We saw evidence confirming that the issues identified had been raised with the building caretaker so they could be addressed as soon as possible. A detailed action plan had been prepared to address the concerns identified.

The practice manager told us they had a contract in place to ensure the regular disposal of clinical waste. However, our interview with the practice nurse indicated that the arrangements for disposing of clinical waste at the Otterburn surgery was unclear and needed further clarification so that staff understood what was expected of them.

Staffing and recruitment:

The practice had up to date recruitment policies that set out the standards to be followed when recruiting clinical and non-clinical staff. Evidence of version control was available on the practice's intranet system. (Version control is useful for documents which are likely to be revised and where a provider might need to keep a record of how the document has changed over time.)

The practice manager was able to explain in detail the processes that would be followed for recruiting new staff and these were in line with the practice's policies. We looked at the recruitment records for the practice manager and found they contained evidence that appropriate recruitment checks had been undertaken prior to their employment. For example, the practice had obtained: proof of identification; references; evidence of previous qualifications, and a Disclosure and Barring Service check. (These 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.) We also looked at the recruitment records for the practice nurse and a dispensing member of staff, both of whom had worked at the practice for a number of years prior to the Registered Provider taking on the contract for this service. We noted that neither of their recruitment records contained evidence that the required pre-employment checks had been carried out.

The practice had indemnity insurance cover for their staff. We were told the GP provider had taken out extended cover, which covered all practice staff, when they took over the NHS contract for this service. However, following a recent query made by the practice nurse about whether the practice had arranged appropriate insurance cover for them, the GP provider had contacted their insurance provider to address this matter. This issue had not been resolved at the time of our inspection visit. Appropriate arrangements had been made to check that the long-term locum GP had suitable indeminity cover.

Staff told us about the arrangements for planning and monitoring the number and mix of staff required to meet patients' needs. Following a recent capacity review undertaken by the GP provider and practice manager, they had increased the length of the practice nurse's clinic by an extra hour to reflect how patients were choosing to use the service. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. Staff told us there were usually sufficient staff to maintain the smooth running of the practice and to keep patients safe. The practice nurse told us that, although no cover was provided when they took leave, they felt they had sufficient hours to deliver the practice's chronic disease programme. However, they also told us they struggled to find the time they needed to carry out the additional responsibilities they had.

Requires improvement

Are services safe?

The majority of feedback we received from patients during the inspection, and from the completed CQC comment cards, indicated most were satisfied with the level of the service they received. A small number of patients did however express concern that the practice would soon lose its long-term locum GP and the potential impact on the quality of the service they received at the branch surgeries. Despite changes to the practice nurse's clinic times, some patients told us the recent capacity review had resulted in a reduced service. They also said they were concerned about the lack of a telephone service at the Harbottle surgery on a Thursday. However, the GP provider explained that patients could still speak to a GP by contacting the Northern Doctors out-of-hours service.

Medicines management

We saw evidence of good medicines management. Medicines management procedures were available for each process undertaken by staff working in the dispensary. Staff had signed and dated the procedures to confirm they had read them. There was a system followed by staff to check the expiry dates of emergency medicines and to ensure the correct level of stock. Dispensary staff issued prescriptions for patients to take to their local pharmacy, or for dispensing at the practice for those patients eligible for 'doctor dispensing'. All dispensed medicines were checked twice by different staff to reduce the risk of dispensing errors. Patients only received dispensed medicines after a GP had checked and signed the prescription.

Medicines liable to misuse, called Controlled Drugs (CDs), were managed safely. Standard operating procedures were in place for managing CDs. Only designated staff had access to the CDs cabinet. We counted a sample of CDs and found that the stock and records were correct.

One of the dispensing staff was appropriately trained in the task of dispensing medicines. A second member of staff was undertaking dispensary training. This staff member had also been working alongside a trained member of staff for about five years and had experience of dispensing and checking medicines. The practice manager told us the practice was signed up to the Dispensing Services Quality Scheme (DSQS) that rewards practices for providing high quality services to patients of their dispensary. She undertook competency checks of the practice's dispensers in line with the DSQS competency template.

Patients were able to order their repeat prescriptions in person, in writing or on-line. There were processes in place to ensure that patients' repeat prescription records were kept up-to-date and that dispensing staff only issued repeat prescriptions and dispensed medicines in line with these records. Only the GPs and the practice nurse were able to make changes to patients' repeat prescription records and re-authorise the issue of repeat prescriptions, for example, after a patient's discharge from hospital. The practice nurse also undertook DRUM reviews (Dispensing Review of the Usage of Medicines). These are face-to-face reviews with patients to check they are taking their medicines safely and that potential problems, such as side effects, are managed.

We discussed the management of high risk medicines, such as the blood thinning medicine called Warfarin, with the practice nurse. They told us there were processes to make sure patients attended for regular monitoring of their use of these medicines to ensure it was safe and appropriate. They also said they visited housebound patients at home to carry out this monitoring. This ensured that a consistent service was provided to all patients who were prescribed these medicines.

The storage of medicines was mostly safe and secure, and medicines were within their expiry dates so that they were fit for use. The temperatures of the medicines refrigerators and the dispensary were monitored daily. However, we noted that one of the refrigerators had occasionally operated outside of the recommended temperature range for the storage of medicines. Also, we were told this refrigerator was sometimes used to stock vaccines. We discussed this with the practice manager who told us they had ordered another refrigerator to address this concern. The practice nurse told us they administered vaccines from time to time at the branch surgeries, and that until recently these had not been transported in a validated, medical grade cool box. During our visit to the Harbottle surgery, we confirmed that a validated medical grade cool box was now being used to ensure the 'cool chain' was maintained during the transport of vaccines to the branch surgeries.

Most dispensed medicines were collected from Harbottle surgery. However, the practice also delivered medicines to designated 'pick up' points for patients who were unable to visit the Harbottle surgery to collect them. We looked at the written procedure for this and found that it required more

detail to ensure that the system was safe and secure. We also found that a risk assessment had not been conducted to identify and manage areas of risk associated with this system.

We checked the arrangements for storing blank prescriptions. (These need to be kept secure to prevent mishandling, diversion and misuse.) We found that these were securely stored at the Harbottle surgery and an audit trail had recently been introduced so their whereabouts could be tracked. However, when we visited the Otterburn surgery we found that a number of blank prescriptions had been left in an unlocked drawer, in a consultation room to which people who were not employed at the practice potentially had access. The provider explained how this had happened and said it was an isolated incident. However, the failure to properly store prescription forms meant they were vulnerable to theft and misuse.

Arrangements to deal with emergencies and major incidents

There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. All staff had received annual basic life support training. A defibrillator and a supply of oxygen were available at the Harbottle surgery. We were told patients visiting the branch surgery located within the Rothbury hospital would receive resuscitation support from the paramedic and ward staff based there. However, neither a defibrillator nor a supply of oxygen was available at the Otterburn branch surgery. The absence of this emergency equipment could make it difficult for staff to appropriately respond to the needs of a patient who became seriously ill whilst attending the surgery. Emergency medicines were easily accessible to staff. They were stored in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use.

The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinical staff carried out assessments and treatment in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice used these guidelines to develop how care and treatment was delivered to meet patients' needs. Systems were in place to ensure all clinical staff were kept up-to-date with any changes to national and local guidelines. The practice's clinical system updated the assessment and care plan templates used by clinical staff as and when those changes took place.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF) scheme. (This is intended to improve the quality of general practice and reward good practice). Staff used the information collected for the QOF and their performance against national screening programmes to monitor outcomes for patients. Overall, the QOF data, for 2013/14, showed the practice had performed well in obtaining 96.6% of the total points available to them. (This was 0.6% below the local Clinical Commissioning Group (CCG) average but 3.1% above the England average.) With regards to specific clinical conditions the QOF data showed, for example:

- Performance for cancer related indicators was better than the local CCG average (0.3% higher) and the England average (4.5% higher);
- Performance for asthma related indicators was better than the local CCG average (0.4% higher) and the England average (2.8% higher).

The practice had performed less well in delivering recommended care and treatment in a small number of the commonly found clinical conditions covered by the QOF. For example:

- Performance for diabetes related indicators was lower than the local CCG average (5.8% below) and the England average (1.1% below);
- Performance for hypertension related indicators was lower than the local CCG average (6.6% below) and the England average (2% below).

However, we were provided with reasonable explanations regarding the factors that had affected the practice's performance in these areas.

The data showed the practice had obtained all of the points available to them for delivering care and treatment aimed at improving public health. For example, their performance for delivering care and treatment to help patients stop smoking was better than the local CCG average (3.8% higher) and the England average (6.3 % higher). This practice was not an outlier for any QOF or other national clinical targets.

The practice's exception reporting rate was 5.7% for 2013/14. This was 2.1% below the local CCG average and 2.2% below the England average. (QOF includes the concept of 'exception reporting' to ensure that practices are not penalised where, for example, patients do not attend for review, or where a medication cannot be prescribed due to a contraindication or side-effect.)

The GP provider told us how clinical audits were carried out to help improve patient outcomes and we saw evidence confirming this. Staff had carried out complete clinical audit cycles on, for example, the use of antibiotic prescribing, the provision of Chronic Obstructive Pulmonary Disorder (COPD) care and the use of wound dressings. Those we looked at demonstrated that potential improvements had been identified and acted on to help ensure patients benefited from the best possible clinical care and treatment. QOF data, for 2013/14, showed the practice participated in external peer reviews which enabled comparison with, and learning from, the performance of other local practices.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment. The practice had an induction programme for newly appointed non-clinical members of staff that covered such topics as safeguarding, fire safety, health and safety and confidentiality. Staff had received most of the training they needed to carry out their roles and responsibilities including, for example, training on safeguarding vulnerable patients, basic life support and fire awareness. However, there were some gaps. For example, the training spread sheet we were sent showed some staff had not completed training in the use of the Mental Capacity Act (2005), infection control and acting as a chaperone. In addition, we also identified that some

Good

Are services effective?

(for example, treatment is effective)

non-clinical staff had not refreshed their basic life support training within the previous 12 months. The Resuscitation Council (UK) recommends that non-clinical staff should have annual updates.

Staff had access to and made use of e-learning training modules and in-house training. There were arrangements in place for staff to have an annual appraisal. However, in the sample of records we checked, we were unable to access the record of the most recent appraisal for the practice manager. They confirmed they had undergone an appraisal during the previous 12 months, but said the record of this was kept at the other GP practice they worked at. The provider later confirmed the practice manager's appraisal had taken place in June 2015.

Coordinating patient care and information sharing

Staff had good access to the information they needed to plan and deliver care and treatment. For example, the practice's patient record system and intranet system included care plans, medical records and test results. However, when we visited the Otterburn surgery, we found that a password enabling clinical staff to gain access to the practice's computer system was openly on display. When we discussed this with the GP provider, they told us this password would not enable the user to access any confidential information because another password was required to do this.

All relevant information was shared with other services in a timely way, for example when people were referred to other services. However, we did identify that staff were not making use of the referral log system that was available on the practice's clinical system. This would enable them to log past referrals and to then check that these had been appropriately referred and dealt with. We shared this during the feedback session and practice staff responded positively stating they would follow through on this.

Staff worked together and with other health and social care services to understand and meet the range and complexity of patients' needs and to assess and plan on-going care and treatment. We saw evidence that multi-disciplinary team meetings took place on a regular basis and that care plans were routinely reviewed and updated.

Consent to care and treatment

Patients' consent to care and treatment was always sought in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act (2005). When providing care and treatment for children and young people, assessments of capacity to consent were also carried out in line with relevant guidance. Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed their capacity and, where appropriate, recorded the outcome of the assessment.

Health promotion and prevention

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged between 40 and 74. Appropriate follow-ups on the outcomes of health assessments and checks were made, where abnormalities or risk factors had been identified.

Staff had identified patients who may be in need of extra support. These included patients who were also carers and those at risk of developing long-term conditions. Patients were then signposted to relevant services. Information about how to access help and support was also available on the practice website.

The practice had a comprehensive screening programme. For example, nationally reported QOF data, for 2013/14, showed the practice had obtained 100% of the overall points available to them for providing recommended care and treatment to patients who smoked. This was 3.8% above the local CCG average and 6.3% above the England average. The data also confirmed the practice had supported patients to stop smoking using a strategy that included the provision of suitable information and appropriate therapy. We were provided with evidence confirming that during 2014/15, the practice had offered smoking cessation advice to 96 patients. Out of these patients, seven had negotiated a 'quit' date, and three had successfully stopped smoking.

The QOF data, for 2013/14, showed the practice had obtained 100% of the points available to them for providing cervical screening services. This was 0.4% above the local CCG average and 2.5% above the England average. The QOF data also showed the practice had protocols that were in line with national guidance. This included protocols for the management of cervical screening, and for informing women of the results of these tests. We were provided with evidence confirming that out of a total of 163 patients, 138

Good

Are services effective?

(for example, treatment is effective)

(84.6%) had undergone cervical screening in the previous five years. The QOF data, for 2013/14, showed the practice had obtained 100% of the overall points available to them for providing contraceptive services to women. This was 3% above the local CCG average and 5.6% above the England average.

The practice offered a full range of immunisations for children. On the basis of the nationally reported data available to the Care Quality Commission (CQC), we saw that, where comparisons allowed, the delivery of the majority of childhood immunisations was higher when compared to the overall percentages for children receiving the same immunisations within the local CCG area. For example, 100% of children aged five had received all of the necessary immunisations. Flu vaccination rates for patients over 65, and those patients in at risk groups, were comparable to the local CCG averages.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed throughout the inspection that members of staff were courteous and very helpful to patients who either attended or telephoned the practice. Patients were treated with dignity and respect. Privacy screens were provided in consulting 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 that conversations taking place in these rooms could not be overheard. Reception staff told us that a private space would be found if patients indicated that they needed to discuss a confidential matter.

As part of our inspection we invited patients to complete Care Quality Commission (CQC) comment cards. We received 27 completed comment cards and these were all positive about the standard of care received. Words used to describe the service included: excellent; brilliant; exceptionally accommodating; and warm, friendly and professional. A very small number of patients expressed concern about the lack of courtesy shown by reception staff. However, feedback from the National GP Patient Survey of the practice, published in July 2015, indicated that 94% of patients found the receptionists at the practice helpful, compared to the local Clinical Commissioning Group (CCG) average of 89% and the national average of 87%. We also received positive feedback from a small number of patients who contacted us before we visited the practice. Patients who completed CQC comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the National GP Patient Survey also showed most patients were happy with how they were treated and the quality of the care and treatment they received. Patient satisfaction scores for GP and nurse consultations were above the local CCG and national averages. For example:

- 99% of patients said the GP was good at listening to them, compared to the local CCG average of 91% and the national average of 89%;
- 100% said the GP gave them enough time, compared to the local CCG average of 89% and the national average of 87%;
- 100% said they had confidence and trust in the last GP they saw, compared to the local CCG average of 96% and the national average of 95%;
- 99% said the last GP they spoke to was good at treating them with care and concern, compared to the local CCG average of 88% and the national average of 85%;
- 98% said the last nurse they spoke to was good at treating them with care and concern, compared to the local CCG average of 93% and the national average of 90%.

Care planning and involvement in decisions about care and treatment

Patients we spoke with, and those who completed CQC comment cards, told us that any health issues were discussed with them and they felt involved in making decisions about the care and treatment they received. They also told us they felt listened to and supported by staff. 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. The results were above the local CCG and national averages. For example, of the patients who responded to the survey:

- 98% said the last GP they saw was good at explaining tests and treatments, compared to the local CCG average of 89% and the national average of 86%;
- 98% said the last GP they saw was good at involving them in decisions about their care, compared to the local CCG average of 86% and the national average of 81%;
- 99% said the last nurse they saw was good at explaining tests and treatments, compared to the local CCG average of 92% and the national average of 90%;
- 98% said the last GP they saw was good at involving them in decisions about their care, compared to the local CCG average of 87% and the national average of 85%.

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations. The practice's IT system alerted clinical staff if a patient was also a carer. Staff kept a register of all patients who were carers. These patients were being supported by, for example, being offered an NHS health check and where

Good

Are services caring?

appropriate, referral to social services for additional support. Information was available for carers to ensure they understood the various avenues of support available to them.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Services were planned and delivered to take into account the needs of different patient groups and to ensure flexibility, choice and continuity of care. For example, the practice:

- Had allocated a named GP to all patients over 75 years of age who was responsible for overseeing their care;
- Undertook home visits for patients who would benefit from these;
- Undertook post-hospital reviews for those discharged from hospital;
- Combined the delivery of influenza clinics with coffee mornings so that staff could meet their patients socially as well having the opportunity to check their health and wellbeing;
- Acted as a host for a local hearing and mobile retinal camera clinic;
- Offered multi-morbidity clinic appointments so that patients could have all of their healthcare needs reviewed at once;
- Arranged for their staff to attend and support the local mother and baby clinic held in Rothbury, and provided patients with access to a childhood immunisation programme;
- Provided patients with access to a healthy lifestyle programme and, where appropriate, referred people to a local gym;
- Provided an early detection of lung cancer programme for current and ex-smokers and also offered colorectal screening;
- Provided support and training to staff working in a local learning disability care home. The practice had identified vulnerable patients and provided longer appointments for people with learning disabilities;
- Undertook dementia screening and provided patients with access to a mental health counsellor.

Access to the service

The Harbottle surgery opening hours were: Monday: 8:30am to 5pm; Tuesday: 8:30am to 6pm; Wednesday: 8:30am to 12:30pm; Thursday: 8:30am to 12:30pm and Friday: 8:30am to 5pm.

The Harbottle surgery GP appointment times were:

Monday: 2pm to 4.15pm, and nurse appointment times ran from 8:30am to 11am;

Tuesday: 2pm to 6pm, and nurse appointment times ran from 8:30am to 11am and between 3pm to 5pm;

Wednesday: 9am to 11:15am;

Friday: 9am to 11:15am, and nurse appointment times ran from 10:15am to 11:15am and between 3pm to 5pm.

The Otterburn branch surgery appointment times were:

Monday: 9am to 10:45am;

Friday: 2:45pm to 4:30pm.

The Rothbury branch surgery appointment times were:

Thursday : 9am to 10am: following an agreement reached with the former primary care trust, staff attended a weekly multi-disciplinary meeting at this time which also involved staff from another local practice as well as community based health staff;

Thursday: 10am to 12:15pm.

The practice manager told us emergency telephone triage was provided by Northern Doctors each Wednesday and Thursday between 12:30pm and 6:30pm so patients could access the care and treatment they needed. Although extended hours surgeries were not offered, staff told us every effort would be made to offer patients an appointment time which met their needs, even if this meant seeing them before or after a planned surgery session. The practice manager said, wherever possible, patients would be given an emergency appointment if they needed one.

Friday: the nurse appointment times ran from 7:30am to 9:30am.

The majority of patients we spoke to on the day of the inspection, as well as those who completed CQC comment cards, were satisfied with access to appointments. Results from the National GP Patient Survey of the practice, published in July 2015, showed that patient satisfaction with access to care and treatment was higher, when compared to local and national averages. For example, of the patients who responded:

- 79% of patients were satisfied with the practice's opening hours, compared to the local CCG average of 77% and the national average of 75%;

Good

Are services responsive to people's needs?

(for example, to feedback?)

- 97% described their experience of making an appointment as good, compared to the local CCG average of 76% and the national average of 73%;
- 100% said the last appointment they got was convenient, compared to the local CCG average of 93% and the national average of 92%;
- 80% patients said they usually waited 15 minutes or less after their appointment time, compared to the local CCG average of 74% and the national average of 65%.

Listening and learning from concerns and complaints

The practice had a system in place for managing complaints. The practice manger was the person designated to handle complaints. Information about how to complain was available for patients in the Harbottle Surgery's reception area and on the practice website. This also told patients how to escalate their complaint externally if they were dissatisfied with how the practice had responded. The practice had received eight complaints during 2015. We looked at these and found they had been investigated and responded to appropriately.

Are services well-led?

Good

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

Our findings

Vision and strategy

Staff demonstrated a commitment to delivering high quality care and promoting good outcomes for patients. The GP provider had prepared a statement of purpose which set out the practice's aims and objectives. The statement described the practice's commitment to providing: a high standard of medical care to meet the individual needs of their patient population; a safe and clean environment and high quality care by providing staff with access to continuous learning and training. The GP provider and practice manager told us about the arrangements they had put in place during the previous five years to develop a range of services that would meet the needs of their rural patient population.

It was clear the GP provider had carefully considered the future demands likely to be placed on the service, and the potential threats to the successful operation of the business. They told us they were currently reviewing what services they provided and how future funding for the practice might affect how they operated. Staff were working with NHS England and the local Clinical Commissioning Group (CCG) to ensure that the practice could continue to offer the range of services it currently provided. At the time of our visit, the GP provider was taking steps to secure a long-term locum GP for the practice, to replace the locum GP who was shortly due to leave.

Governance arrangements

Overall, we saw evidence of good governance arrangements. The practice had policies and procedures to govern their activity and there were systems in place to monitor and improve quality and identify areas of risk. Regular practice and multi-disciplinary team meetings took place which helped to ensure that patients received effective and safe clinical care. Arrangements had been made which supported staff to learn lessons when things went wrong, and to support the identification, promotion and sharing of good practice. The practice proactively sought feedback from patients and had an active virtual patient participation group (PPG). However, we identified that practice quality monitoring and risk assessment processes could be strengthened. For example, by carrying out audits of medicine management processes, particularly in relation to the handling of prescription forms at the Otterburn surgery, and delivery of patient medicines to outlying areas.

Leadership, openness and transparency

The GP provider had the experience and capability to run the practice and ensure high quality care. Most patients reported that the long-term locum GP had, overall, provided a good service at the branch surgeries. Feedback from the National GP Patient Survey, published in July 2015, indicated patients had a high level of satisfaction with the quality of the GP and nurse consultations they received.

The practice manager worked part-time at the Harbottle surgery. This involved her attending the practice every other week on a Tuesday or a Wednesday, or more often when considered necessary. On alternate weeks, the practice manager attended meetings that were relevant to the management of the practice. The remainder of their time was spent managing the provider's other GP practice. Staff were able to contact the practice manager when she was not working at the Harbottle surgery by telephone or on-line. We felt the practice manager could improve the arrangements for managing the practice by increasing the hours they worked there.

Regular staff meetings took place at the practice, and we were told staff were encouraged to raise any issues or concerns, However, one member of the team told us they did not always feel confident that any concerns they had would be fully addressed.

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

The practice had a virtual patient participation group (PPG). This consisted of 37 members, which was 4% of the practice population. The practice manager told us they felt the virtual PPG provided a better opportunity for patients to comment on how the practice operated, given the large geographical area it covered. Staff had gathered feedback from their virtual PPG and the Family and Friends Survey (FFS). Information summarising the feedback received from the PPG was available on the practice website, as well as information about how the practice was trying to improve the services they provided. However, we think the practice could develop how they report on the feedback given by the PPG. For example, by including more information about what issues were raised with them and what they did in

Are services well-led?

Good

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

response. Some patients told us they were not aware that the practice had a PPG. However, information about the PPG had been posted on local bus stops, as well as in the local first school. A survey of patients had also been carried out on behalf of the practice by an external organisation, in 2013/14. This showed that 97% of all patient ratings about this practice were either good, very good or excellent.

Feedback from patients who had completed FFS comment cards was positive. A total of 31 responses were received by the practice during December 2014 and January 2015. From these responses, 100% of patients said they would be 'extremely likely' to recommend the practice to their friends and family. As the practice had only received positive feedback from the FFS, the GP provider had decided to carry out a more in-depth survey of patients in order to obtain their views about how the practice operated, what it did well and how it could improve.

Innovation

There was a strong focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and, because of their commitment to meeting their patients' needs, they had developed and were providing a range of services which helped to deliver clinical care closer to the communities within which patients lived. For example, the practice nurse had supported the delivery of a system to support patients taking Warfarin to test, and self-manage their anti-coagulant levels. The practice acted as a host for local hearing and mobile retinal camera clinics, and offered multi-morbidity clinic appointments so that patients could have all of their healthcare needs reviewed at the same appointment.