# Bellingham Practice

## Quality Report

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

## Ratings

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

# Summary of findings

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## Overall summary

**Letter from the Chief Inspector of General Practice**

We carried out a comprehensive inspection of Bellingham Practice on 2 October 2014. We inspected the main surgery but did not visit the twice weekly branch surgery at Otterburn Village Hall.

We rated the practice overall as good, with some areas of outstanding practice identified.

Our key findings were as follows:

- The practice covered a large geographical and rural area, services had been designed to meet the needs of the local population.
- Feedback from patients was overwhelmingly positive, they told us staff treated them with respect and kindness.
- Staff reported feeling supported and able to voice any concerns or make suggestions for improvement.

We saw several areas of outstanding practice including:

- The provision of services for young people. Significant time and effort had been taken to engage with young people. Services were specifically designed to meet local young people's needs.
- A patient centered approach to delivering care and treatment. All were aware of and sympathetic to, the particular difficulties faced by the local population. The practice had taken action to bring additional services to patients to help address some of those issues.

However, there was also an area of practice where the practice needs to make improvements.

The practice should:

- improve its arrangements for recruiting new members of administrative staff.

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

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

**Are services safe?**

Good

The practice is rated as good for safe. Processes were in place to identify unsafe practices and measures put in place to prevent avoidable harm to people. The practice learned from incidents and took action to prevent a recurrence. Staff were aware of safeguarding procedures and took appropriate action when concerns were identified. The practice should ensure that appropriate recruitment checks are carried out for new staff.

**Are services effective?**

Good

The practice is rated as good for effective. Care and treatment was being delivered in line with current published best practice. Patients' needs were being met and referrals to other services were made in a timely manner. The practice regularly undertook clinical audit, reviewing their processes and monitoring the performance of staff. Care and support for young people was outstanding.

**Are services caring?**

Good

The practice is rated as good for caring. Feedback from patients about their care and treatment was consistently and strongly positive. Many patients commented that staff went 'above and beyond' their level of duty. We observed a patient centred culture and found many positive examples to demonstrate how people's choices and preferences were valued and acted on.

**Are services responsive to people's needs?**

Outstanding

The practice is rated as outstanding for responsive. The practice understood the different needs of the population and acted on these needs in the planning and delivery of its services. We found the practice had initiated many positive service improvements for their patient population that were over and above their contractual obligations, particularly for young people. The practice was supported by a very active Patient Participation Group (PPG) which helped with a number of the initiatives to benefit patients. Patients reported good access to the practice. The practice had good facilities and was well equipped to treat patients and meet their needs.

**Are services well-led?**

Good

The practice is rated as good for well-led. Staff were clear about the practice's vision and their responsibilities in relation to this. Feedback we received from patients showed they felt valued and well cared for by staff. There was an established management structure within the practice. Staff reported feeling supported and

# Summary of findings

| | |
|---|---|
| valued by their peers. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and acted on any relevant suggestions. | |

# Summary of findings

## The six population groups and what we found

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

**Older people**

Good

The practice had a higher proportion of patients over the age of 65 compared to other practices nationally. All patients over the age of 75 had a named accountable GP and had been informed by letter of this. The practice reviewed hospital admissions and discharges weekly so they could provide support to those patients and their relatives.

The practice provided services for people who cared for others (carers). This included working with local organisations and maintaining a practice register of carers. We saw there was an 'Information for carers' file in the waiting room for patients to access.

A 'Planning for the future' event had recently been arranged by the practice. This was aimed at providing patients with information so they could plan for their future care.

The practice had close links with a range of healthcare professionals for patients who required additional support. This included district and Macmillan nurses and health visitors.

There were systems in place to offer vaccinations to older people, including pneumococcal vaccinations and an annual flu vaccination.

**People with long term conditions**

Good

The practice had systems to ensure care was tailored to individual needs and circumstances, this took into account patient's expectations, values and choices. We spoke with GPs and nurses who told us regular patient care reviews took place at six monthly or yearly intervals; for example for patients with chronic obstructive pulmonary disease (COPD) or asthmatic conditions. These appointments included a review of the effectiveness of their medicines, as well as patients' general health and wellbeing.

The practice was achieving nearly all of its Quality and Outcomes Framework (QOF) points (for the latest data available, in 2012/13). It had achieved 96.7% of the available points for the 'clinical domain indicator groups'; a significant number of which related to the management of patients with long term conditions.

The practice ensured timely follow up of patients with long term conditions by adding them to the practice registers. Patients were then recalled as appropriate, in line with agreed recall intervals.

# Summary of findings

**Families, children and young people**

Outstanding 

We saw the practice had processes in place for the regular assessment of children's development. This included the early identification of problems and the timely follow up of these. GPs, midwives, health visitors and school nurses all had an important role in safeguarding children, which included the early identification of needs and the ability to offer help.

The practice advertised services and activities available locally to families. Lifestyle advice for pregnant women about healthy living, including smoking cessation and alcohol consumption was given by the GPs and midwives.

The practice wrote to all registered patients when they reached 14 and 16 years of age. The letters outlined the services available and advised patients on how they could access services. This included the option to request to wait for their appointment in an area away from the waiting room.

Following on from this a 'Young People's Group' was established. The practice worked with the group and asked them what type of sessions they would like to see in the meetings. There were sessions on sexual health, contraception and cardiopulmonary resuscitation (CPR) training.

In order to reach more of the local young people, one of the GPs and the IT & medicines manager attended the local school to present health awareness sessions.

The practice was taking part in a pilot for 'Plan C' (to promote early detection and treatment of chlamydia) with a local NHS Trust. The practice had posters to inform patients of the availability of chlamydia testing kits in the toilets. Arrangements were in place for these to be left in the receptacle provided at reception at any time.

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

Good 

Access to services for patients in this population group was in line with that for other patient groups. This included flexible appointment times, same day telephone call-backs from clinicians and home visits, should these be required. Patients also had the facility to book GP appointments online, once they had registered with the practice for this service. The practice did not run any open access clinics, however it offered late opening until 7:15pm one night a week and early opening on a Monday. Each GP had slots available during these times so patients could choose whether they saw a male or female doctor.

# Summary of findings

We saw health promotional material was made easily accessible to people of working age through the practice's website. This included signposting and links to other websites including those dedicated to weight loss, sexual health and smoking cessation.

**People whose circumstances may make them vulnerable**

Good

The practice had systems in place to identify patients, families and children who were at risk or vulnerable within this population group. The practice ensured these patients were offered regular reviews.

The practice communicated with other agencies, for example health visitors, to ensure vulnerable families and children were monitored to make sure they were safe. The practice received letters from services who treated patients for addictions. This helped them to monitor their recovery.

We saw there were areas where reception staff could speak with patients privately, should they express a wish to do so. Staff we spoke with demonstrated an awareness that people within this population group may benefit from a sensitive approach.

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

Good

GPs we spoke with told us the practice had access to an expert learning disability team. We were told the GPs took the lead for the practice in the first instance with regards to patients experiencing poor mental health. Annual health checks were carried out for patients. These were completed by a GP or nurse.

The practice worked in partnership with other local services to ensure patients experiencing poor mental health were supported. We were told a counsellor came into the practice on a regular basis and could be accessed by patients.

# Summary of findings

## What people who use the service say

We spoke with 11 patients, including two members of the practice's Patient Participation Group. We spoke with people from different age groups, who had varying levels of contact and had been registered with the practice for different lengths of time.

The patients we spoke with were very complimentary about the services they received at the practice; the overall friendliness, caring nature and their desire to help was mentioned. All patients said the doctors and nurses were extremely competent and knowledgeable about their treatment needs. They said that the service was exceptionally good and that their views were valued by the staff.

Patients reported that staff treated them with dignity and respect and always allowed them time, they did not feel rushed.

We reviewed 51 CQC comment cards which had been completed by patients prior to our inspection. All were complimentary about the practice, staff who worked there and the quality of service and care provided. Two comments suggested it was sometimes difficult to get an appointment at the branch surgery, however the majority of feedback was again positive.

The latest GP Patients Survey completed in 2014 showed the large majority of patients were satisfied with the services the practice offered. The results were among the best for GP practices nationally. The results were:

- The proportion of patients who would recommend their GP surgery – 90%
- GP Patient Survey score for opening hours – 86%
- Percentage of patients rating their ability to get through on the phone as very easy or easy – 95%
- Percentage of patients rating their experience of making an appointment as good or very good – 93%
- Percentage of patients rating their practice as good or very good – 95%.

## Areas for improvement

**Action the service SHOULD take to improve**

The practice should improve its arrangements for recruiting new members of administrative staff.

## Outstanding practice

We saw several areas of outstanding practice including:

- The provision of services for young people. Significant time and effort had been taken to engage with young people. Services were specifically designed to meet local young people's needs.
- A patient centered approach to delivering care and treatment. All staff were aware of, and sympathetic to, the particular difficulties faced by the local population. The practice had taken action to bring additional services to patients to help address some of those issues.

# Bellingham Practice

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

a CQC Lead Inspector. The team also included a GP, a specialist advisor with experience of GP practice management and governance and a further CQC inspector.

## Background to Bellingham Practice

The practice is located in the village of Bellingham in Northumberland and provides primary medical care services to patients living in the village and surrounding rural areas. The practice provides services to around 3,300 patients, spread over approximately 800 square miles, from the Scottish borders north of Byrness and Kielder to Kirkwhelpington and Barrasford to the south. A relatively high proportion of the patients are elderly and/or housebound and access to public transport is limited.

The practice provides services from two locations – Bellingham, Hexham, Northumberland, NE48 2HE and a branch surgery on Tuesday and Friday afternoons at Otterburn Memorial Hall, Otterburn, Northumberland, NE19 1NP. We visited the main surgery at Bellingham as part of the inspection. The practice is located in a two storey building, all patient facilities are situated on the ground floor. It also offers on-site parking, disabled parking, a disabled WC, wheelchair and step-free access.

The practice has three GP partners (2 female and 1 male), two training doctors, a nurse practitioner, two practice nurses, two healthcare assistants, a practice administrator, an IT & practice medicines manager and seven staff who carry out reception and administrative duties.

Surgery opening times at Bellingham are between 8:30am and 6:00pm everyday except Thursday. An extended surgery is provided on a Monday between 7:30am and 8:30am and on an evening until 7:00pm. The practice is closed on a Thursday afternoon but open again to patients between 4:00pm and 7:15pm.

The practice offers appointments with a GP at the branch surgery in Otterburn on a Tuesday and with a nurse or healthcare assistant on a Friday, both days between the hours of 11:30am and 1:15pm.

The service for patients requiring urgent medical attention out of hours is provided by Northern Doctors Urgent Care (NDUC).

## Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. This practice had not been inspected before and that was why we included them.

## How we carried out this inspection

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

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

# Detailed findings

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

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

Before our inspection we carried out an analysis of data from our Intelligent Monitoring system. This did not highlight any significant areas of risk across the five key question areas. As part of the inspection process, we contacted a number of key stakeholders and reviewed the information they gave to us. This included the local Clinical Commissioning Group (CCG). We also spoke with two members of the practice's Patient Participation Group (PPG).

We carried out an announced visit on 2 October 2014. We spoke with 11 patients and eight members of staff from the practice. We spoke with and interviewed the Practice Administrator and the IT & Practice Medicines Manager, two GPs, a Practice Nurse and two staff carrying out reception and administrative duties. We observed how staff received patients as they arrived at or telephoned the practice and how staff spoke with them. We reviewed 51 CQC comment cards where patients and members of the public had shared their views and experiences of the service. We also looked at records the practice maintained in relation to the provision of services.

Good

# Are services safe?

## Our findings

### Safe Track Record

When we first registered this practice in April 2013, we did not identify any safety concerns that related to how the practice operated. Patients we spoke with said they felt safe when they came into the practice to attend their appointments. Comments from patients who completed CQC comment cards reflected this.

Information from the Quality and Outcomes Framework, which is a national performance measurement tool, showed that in 2012-2013 the practice appropriately identified and reported incidents. Where concerns arose they were addressed in a timely way.

We saw mechanisms were in place to report and record safety incidents, including concerns and near misses. The staff we spoke with demonstrated an understanding of their responsibilities and could describe their roles in the reporting process. They told us there was an individual and collective responsibility to report and record matters of safety. Where concerns had arisen, they had been addressed in a timely manner. We saw outcomes and plans for improvement arising from complaints and incidents were discussed and recorded within staff meeting minutes.

There were formal arrangements in place for obtaining patient feedback about safety. The practice had carried out an in-practice patient survey and had an active Patient Participation Group (PPG). The practice administrator told us that any concerns raised would be used to inform action taken to improve patient safety.

### Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. All staff had responsibility for reporting significant or critical events and our conversations with them confirmed their awareness of this. The practice administrator was the person who collated this information and staff we spoke with were aware of this.

The practice was open and transparent when there were near misses or when things went wrong. We saw there were monthly meetings to specifically discuss any such events. We looked at the schedule of critical events for 2013-2014. The schedule detailed the events and any learning points and subsequent action taken. Staff meeting minutes showed these events were discussed within the practice, with actions taken to reduce the risk of them happening again. We saw there had been a significant event where a patient had not been recalled on a timely basis. We saw evidence that a thorough and rigorous investigation had taken place. This had identified some key learning points, to ensure information was coded correctly and to ensure recalls were generated on a monthly report. The changes were implemented and reviewed at a later date to confirm they remained effective.

We discussed the process for dealing with safety alerts with the IT and practice medicines manager. Safety alerts inform the practice of problems with equipment or medicines or give guidance on clinical practice. They told us alerts came into the practice from the NHS England Local Area Team Central Alert System. They were logged then discussed with one of the GPs. Actions were agreed then distributed to staff via the practice's computer system. In addition, issues were discussed at practice meetings which were attended by all staff. We saw the log book and meeting minutes reflected these discussions.

### Reliable safety systems and processes including safeguarding

We saw the practice had safeguarding policies in place for both children and vulnerable adults. There were identified members of staff with clear roles to oversee safeguarding within the practice. This role included reviewing the procedures used in the practice and ensuring staff were up to date and well informed about protecting patients from potential abuse. The clinicians held quarterly meetings to discuss ongoing or new safeguarding issues. The staff we spoke with had a good knowledge and understanding of the safeguarding procedures and what action should be taken if abuse was witnessed or suspected. We saw records which confirmed all staff had attended training on safeguarding. The GPs and the nurse practitioner had received the higher level of training (Level 3), practice nurses and healthcare assistants had received Level 2 training whilst all other staff attended Level 1 training sessions.

The practice had a process to highlight vulnerable patients on their computerised records system. This information would be flagged up on patient records when they attended any appointments so that staff were aware of any issues. In addition, the practice operated an 'early warning system', whereby any concerns about patients were noted and discussed at the safeguarding meetings.

Good

# Are services safe?

The practice had a chaperone policy. A notice was displayed in the patient waiting area and in all of the consultation rooms to inform patients of their right to request a chaperone. We asked staff about how the role of chaperone was fulfilled within the practice. They told us that normally a practice nurse or healthcare assistant undertook this role. However other staff would undertake this role if both of these staff members were unavailable. Staff were clear about the requirements of the role.

## Medicines Management

We found there were medicines management policies in place and staff we spoke with were familiar with them. We saw that medicines for use in the practice were kept stored securely, with access restricted to those that needed it. Records were kept whenever any medicines were used.

Medicines were regularly checked to ensure they were in date and remained safe to use. This included medicines kept by GPs in their emergency bags. Staff told us the practice nurse carried out regular checks of the bags and medication expiry dates. We checked the medicines within one of the GP bags. We found the medicines were all in date.

We saw fridge temperatures where medicines were stored were checked daily to ensure the medicines were stored in line with manufacturer's guidance. Records of these checks were maintained. We checked a sample of medicines stored in the fridge in the treatment and minor surgery rooms and found they were all in date.

The practice held emergency drugs on site, including those for anaphylaxis and injectable antibiotics. We saw regular checks had been carried out to ensure these drugs remained in date and were safe to use. We looked at how controlled drugs were managed. Controlled drugs are medicines that require extra checks and special storage arrangements because of their potential for misuse. We found the practice had a robust system for storing, recording, and checking which controlled drugs had been used by the GPs.

The practice had a process and audit trail for the authorisation and review of repeat prescriptions. The staff involved with this process were clear about the steps to be taken when the authorised number of repeat prescriptions was reached. We saw evidence to confirm this was put into practice.

Appropriate arrangements for the receipt, recording and storage of blank prescription forms were in place. We saw boxes of blank prescription forms were kept in a locked cupboard within a locked room. Staff told us records were kept of the first and last serial number associated with each box of blank prescriptions. We saw records to confirm this.

When changes had been requested to a prescription for medication for patients by other health professionals, such as NHS consultants and/or following hospital discharge, the surgery had a system for ensuring these changes were carried out in a timely manner. The request was seen by the duty doctor and the patient's own GP; who then identified any actions to be taken. This was logged on the practice computer system.

## Cleanliness & Infection Control

We looked around the practice and saw it was clean, tidy and well maintained. Patients we spoke with told us they were happy with the cleanliness of the facilities. Comments from patients who completed CQC comment cards reflected this.

The practice had a nominated infection control lead. We saw there was an up to date infection control policy and detailed guidance for staff about specific issues. For example, action to take in the event of a spillage. All of the staff we spoke with about infection control said they knew how to access the practice's infection control policies.

The risk of the spread of infection was reduced as all instruments used to examine or treat patients were single use, and personal protective equipment (PPE) such as aprons and gloves were available for staff to use. The treatment room had walls and flooring that was impermeable, and easy to clean. Hand washing instructions were also displayed by hand basins and there was a supply of liquid soap and paper hand towels. The privacy curtains in the consultation rooms were disposable. We saw the curtains were clearly labelled to show when they were due to be replaced.

The practice employed its own domestic staff. We saw the domestic staff completed cleaning schedules, on a daily, weekly, monthly and annual basis. One of the practice nurses carried out regular infection control audits. We saw records confirming recent checks had been carried out on the sharps bins and the patient toilet areas.

We saw there were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and

blades. We looked at some of the practice's clinical waste and sharps bins located in the consultation rooms. All of the clinical waste bins we saw had the appropriately coloured bin liners in place and all of the sharps bins we saw had been signed and dated as required.

Staff were protected against the risk of health related infections during their work. We asked the reception staff about the procedures for accepting specimens of urine from patients. They showed us there was a box for patients to put their own specimens in. The nursing staff then used PPE to empty the box and transfer the specimens. We confirmed with a practice nurse that all clinical staff had up to date hepatitis B vaccinations. We saw there were spillage kits (these are specialist kits to clear any spillages of blood or other bodily fluid) located throughout the building.

### Equipment

Staff had access to appropriate equipment to safely meet patients' needs. The practice had a range of equipment in place that was appropriate to the service. This included medicine fridges, patient couches, access to a defibrillator and oxygen on the premises, sharps boxes (for the safe disposal of needles), electrocardiogram (ECG) machines and fire extinguishers. We looked at a sample of medical and electrical equipment throughout the practice. We saw regular checks took place to ensure the equipment was in working condition.

### Staffing & Recruitment

We saw the practice had recruitment policies in place that outlined the process for appointing staff. These included processes to follow before and after a member of staff was appointed. We reviewed the records for the three most recent members of staff. The files for two members of staff did not contain written application form or curriculum vitae (CV) or any references. The IT & practice medicines manager told us these documents were on file but they were unable to locate them during the inspection.

All staff had been subject to disclosure and barring (DBS) checks, in line with the recruitment policy.

The practice employed sufficient numbers of suitably qualified, skilled and experienced staff. The practice administrator said when a GP was on leave or unable to attend work, another GP from the practice provided cover. In addition, 'extra blocks of appointments' could be added on to the start or end of GP sessions to meet an increase in demand. We were told by the GPs that locum GP's (GP's who are employed by practices when they have a staffing shortage for example during holiday periods) were not used very often. However, there was a comprehensive induction/introduction pack available to any locums to ensure they were fully orientated into the practice.

The administrative staff team had a weekly rota. Staff were trained to carry out various tasks to ensure they could cover all roles within the team. Staff we spoke with told us this worked well. When staff were on holiday or absent, cover was provided by other members of the team. This was monitored by the practice administrator.

We asked the practice administrator how they assured themselves that GPs and nurses employed by the practice continued to be registered to practice with the relevant professional bodies (For GPs this is the General Medical Council (GMC) and for nurses this is the Nursing and Midwifery Council. They told us they checked the registration status every six months. We saw records which confirmed these checks had been carried out.

### Monitoring Safety & Responding to Risk

The practice had developed clear lines of accountability for all aspects of patient care and treatment. The GPs and nurses had lead roles such as medicine lead and infection control lead. Each clinical lead had systems for monitoring their areas of responsibility, such as routine checks to ensure staff were using the latest guidance and protocols.

Staff had sufficient support and knew what to do in emergency situations. The practice had resuscitation equipment and medication available for managing medical emergencies. All of the staff we spoke with told us they had attended CPR (resuscitation) training. The practice administrator told us clinical staff attended CPR training every 18 months and administrative staff every three years. We looked at records which confirmed this.

The fire alarms were tested on a weekly basis. The practice administrator told us fire drills were carried out every six months.

### Arrangements to deal with emergencies and major incidents

The practice had detailed plans in place to ensure business continuity in the event of any foreseeable emergency, for example, fire or flood. The practice administrator told us these plans had been successfully put into place during power failures.

Good

# Are services safe?

Each of the doctors had their own 'on-call' bag. This meant if they were called to a rural area some distance from the practice they would have the appropriate equipment available without having to return to the practice. All of the GP partners and some other team members had 4 wheel drive vehicles so in the event of severe weather staff could still visit patients.

We looked at the arrangements in place to cope with changes in demand for the service, for example, seasonal variations. The practice administrator told us that during the previous summer there had been a significant number of patients attending the practice from the local army cadet camp. They told us in previous years the camp employed its own nursing team. They said that despite not receiving any specific funding, any cadets that requested an appointment were seen by the practice.

Good

# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

Care and treatment was delivered in line with recognised best practice standards and guidelines. We found all of the doctors had a good level of knowledge and were up to date with clinical guidelines, including guidance published by professional and expert bodies.

All clinicians we interviewed were able to describe and demonstrate how they access guidelines from the National Institute for Health and Care Excellence (NICE) and from local health commissioners. We saw there was information on local commissioning guidelines in each of the consultation rooms, this was also available on the practice computer system.

The clinicians we interviewed demonstrated evidence based practice. We saw minutes of practice seminars where new guidelines were disseminated and the implications for the practice's performance and patients were discussed. Whilst there was no formal policy for ensuring clinicians remain up-to-date, all the GPs interviewed were aware of their professional responsibilities to maintain their knowledge.

### Management, monitoring and improving outcomes for people

Delivery of care and treatment achieved positive outcomes for people. We reviewed the most recent Quality and Outcomes Framework (QOF) scores for the practice. The QOF is part of the General Medical Services (GMS) contract for general practices. Practices are rewarded for the provision of quality care. The practice's overall score for the clinical indicators was higher than the local and national average.

The practice had a system in place for completing clinical audit cycles, which led to improvements in clinical care. We saw a number of clinical audits had recently been carried out. The results and any necessary actions were discussed at the weekly GPs meetings. Examples of clinical audits included an audit on prescribing antibiotics and medicines known as Proton Pump Inhibitors (PPI's) and the impact of prescribing particular antibiotics to patients with renal failure. We saw both audits had been completed earlier this year; plans were in place to repeat the audits to measure the impact of any changes made.

One of the GPs told us about how the practice analysed its referral rates to secondary care services. The differences in the way each of the GPs referred patients were discussed and analysed, then plans were implemented to reduce referrals where appropriate.

Complete, accurate and timely performance information was published by the practice on their website. This included the results of the patient survey and the subsequent action plan.

### Effective staffing

Staff were appropriately qualified and competent to carry out their roles safely and effectively.

There were effective induction programmes in place for all staff, including locums. The IT & medicines manager described the programme for the administrative staff. Staff were introduced to individual tasks with full support from another member of the team. As new staff became more confident the support would be reduced, but there would still be someone to assist where necessary. When we spoke with staff they confirmed these arrangements and told us they had been well supported during their induction.

The practice had mechanisms in place to ensure staff appraisal took place. Appraisals included the individual's review of their own performance, feedback from their line manager and planning for future development. Staff were also given the opportunity to comment on their progress. The administration staff had an annual appraisal with the IT & medicines manager and nurses were appraised by one of the GPs. We looked at records and found these were up to date. All of the staff we spoke with confirmed they had regular appraisals and felt supported.

Following the annual appraisals, a personal development plan (PDP) was agreed with each member of staff. This outlined their individual training requirements. The PDPs were then reviewed to produce an overall training plan. The practice was also designated as a training practice for GP Registrars and two of the GPs were designated trainers.

Staff had opportunities for professional development beyond mandatory training. Two staff were undertaking an NVQ (national vocational qualification) in business administration, supported by the practice.

The practice closed every Thursday afternoon for Protected Learning Time (PLT). Some of the time during these

Good

# Are services effective?

## (for example, treatment is effective)

afternoons was dedicated to training. Some training was also delivered by external experts, for example, a paediatric team from the local NHS Trust provided an education session.

We saw evidence which confirmed that all GPs undertook annual appraisals and that they had either been revalidated or had a date for revalidation.

### Working with colleagues and other services

The practice worked closely with other health and social care providers, to co-ordinate care and meet people's needs. We saw various multi-disciplinary meetings were arranged. This included a bi-monthly 'supporting families' meeting, which involved practice staff, health visitors, midwives and school nurses. Regular safeguarding and palliative care meetings were also held with staff from the NHS Trust, social services and Macmillian nurses. A paramedic from the North East Ambulance Service was based in the same premises as the practice. They, along with the community nurses, attended the practice's clinical meetings. This helped to share important information about patients including those who were most vulnerable and high risk.

Staff also told us how they engaged in regular meetings with other practice staff from across the locality to discuss issues and share good practice.

We found appropriate and effective end of life care arrangements were in place. The practice maintained a palliative care register. We saw there were procedures in place to inform external organisations about any patients on a palliative care pathway. This included identifying such patients to the local out of hours provider, Northern Doctors Urgent Care (NDUC).

Correspondence from other services such as test results and letters from hospitals were received either electronically or via the post. All correspondence was scanned and passed to the patient's referring GP. The reception staff told us it was also copied to the duty doctor, in case the referring GP was not available. We saw the practice computer system was used effectively to log and progress any necessary actions.

### Consent to care and treatment

Before patients received any care or treatment they were asked for their consent and the practice acted in accordance with their wishes. We asked staff how they ensured they obtained patients' consent to treatment. Staff were all able to give examples of how they obtained verbal or implied consent. We saw where necessary, written consent had been obtained, for example, for minor surgery procedures or joint injections.

GPs we spoke with showed they were knowledgeable of Gillick competency assessments of children and young people. Gillick competence is a term used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge. We saw there was a practice template, accessible to all clinical staff, containing guidelines for staff to follow. One of the GP's told us this was used regularly and any instances were discussed with colleagues to share learning.

Decisions about or on behalf of people who lacked mental capacity to consent to what was proposed were made in the person's best interests and in line with the Mental Capacity Act (MCA). We found the doctors were aware of the MCA and used it appropriately. The doctors described the procedures they would follow where people lacked capacity to make an informed decision about their treatment. They gave us some examples where patients did not have capacity to consent. The doctors told us an assessment of the person's capacity would be carried out first. If the person was assessed as lacking capacity then a "best interest" discussion needed to be held. They knew these discussions needed to include people who knew and understood the patient, or had legal powers to act on their behalf.

We saw a training session on the MCA had been arranged for the following month for all clinical staff.

### Health Promotion & Prevention

The practice proactively identified people who needed ongoing support. This included carers, those receiving end of life care and those at risk of developing a long term condition. Patients with long term conditions were reviewed at least annually, with most reviewed every six months.

We found that new patients were offered a 'new patient check', with one of the practice nurses, to ascertain details of their past medical histories, social factors including occupation and lifestyle, medications and measurements of risk factors (e.g. smoking, alcohol intake, blood pressure, height and weight).

Good

# Are services effective?

## (for example, treatment is effective)

Information on a range of topics and health promotion literature was available to patients in the waiting area of the practice. This included information about screening services, smoking cessation and child health. Patients were encouraged to take an interest in their health and to take action to improve and maintain it. The practice's website also provided some further information and links for patients on health promotion and prevention.

The IT & medicines manager told us how the practice wrote to all registered patients when they reached 14 and 16 years of age. The letters outlined the services available and advised patients on how they could access services. This process had been well received. Following on from this a 'Young People's Group' was established. The practice worked with the group and asked them what type of sessions they would like to see in the meetings. A plan was agreed and there were sessions on sexual health, contraception and CPR training.

In order to reach more of the local young people, one of the GPs and the IT & medicines manager attended the local school to present health awareness sessions.

The practice was taking part in a pilot for 'Plan C' (to promote early detection and treatment of chlamydia) with a local NHS Trust. We saw posters on display throughout the building, to inform patients of the availability of chlamydia testing kits in the toilets. The practice was keen to promote use of the tests, so the kits were left in the toilets to ensure anonymity for those patients who wished to take the test. Arrangements were in place for these to be left in the receptacle provided at reception at any time.

We spoke with two members of the patient participation group (PPG). They told us about a 'Planning for the future' event which had recently been arranged. This was aimed at providing patients nearing retirement age, with information so they could plan for possible future care. We saw several organisations were involved, including, the practice nurse practitioner, the district nursing team, Carers Northumberland, a dementia support group and the Northumberland Cancer network. The nurse practitioner spent time talking about 'Advanced care planning' (this is a process of discussing and recording preferences and wishes for future care and treatment). Feedback from the event was that people found it very useful, as they had the opportunity to discuss such issues with the relevant support organisations and professionals.

Good

# Are services caring?

## Our findings

### Respect, Dignity, Compassion & Empathy

We spoke with 11 patients on the day of our inspection. They were all happy with the care they received. People told us they were treated with respect and were positive about the staff. Comments left by patients on the 51 CQC comment cards we received also reflected this. Words used to describe the approach of staff included caring, courteous, respectful, understanding, helpful, friendly and comforting.

Staff were familiar with the steps they needed to take to protect people's dignity. Consultations took place in purposely designed consultation rooms with an appropriate couch for examinations and curtains to maintain privacy and dignity. There were signs, both in the waiting room and in the consultation rooms explaining that patients could ask for a chaperone during examinations if they wanted one. Patients we spoke with were aware that chaperones were available.

We saw the reception staff treated people with respect and ensured conversations were conducted in a confidential manner. Staff spoke quietly so their conversations could not be overhead. Phone calls were taken away from the front reception desk and staff were aware of how to protect patient's confidential information. There was a room available if patients wanted to speak to the receptionist privately, although this was not advertised.

The rural setting of the practice meant that many patients knew each other. The practice administrator told us that some people preferred to wait in an area away from the main waiting room. We saw there was a separate room which was used for this purpose. The practice administrator said that young patients were offered the opportunity to arrange this when they booked an appointment. We spoke with some of the reception staff, who confirmed this was offered. Some of the comments on the CQC comment cards reflected how other patients also welcomed this facility.

We looked at data from the National GP Patient Survey data, published in July 2014. This demonstrated that patients were satisfied overall with the practice. In particular, the practice performed better than comparators on the helpfulness of reception staff, the experience of making an appointment, and on GPs and nurses treating them with care and concern.

The practice had an active PPG, with representatives from a cross section of patient population groups. The two patient participation group members we spoke with both told us that the practice valued their contribution to the operation of the service and listened to their insights into the patient experience. One member told us how they felt the PPG was a two way bridge between the practice and the patients. Another said they felt listened to and that action was taken to address any issues identified.

### Care planning and involvement in decisions about care and treatment

Patients told us they felt they had been involved in decisions about their care and treatment. They said the clinical staff gave them plenty of time to ask questions and responded in a way they could understand. They were satisfied with the level of information they had been given. We reviewed the 51 CQC comment cards and saw several patients had commented that they felt they were a 'partner' in their care.

The results of the national GP survey from July 2014 showed 83% of patients surveyed rated the question 'Rating of GP involving you in decisions about your care' as good or very good. This was higher than both the national and local averages.

### Patient/carer support to cope emotionally with care and treatment

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

The practice provided services for people who cared for others (carers). This included working with local organisations and maintaining a practice register of carers. We saw there was an 'Information for carers' file in the waiting room for patients to access. This contained a wealth of information about the support available throughout Northumberland.

The practice had strong links with palliative care services. Staff told us there was no hospice in the local area. The practice therefore worked with a local hospice 'at home' service to provide much of the end of life care for patients

Good

# Are services caring?

and their families in their own homes. Weekly information sharing meetings were held with district nurses to ensure patients were supported appropriately. Staff told us the GPs had given out their personal telephone numbers to palliative care patients and their relatives so they were able to contact them at any time. This level of care was reflected in some of the comments made by patients on the CQC comment cards.

Support was provided to patients during times of bereavement. The practice administrator told us a visit to those who had lost a loved one was offered once the practice had been notified. The practice also offered details of bereavement services upon request, with information displayed on notice boards in the patient waiting area. Staff we spoke with in the practice recognised the importance of being sensitive to people's wishes at these times. Support was tailored to the needs of individuals, with consideration given to their preference at all times.

The practice administrator told us how they monitored hospital admissions and discharges on a weekly basis. We looked at records which confirmed this. We saw the names of patients who were currently in hospital were on a noticeboard in the administration office, to ensure staff were made aware. Many people commented that the staff at the practice 'went the extra mile'. One patient told us they had been prescribed many different types of medication and were not clear about which ones to take and when. They phoned the practice and one of the GPs called in after the surgery closed to help them put the medicines in order. Another patient told us their relative had been in hospital and the practice phoned twice to enquire after their relative.

Outstanding ☆

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

Staff told us that where patients were known to have additional needs, such as being hard of hearing, were frail, or had a learning disability this was noted on the medical system. This meant the GP or nurses would already be aware of this and any additional support could be provided, for example, a longer appointment time. The clinicians would also always go to the waiting area to escort the patient to the consultation room. We saw there was a hearing aid support drop in service provided on a monthly basis. There were hearing loops installed in the practice and there was a mobile unit available for home visits.

Due to the rural location, local hospital services were difficult to access for many patients living in the practice area. The practice had therefore arranged for some services to be provided at the practice itself. Some of the GPs had been trained to carry out joint injections and some minor surgical procedures were carried out. This reduced the number of referrals to other services and meant patients didn't have to travel as far. We saw there was a physiotherapist, a podiatrist and a community midwife presence each week. In addition, the practice administrator told us that due to the size of the practice there was no counselling service provided. To compensate for this, they had approached the Northern Guild for Psychotherapists who provided hour long sessions by a trainee counsellor for local patients.

There was information available to patients in the waiting room and reception area, about support groups, clinics and advocacy services. We saw there was a separate discreet area, away from the main waiting room containing information for young people.

The PPG members we spoke with before the inspection both told us the practice took notice and responded to requests and concerns the group fed back to them. They said this included simple things, for example, a suggestion had been made to put a clock in the waiting room. They said this had been done and was welcomed by the PPG and patients in general.

### Tackling inequity and promoting equality

The practice was set in a rural location and patients lived in an area of approximately 800 sq. miles. A relatively high proportion of the patients were elderly and/or housebound. We found the practice had good arrangements in place to ensure it met the needs of its patients. Some of the staff told us they also visited patients on their way to or from the practice. This was confirmed by some of the patients we spoke with.

We asked staff how they made sure that people who spoke a different language were kept informed about their treatment. Staff told us they had access to an interpretation service. The practice administrator said there was a small Polish community within the area, when a patient booked an appointment, staff were able to book an interpreter to accompany them. They told us about a patient who preferred a particular interpreter, staff were aware of this and made the relevant booking.

Free parking was available in a car park directly outside the building. We saw there marked bays for patients with mobility difficulties. The practice building was accessible to patients with mobility difficulties. We saw there were low level buttons on the walls at the entrance to the practice, when pressed the doors would open automatically. The consulting rooms were large with easy access for all patients. There was also a toilet that was accessible to disabled patients. There was a large waiting room with plenty of seating; including smaller chairs for children and an orthopaedic high backed chair.

### Access to the service

The practice is open between 8:30am and 6:00pm everyday except Thursday. An extended surgery is provided on a Monday between 7:30am and 8:30am and on an evening until 7:00pm. The practice is closed on a Thursday afternoon but open again to patients between 4:00pm and 7:15pm.

We found that patients were able to book appointments either by calling into the practice, on the telephone or using the on-line system. Face to face and telephone consultations were available to suit individual needs and preferences. Due to the rurality of the area covered by the practice, home visits were also made available everyday. For example, one day each week visits were carried out in the Kielder area. This was flexible, if a patient did not live in that area and needed a home visit on that day then the practice would arrange.

The practice administrator told us if a patient wanted an emergency appointment then they could have one the

# Are services responsive to people's needs?

## (for example, to feedback?)

same day. This was confirmed when we observed reception staff taking calls from patients; patients were offered appointments on the same day. If there were no appointments available then a 'task' would be sent via the practice's computer system to one of the GPs. The GP would then telephone the patient and if necessary ask them to attend the practice later in the day.

The majority of patients we spoke with and those who filled out CQC comment cards said they were satisfied with the appointment systems operated by the practice. Many people commented that they were able to get an appointment or speak to someone at short notice. This was reflected in the results of the most recent GP Survey (2013). This showed 93.1% of respondents were satisfied with booking an appointment and 86.5% were satisfied with the practice's opening hours. These results were 'among the best' for GP practices nationally.

There were notices throughout the practice advertising flu clinics. We saw the clinics were planned for various days, including weekends, and at various locations to give as many patients as possible the opportunity to attend.

The practice administrator explained that many of the children living in the area attended a local boarding school during the week. They said the practice was mindful of this and tried to offer appointments on a Friday evening when the school bus brought them back to the village. Staff were aware of the difficulties in accessing services due to a lack of public transport. They would therefore offer appointments to young people to co-ordinate with bus times.

Staff told us that the practice was very flexible when booking appointments for poorly children. They said that following an initial consultation, the parents would be advised to go back to the practice later the same day if they were still worried about their child, rather than make a long journey to a hospital. The practice administrator said they were aware that when children were collected from school or nursery they may appear unwell. They said they would always endeavour to see children when required. When we reviewed the CQC comment cards we found many positive comments about the services provided for children.

### Listening and learning from concerns & complaints

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

The complaints policy was outlined in the practice brochure and was available on the practice's website. The practice also had a comments box situated in the entrance foyer to enable patients to provide feedback about the service provided.

None of the 11 patients we spoke with on the day of the inspection said they had felt the need to complain or raise concerns with the practice. In addition, none of the 51 CQC comment cards completed by patients indicated they had felt the need to make a complaint.

Staff we spoke with were aware of the complaints policy. They told us they would deal with minor matters straight away, but would inform the practice administrator of any complaints made to them. This meant patients could be supported to make a complaint or comment if they wanted to.

We saw the practice had received three formal complaints within the last 12 months. We reviewed these and found the complaints had been recorded and fully investigated. We found the practice listened and learned from the complaints. For example, following one complaint we saw an education session with a specialist team had been arranged for the GPs to improve their knowledge and understanding.

# Are services well-led?

Good

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

## Our findings

### Vision and Strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's aims and objectives. The practice vision and values included the provision of good quality primary care services, proactive management of long term conditions and liaison with other agencies and NHS colleagues to focus on what is best for the patient.

We spoke with eight members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. They all told us they put the patients first and aimed to provide person-centered care.

### Governance Arrangements

The practice had a clear corporate structure designed to support transparency and openness. Weekly 'primary healthcare team' meetings were held, attended by the GPs and practice nurse team. These sessions were used to discuss any serious incidents, complaints and clinical governance issues in detail. Any lessons learnt or actions identified were then cascaded to the other members of the team.

The practice administrator and GPs actively encouraged staff to be involved in shaping the service. We found that staff felt comfortable to challenge existing arrangements and looked to continuously improve the service being offered.

We found all staff had individual development plans that were time bound for completion. Staff could access training from external sources if appropriate.

Staff told us they were aware of the decision making process. For example, staff who worked within reception demonstrated to us they were aware of what they could and couldn't do with regards to requests for repeat prescriptions. We also found clinical staff had defined lead roles within the practice, for example, safeguarding and infection control. The purpose of the lead roles was to liaise with external bodies where necessary, act as a point of contact within the practice and ensure the practice remained up to date with any new or emerging guidance. Other staff were aware of who the leads were and told us they would approach them if they had any concerns or queries.

The practice had strong links with the medical schools at Newcastle University and Imperial College, London. Students worked at the practice for a three week period and carried out clinical audits. We saw examples of audits on contraceptive implants and antibiotics. Following the audits we saw action plans were developed, issues were discussed at staff meetings and actions followed up to ensure improvements were maintained.

### Leadership, openness and transparency

There was a well established management structure with clear allocation of responsibilities. The GPs all had individual lead roles and responsibilities, for example, safeguarding, risk management, performance and quality. We spoke with eight members of staff and they were all clear about their own roles and responsibilities. Managers had a good understanding of, and were sensitive to, the issues which affected patients and staff. For example, there was an awareness of how poor weather conditions may impact on people being able to get to the practice. We saw contingency plans were in place to address this.

Staff told us there was an open culture in the practice and they could report any incidents or concerns they might have. This ensured honesty and transparency was at a high level. We saw evidence of incidents that had been reported, and these had been investigated and actions identified to prevent a recurrence. Staff told us they felt supported by the practice managers and the clinical staff and they worked well together as a team.

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

All of the practice staff met regularly. There were various weekly meetings, including a practice meeting attended by the GPs, nurses and practice management team. The weekly meeting was held on alternate days each week to ensure part time staff were able to attend regularly.

In addition to clinical team meetings, there were monthly administrative team meetings and training sessions. Staff told us they felt listened to and were able to raise any concerns they had.

# Are services well-led?

Good

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

The practice had robust whistleblowing procedures and a detailed policy in place. Staff we spoke with were all able to explain how they would report any such concerns. They were all confident that concerns would be acted upon.

The practice had an active Patient Participation Group (PPG). We saw there were approximately 20 patient members of the PPG and representatives from the practice. The members represented a cross section of the practice population. The PPG generally met every few months; all minutes were available on the practice website or at reception upon request.

PPG members told us they were fully involved in how the practice operated. They told us they were fully involved in setting objectives with the practice for the year ahead, and contributed to any changes required following the annual patient survey. They said they were listened to and felt that patient opinion and feedback was always welcomed by the practice and suggestions were acted upon. For example, the PPG discussed the subject of obesity and asked the practice how it was tackling the problem. The practice administrator told us that as a result of the discussions a number of actions were taken. This included the provision of scales in a discrete area of the building and the introduction of a weekly weight loss clinic. This had been well received and around 15 patients had signed up to the clinic.

### Management lead through learning & improvement

The practice had management systems in place which enabled learning and improved performance. The IT & medicines manager was the designated lead for performance management. They showed us how they made use of the Clinical Commissioning Group (CCG)'s comparative data to analyse performance.

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

The team met monthly to discuss any significant incidents that had occurred. The practice had a robust approach to incident reporting in that it reviewed all incidents even ones that were out of their control but involved their patients. The practice administrator shared one such incident with us relating to the dispensing of medication at a local NHS hospital. Learning from this was that the GP's at the practice would now inform patients about the arrangements for collecting hospital prescriptions.

The team discussed if anything, however minor, could have been done differently at the practice. All staff were encouraged to comment on the incidents. All of the staff we spoke with told us this was done in an open, supportive and constructive way.