Reeth Medical Centre

Quality Report

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

Ratings

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

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Reeth Medical Centre on 1 May 2015. Overall the practice is rated as outstanding.

Specifically, we found the practice to be outstanding for effective, caring, responsive and well led. It was also outstanding for providing services for all the population groups. It was good for providing safe services. The performance that led to the ratings of outstanding in effective, caring, responsive, and well-led services applies to everyone using the practice. The achievement of these ratings meant the practice also provided outstanding services to all population groups including older people, families, children and young people, working age people, people whose circumstances may make them vulnerable and people experiencing poor mental health.

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

- The practice used innovative and proactive methods to improve patient outcomes.
- The practice demonstrated they were accutely aware of their population groups and responded to context. They focussed on the challenges faced by a rural community and planned their services around this.
- The practice responded and was engaged with notable local groups and stakeholders.
- Staff demonstrated they supported patients' emotional and social needs and recognised they were as important as patients physical needs. Care needs were assessed and care was planned and delivered following best practice guidance.
- The continuing development of staff skills, competence and knowledge was recognised as integral to ensuring high quality care. Staff had received training appropriate to their roles and additional training to enhance the service offered to patients.
- Feedback from patients who used the service and stakeholders was continually positive about the way staff treated patients. Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Discussions with staff and feedback from patients demonstrated staff were highly motivated

Summary of findings

and were inspired to offer care that was kind, caring and supportive and that met the needs of the population. Patients visited the practice on the day of the inspection specifically to share their positive experiences with us. A large proportion of the patients told us that staff went the extra mile and the care they received exceeded their expectations.

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand.
- Leadership at the practice was reflective, strong and decisive. Although already achieving high outcomes in a number of areas, the practice team wished to improve their services and the experience of patients. They actively explored ways to do this.

We saw a wide range of outstanding practice, examples of which included:

- The practice supported patients to live healthier lives through a targeted and proactive approach to health promotion and prevention of ill health. The practice was actively involved in the local community; they had reached out to them to promote better health. For example, they wrote a regular column in the local newspaper and had attended pre-schools to administer flu vaccines.
- The practice offered an e-mail consultation service. Patients using the electronic consultation usually received a response within one working day.
- The practice had taken numerous locally available opportunities to implement service improvements and manage delivery challenges to its population. Two specific examples included the 'Find Your 1% campaign and the Population intervention for fall and injury prevention in the over 75 year olds. In January 2011 the practice published an article in the local newspaper about making advanced decisions in response to the find your 1% campaign. The Dying Matters Coalition campaign was part of the government's Quality, Innovation, Productivity and Prevention (QIPP) agenda. Around 1% of the population dies each year and the 'Find Your 1%' campaign aimed to get GPs talking to patients likely to die within the year 'as early as possible' about wishes for palliative care. It sought to persuade GPs to discuss end-of-life care with patients who were likely to die in the next 6-12 months, in order to increase the number of people dying in their usual place of residence. Both GPs had either completed or were in the process of completing a palliative care diploma to improve their confidence at both identifying those nearing the end of life and initiating discussion about people's wishes. As a result, 1.5% of the practice list currently had an advanced directive or community do not resuscitate order in place. The second example was the practice was the only one to secure funding from the CCG following submission of a comprehensive bid to run a population intervention for fall and injury prevention in the over 75 year olds. The practice recognised that patients living in the community were at risk and calculated based on International studies that a large proportion of their patients were at risk of fall related injuries. The practice had put in place a comprehensive plan to address this matter as a community rather than using an individual approach.
- The practice had become a member of the Upper Dales Area Partnership as they felt it likely there would be issues of common interest and concern between all different community groups. The meetings allowed an exchange of information, compliments, comments and concerns between members of the public, community groups and locally elected representatives.

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 providing safe services.

Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. The practice used every opportunity to learn from internal and external incidents, to support improvement. Information about safety was highly valued and was used to promote learning and improvement.

The practice demonstrated a proactive approach to anticipating and managing risks to people who used services. Risk management was comprehensive, well embedded and recognised as the responsibility of all staff. The practice took account of current best practice to help keep patients safe. There were enough staff to keep patients safe.

Are services effective?

Outstanding

The practice is rated as outstanding for providing effective services.

Systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence guidelines and other locally agreed guidelines. The practice had a comprehensive system in place for completing clinical audit cycles and all staff engaged in this process. We saw evidence to confirm that these guidelines were positively influencing and improving practice and outcomes for patients. The practice was using innovative and proactive methods to improve patient outcomes and it linked with other local providers to share best practice. The practice supported patients to live healthier lives through a targeted and proactive approach to health promotion and prevention of ill health. The practice provided a wide range of enhanced services. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). Some of these services were of particular significance to patients due to the rural location of the practice and the proximity of the nearest hospital being a significant distance away. Opportunities to participate in benchmarking, peer review and accreditation was proactively pursued.

The continuing development of staff skills, competence and knowledge was recognised as integral to ensuring high-quality care. Staff were proactively supported to acquire new skills. There was evidence of appraisals and personal development plans for all staff. The practice was committed to working collaboratively with other healthcare professionals to help ensure patients were delivered more joined up care.

Summary of findings

Are services caring?

Outstanding

The practice is rated as outstanding for providing caring services.

Data showed that patients rated the practice higher than others for almost all aspects of care. Feedback from patients who used the service and stakeholders was continually positive about the way staff treated patients. Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Discussions with staff and feedback from patients' demonstrated staff were highly motivated and were inspired to offer care that was kind, caring and supportive and that met the needs of the population. Patients visited the practice on the day of the inspection specifically to share their positive experiences with us. A large proportion of the patients told us that staff went the extra mile and the care they received exceeded their expectations.

Views of external stakeholders were positive and aligned with our findings.

Are services responsive to people's needs?

Outstanding

The practice is rated as outstanding for being responsive.

We found the practice had initiated positive service improvements for their patients. There was a proactive approach to understanding the needs of different groups of patients and to deliver care in a way that met their needs. Patients were able to access a wide range of services at the practice, which enabled patients to be treated nearer to their home. The practice were acutely aware of the needs and challenges of their local population and engaged with the NHS Area Team (AT) and clinical commissioning group (CCG) to secure service improvements where these had been identified.

The involvement of other organisations and the local community was integral to how services were planned. The practice provided multiple examples of working with other organisations and the local community to demonstrate how the practice offered additional services to the community. For example the practice provided unfunded voluntary support to Yorkshire Ambulance Service, offered paramedic decision support and provided medical support for the Tour de France.

Are services well-led?

Outstanding

The practice is rated as outstanding for being well-led.

The practice had a clear vision with quality and safety as its top priority. The practice objectives were challenging and innovative.

Summary of findings

High standards were promoted and owned by all practice staff. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice.

A clear leadership structure was in place. The leadership demonstrated a drive for continuous improvement. There was a clear proactive approach to seeking out and embedding new ways of providing care and treatment to improve outcomes for their patients. The practice took every opportunity for learning from current experience and used it towards developing better care provision for the future. Challenge from people who used the service, the public and stakeholders was welcomed and seen as an integral way of holding the service to account. They demonstrated a determined attitude to overcome barriers the population and the practice faced.

Summary of findings

The six population groups and what we found

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

Older people

Outstanding ☆

The practice is rated as outstanding in providing effective, caring, responsive and well-led services. The high standards which led to these ratings apply to everyone using the practice including this population group.

Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. Data showed the uptake of flu vaccinations for the over 65 years was above the national average.

Almost a third of the patient list size was over the age of 65 years and contributed to the majority of patient consultation time. The practice offered proactive, personalised care to meet the needs of the older patients in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older patients, and offered home visits and rapid access appointments for those with enhanced needs. The practice was flexible in seeing patients outside of normal appointment times, for example if they were reliant on bus services. The practice had identified a risk for patients in this group and secured funding from the CCG to run a falls prevention scheme for the over 75s.

The practice had care plans in place for 2.1% of their population. This had benefited frail elderly patients who wished to remain in their own home, which is of particular benefit as there are no care homes within the area.

People with long term conditions

Outstanding ☆

The practice is rated as outstanding in providing effective, caring, responsive and well-led services. The high standards which led to these ratings apply to everyone using the practice including this population group.

The practice adopted a holistic approach to the care of patients in this group. Staff had lead roles 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 these patients had a named GP and a structured annual review to check that their health and medication needs were being met. Appointments were structured to avoid multiple appointments. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Summary of findings

Patients in this group had specific plans which detailed the action to take if the symptoms of their condition started to worsen. For example, patients with diabetes had a personal care plan and a copy of their results. On-line support was available for patients to manage their condition. Emergency admission rates for long term conditions, for example asthma was lower than the national average.

Families, children and young people

Outstanding ☆

The practice is rated as outstanding in providing effective, caring, responsive and well-led services. The high standards which led to these ratings apply to everyone using the practice including this population group.

The needs of patients in this population group had been identified. They had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice always accommodated children outside of usual consulting times if there was a concern.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for the childhood immunisations programme was 100% which was above the national average. There was a clear policy for following up non-attenders in place. The practice ran flu vaccination clinics specifically for pre-school children. The clinics were timed to coincide with the school day to improve accessibility for patients. The practice engaged with the local community to increase the uptake of immunisations.

The practice provided a range of contraceptive, pre-conceptual, maternity and child health services with some clinical staff holding specific qualifications in these areas. The practice sign-posted patients to other services in the area and national advice services. All young people (16 – 24 years) had an alert on their records to offer chlamydia screening.

The whole team was engaged in safeguarding systems. All staff had received training in safeguarding children and demonstrated an understanding and awareness of their responsibilities to raise safeguarding concerns.

Working age people (including those recently retired and students)

Outstanding ☆

The practice is rated as outstanding in providing effective, caring, responsive and well-led services. The high standards which led to these ratings apply to everyone using the practice including this population group.

Summary of findings

The practice was aware of the patients that were within this population and recognised that due to the rural location and their employment that a large number were hard to reach and often presented late with symptoms.

The practice offered an e-mail consultation and a telephone consultation service which was particularly useful to patients in this group. For example patients could access on-line support for insulin management. Patients using the electronic consultation usually received a response within one working day. Patients could loan equipment to use at home, such as blood pressure monitors and send their readings to the practice electronically, reducing the need for them to attend the practice. The practice was proactive in offering online services as well as a full range of health promotion, such as a regular newspaper article and screening that reflected the needs for this age group.

People whose circumstances may make them vulnerable

Outstanding

The practice is rated as outstanding in providing effective, caring, responsive and well-led services. The high standards which led to these ratings apply to everyone using the practice including this population group.

The practice held a register of patients living in vulnerable circumstances. We were provided with examples and saw evidence of how proactive the practice was in visiting these patients on a regular basis. A register of patients with a learning disability was also kept. Records showed that when agreed by a patient they had a care plan in place and received an annual health check.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Outstanding

The practice is rated as outstanding in providing effective, caring, responsive and well-led services. The high standards which led to these ratings apply to everyone using the practice including this population group.

Practice staff were aware of their patients with poor mental health. All patients experiencing poor mental health had received an annual physical health check. The practice worked with multi-disciplinary

Summary of findings

teams in the case management of patients experiencing poor mental health including those with dementia. The practice had signed up to the dementia diagnosis scheme and had achieved a 73.4% practice diagnosis rate. The practice proactively managed advance care planning for patients with dementia.

Arrangements were in place for dispensing staff to flag up any concerns regarding over or under ordering of medicines and staff worked to a Standard Operating Procedure for patients on certain medicines, for example, patients on lithium who defaulted on check- ups. The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.

Summary of findings

What people who use the service say

We spoke with eleven patients who were using the service on the day of our inspection and reviewed forty completed CQC comment cards. The feedback we received was positive. Staff were described as helpful, amazing, caring, kind and responsive. Some patients said the practice went over and above what was required of them. They said they were really interested in all aspects of the patients' wellbeing. Some patients said they may have to wait for some time to see a GP at the 'sit and wait' morning appointments, but they said they really appreciated this and it was a crucial part of the service offered.

The results of the Friends and Family Test for January, February and March 2015 showed that of the 35 responses received during this time, 34 were extremely likely to recommend the practice and one was likely.

The GP Patient Survey results (an independent survey run by Ipsos MORI on behalf of NHS England) published on 8 January 2015 showed the practice scored above 95% in 12 out of the 23 questions and above 90% in 8 out of the 23 questions. Three questions ranged between 40% and 79%.

These are the three results for this practice from the GP patient survey that are the highest compared to the CCG average.

90% of respondents with a preferred GP usually get to see or speak to that GP

Local (CCG) average is 71%

97% of respondents say the last GP they saw or spoke to was good at involving them in decisions about their care

Local (CCG) average is 89%

99% of respondents say the last GP they saw or spoke to was good at treating them with care and concern

Local (CCG) average is 91%

What this practice could improve

These are the three results for this practice that are the lowest compared to the CCG average

40% of respondents usually wait 15 minutes or less after their appointment time to be seen

Local (CCG) average is **71%**

90% of respondents say the last appointment they got was convenient

Local (CCG) average is **95%**

79% of respondents are satisfied with the surgery's opening hours

Local (CCG) average is **84%**

There were 238 surveys sent out, 117 returned giving a completion rate of 49%. This equates to 7% of the practice patient list size.

Outstanding practice

We saw a wide range of outstanding practice, examples of which included:

- The practice supported patients to live healthier lives through a targeted and proactive approach to health promotion and prevention of ill health. The practice was actively involved in the local community; they had reached out to them to promote better health. For example, they wrote a regular column in the local newspaper and had attended pre-schools to administer flu vaccines.
- The practice offered an e-mail consultation service. Patients using the electronic consultation usually received a response within one working day.
- The practice had taken numerous locally available opportunities to implement service improvements and manage delivery challenges to its population. Two specific examples included the 'Find Your 1% campaign and the Population intervention for fall and injury prevention in the over 75 year olds. In January 2011 the practice published an article in the local newspaper about making advanced decisions in response to the find your 1% campaign. The Dying

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Matters Coalition campaign was part of the government's Quality, Innovation, Productivity and Prevention (QIPP) agenda. Around 1% of the population dies each year and the 'Find Your 1%' campaign aimed to get GPs talking to patients likely to die within the year 'as early as possible' about wishes for palliative care. It sought to persuade GPs to discuss end-of-life care with patients who were likely to die in the next 6-12 months, in order to increase the number of people dying in their usual place of residence. Both GPs had either completed or were in the process of completing a palliative care diploma to improve their confidence at both identifying those nearing the end of life and initiating discussion about people's wishes. As a result, 1.5% of the practice list currently had an advanced directive or community do not resuscitate order in place. The second example was the practice was the only one to secure funding from the CCG following submission of a comprehensive bid to run a population intervention for fall and injury prevention in the over 75 year olds. The practice recognised that patients living in the community were at risk and calculated based on International studies that a large proportion of their patients were at risk of fall related injuries. The practice had put in place a comprehensive plan to address this matter as a community rather than using an individual approach.

- The practice had become a member of the Upper Dales Area Partnership as they felt it likely that there would be issues of common interest and concern between all different community groups. The meetings allow an exchange of information, compliments, comments and concerns between members of the public, community groups and locally elected representatives.

Reeth Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a CQC Pharmacist and two CQC specialist advisors; a GP and a practice nurse.

Background to Reeth Medical Centre

Reeth Medical Centre, Back Lane, Reeth, DL11 6SU is situated in a rural village near Richmond serving the two dales of Swaledale and Arkengarthdale, caring for 1600 patients in an area of 200 square miles. The overall practice deprivation is on the fourth least deprived decile. The practice is a dispensing practice. The practice is a partnership made up of a GP partner and non-clinical partner with a second salaried GP. There is one male and one female GP and one practice nurse. One GP works at the practice at a time and the nurse is available twenty hours per week. There is a practice manager who is also the non-clinical partner, dispensing staff and a range of administration/secretarial staff.

The practice offers a mixture of open and booked appointments daily. Sit and wait appointments are available every morning from 08:30 to 10:00, bookable appointments at 11:30 and booked appointments from 16:00 to 17:30 daily. Emergency appointments are available between the hours of 08:00 and 18:00 daily. Appointments with the nurse are by booked appointment only. The dispensary is open on a Monday 08:30-13:00 and 16:00-18:00, Tuesday 08:30-13:00, Wednesday 08:30-13:00 and 16:00-18:00, Thursday 08:30-13:00 and Fri 08:30-13:00 and 16:00-18:00. The out of hours care is accessed through the 111 service and is provided by Harrogate District Hospital Foundation Trust.

The practice has a general medical service (GMS) Contract under section 84 of the National Health Service Act 2006.

Why we carried out this inspection

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

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 whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before our inspection we reviewed a range of information we held about the practice and asked other organisations to share what they knew. We asked Hambleton, Richmondshire and Whitby CCG to tell us what they knew about the practice and the service provided. We reviewed some policies and procedures and other information received from the practice prior to the inspection.

We carried out an announced inspection on 1 May 2015. During our inspection we spoke with eight members of staff. This included the two GPs, the practice nurse, practice manager, administration and dispensing staff. We spoke to eleven patients, some of whom attended the practice that day for an appointment and some who had specifically come to talk with us to share their experiences. We also spoke with a member of the community nursing team. We reviewed comments from forty CQC comments cards which had been completed. We were contacted by a two members of the Upper Dales Area Partnership (UDAP) who wanted to share their experiences with us. The UDAP is a group made up of County, District and Parish Councillors, public sector representatives such as the Police, voluntary sector, business people and members of the public living and working in the Upper Dales.

We observed interaction between staff and patients in the waiting room.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts, risk management tools, academic studies, as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, following an incident the practice had put in place new arrangements when following up test results for patients who had had a specific test carried out. The records showed the actions had been revisited after a six month period as part of the action plan and no further issues had been identified.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last seven years. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a comprehensive system in place for reporting, recording and monitoring significant events, incidents and accidents which allowed the practice to look at both the positive and negative points of the event, record suggestions for improvement, actions and a follow up and review. We looked at the record of significant events for the past twelve months. Significant events were reviewed on a regular basis. Records showed the practice took the opportunity to learn from external safety incidents to help improve the patient experience. We saw incidents from other areas had been reviewed and acted on which had led to improved outcomes for patients. For example there had been a significant event in an Out of Hours service in an area outside of their CCG. The practice had reviewed this and taken action to mitigate the risk of such a significant event occurring for the known patient with a particular condition. We found all staff to be open and transparent and committed to reporting all types of incidents. We were told that when staff had raised a significant event that they had been supported to do this.

Arrangements were in place to disseminate National patient safety alerts. Records showed alerts were discussed to ensure all staff were aware of any that were relevant to the practice and where they needed to take action. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed all staff had received relevant role specific training on safeguarding. Staff knew how to recognise signs of abuse in older patients, vulnerable adults and children. They were aware of their responsibilities and knew how to share information. They recorded safeguarding concerns and how to contact the relevant agencies, in working hours and out of normal hours.

The practice had an appointed dedicated GP as lead for safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. The practice was engaged in reviewing and improving safety and safeguarding systems. The practice demonstrated good liaison with partner agencies in relation to safeguarding and as such health visitors, district nurses, school nurses and midwives were consulted with if any concerns arose.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans.

There was a comprehensive chaperone policy in place and posters promoting this service were visible in the waiting room and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). Only staff that had been trained and had criminal records check from the Disclosure and Barring Service (DBS) acted as a chaperone. When a chaperone was offered and/or used this was entered into the patient's notes.

Medicines management

The practice had appropriate written procedures in place for the production of prescriptions and dispensing of medicines that were regularly reviewed and accurately

reflected current practice. The practice was signed up to the Dispensing Services Quality Scheme to help ensure processes were suitable and the quality of the service was maintained. Dispensing staff had all completed appropriate training and had their competency annually reviewed.

We saw a positive culture in the practice for reporting and learning from medicines incidents and errors. Incidents were logged efficiently and then reviewed promptly. This helped make sure appropriate actions were taken to minimise the chance of similar errors occurring again. We saw processes in place for managing national alerts about medicines, such as safety issues. Records showed that the alerts were distributed to relevant staff and appropriate action taken.

There was a clear system for managing the repeat prescribing of medicines and a written risk assessment about how this was to be managed safely. Dispensary staff controlled the ordering and supply of repeat prescriptions and the GP's oversaw this. Patients could order their medicines in person, on line, by telephone or by post. However we found that repeat prescriptions were dispensed and supplied to patients before they were signed by the GP which did not follow current best practice. The practice manager took immediate action when we identified this and a new procedure was put in place before we left which followed national guidance.

Changes in patients' medicines, for example when they had been discharged from hospital, were checked by the GP who made any necessary amendments to their medicines records. This helped ensure patients' medicines and repeat prescriptions were appropriate and correct.

We checked the dispensary; treatment rooms, medicine refrigerators and GPs' bags and found medicines were safely stored with access restricted to authorised staff. Suitable procedures were in place for ensuring medicines that required cold storage were kept at the required temperatures.

Stocks of controlled drugs (medicines that have potential for misuse) were managed, stored and recorded properly following standard written procedures that reflected national guidelines. Processes were in place to check medicines were within their expiry date and suitable for use. Out of date and unwanted medicines were disposed of in line with waste regulations.

Blank prescription forms and paper were handled according to national guidelines and were kept securely. Vaccines were administered by nurses using Patient Group Directions (PGDs) that had been produced in line with national guidance. PGDs were up to date and there were clear processes in place to ensure the staff that were named in the PGDs were competent to administer vaccines.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control who had undertaken training to enable them to provide advice on the practice infection control policy. All staff received regular infection control training. An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. Staff understood their responsibility in following infection control policies.

The practice had a policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

The practice had completed an audit against Part 3 of The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections. They had reviewed each criterion within the Code of Practice and rated its performance against this. The practice had rated themselves as 100% compliant against the criterion and our findings were aligned with this. We saw evidence that audits had been carried out and any improvements identified for action were completed on time.

Good

Are services safe?

We looked in all areas of the practice. We found them to be clean and well equipped. A programme of improvement was in place for some areas of the practice, for example, replacing the hand operated taps and damaged flooring.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. We saw evidence of calibration of relevant equipment; for example weighing scales and blood pressure measuring devices.

Staffing and recruitment

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice had arrangements in place for ensuring adequate staffing levels were maintained at all times. They followed a staffing policy which set out the minimum number of staff to be available at the practice at any given time. Records confirmed that maintaining adequate staffing cover was discussed at practice meetings. Two GPs worked on separate days. The nurse worked 20 hours per week and the GPs were trained to carry out tasks in their absence, for example managing dressings.

The practice had a recruitment policy in place and a policy that detailed what checks the practice would carry out before a person commenced employment. This included checking professional registrations, right to work checks and disclosure and barring services (DBS) checks. We looked at records relating to the most recently recruited clinical and administrative staff. We found appropriate pre-employment checks such as obtaining references and a criminal record check through the Disclosure and Barring Service (DBS) had been carried out. The practice had arrangements in place to assure them that the clinical staffs' professional registrations were up to date with the relevant professional bodies and records confirm the required staff had medical indemnity insurance in place.

Monitoring safety and responding to risk

The practice had comprehensive systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to keep them safe. These included checks of the building, the environment, medicines management, clinical and non-clinical audits, staffing, dealing with emergencies and equipment.

The practice had a range of policies relating to health and safety and there was detailed information available for patients and staff to refer to. There was an identified member of staff who managed health and safety and we saw evidence to show they proactively managed this.

Multiple, effective systems were in place for managing safety and responding to risk. The practice identified high risk patients through the use of a bespoke healthcare intelligence tool and patient care plans. They had well established multi-disciplinary relationships with other healthcare professionals. The practice demonstrated, through multiple examples, how they swiftly acted on any form of intelligence they received. For example the practice had received a presentation from a local cardiologist about implantable defibrillators. The practice acted on the information they had received and identified patients who had previously had a heart attack but had been assessed as not needing an implantable defibrillator. These patients were referred to the cardiologist for further assessment and treatment.

There was a proactive approach to anticipating and managing risks to patients, and all staff recognised and embedded this in their work. The practice provided us with several detailed examples of how their acute awareness of the patients they provided a service to had meant that health issues had been detected. For example, the last two confirmed dementia diagnosis had been instigated by the reception staff initially raising their concern with the GP. We also heard how concerns about a patient had been picked up over the telephone and how the GP had visited this patient at home and identified significant health issues.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed all staff had received training in basic life support. Emergency equipment appropriate for children and adults was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they knew the location of this equipment and records confirmed it was checked regularly.

Good

Are services safe?

Emergency medicines were available in secure areas of the practice. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place, which staff were aware of, to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, incapacity of staff, adverse weather, unplanned sickness and access to the building. The plan contained relevant contact details for staff to refer to. The document was stored securely, both in and outside of the practice.

The practice had carried out a fire risk assessment. It included actions required to maintain fire safety. Records showed staff were up to date with fire training and they practised regular fire drills. The practice had appointed fire wardens and information on what to do in the event of a fire was displayed within the practice.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE), local commissioners and a range of other sources. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure each patient received support to achieve the best health outcome for them. For example we saw an audit that had been completed as NICE guidelines showed that patients with a history of myocardial infarction and subsequent severe left ventricular dysfunction were at a high risk of sudden death and should be considered for device therapy. The practice had reviewed their patient list and identified two possible patients for an echocardiogram. We found from our discussions with the GPs and nurses they completed thorough assessments of patients' needs in line with NICE guidelines. These were reviewed when appropriate.

The practice provided a wide range of enhanced services. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). Examples include extended hours access, avoiding unplanned admissions, chlamydia screening, minor surgery, acute retention catheterisation, deep vein thrombosis (DVT) diagnosis and management and warfarin monitoring systems. Some of these services were of particular significance to patients due to the rural location of the practice and the nearest hospital being a significant distance away. The practice provided 2.1% of patients at risk of unplanned admissions to hospital with an individualised care plan which the practice told us had been helpful for the frail elderly who wished to remain at home. This was part of the unplanned admissions Enhanced Service (ES) that the practice had signed up to. The ES had been introduced as part of a move to reduce unnecessary emergency admissions to secondary care. The main work of the ES is the proactive case management of at-risk patients which required coverage of the 2% of the practice population most at risk of needing admission over 18 years of age. The practice had systems and identified leads in place to deliver and monitor its performance against the enhanced services and we saw completed data returns to the CCG to demonstrate the delivery of enhanced services.

Clinical staff led and had received training in specialist areas such as diabetes, heart disease, palliative care and asthma. The staff we spoke with were open about asking for and providing colleagues with advice and support. They told us they met regularly which enabled them to review and discuss new best practice guidelines. Minutes of staff meetings confirmed this.

The practice held a General Medical Services (GMS) contract with NHS England for delivering primary care services to their local community. As part of this contract, quality and performance was monitored using the Quality and Outcomes Framework (QOF). The QOF data for this practice showed it was performing above national standards and had achieved a score of 100% which was above the national average of 94%.

The practice had comprehensive systems in place to manage patients who were either about to access or had accessed secondary care (hospital). The practice was proactive in monitoring referrals to and reviewing patients recently discharged from secondary care. For example, the practice followed up two week referrals, after three days of making the referral to make sure it had been received and an appointment confirmed. Clinical staff confirmed they used national standards for the referral of patients with suspected cancers.

Discrimination was avoided when making care and treatment decisions. Interviews with all staff showed the culture in the practice was that patients were cared for and treated based on need. They took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. All the staff we spoke with were actively engaged in activities to monitor and improve quality and outcomes for patients. We were provided with multiple examples which demonstrated how the practice was innovative in their approach to improving outcomes for patients and how they worked collaboratively with other partners to achieve this. For example, the practice had put in place a urinary catheter scheme which

meant the practice could fit a patient with a catheter. This service avoided patients having to make a long journey to the nearest hospital which was approximately an hour away. The catheterisation protocol had subsequently been rolled out across the CCG. Similarly, the practice could diagnose and treat deep vein thrombosis which was of significant benefit to patients due to the proximity of the nearest hospital. The practice had purchased blood pressure monitoring devices which patients could loan to use at home. The practice had identified that patients' blood pressure results could potentially be more accurate if taken in the home environment where they were more relaxed. Patients had the facility to e-mail their readings to the practice or bring them in in person and if needed, a review with the GP arranged. This also benefited patients as they did not always have to attend the practice in person and meant that some patients who may not have attended the surgery may e-mail their results to the practice to be reviewed. It also provided the practice with the ability to respond to changes in patient conditions in a more timely way.

The practice had a comprehensive system in place for completing clinical audit cycles and all staff engaged in this process. The practice showed us six clinical audits completed in the last 12 months. We looked specifically at two completed audit cycles (methotrexate and otitis media). The methotrexate audit was carried out by the dispensing staff and was put in place to make sure the practice was following current guidelines set by the National Patient Safety Agency (NPSA). Following the audit the practice made some minor changes to achieve 100% compliance with the guidelines. This included changing the medication label. This audit demonstrated the practice had been innovative in supporting a patient with the recording of their medicine to suit their needs. Following re-audit the practice was 100% compliant with the guidelines. Following each clinical audit changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved. Other audit examples included following up defaulters on a screening programme (atrial fibrillation risk) and an audit of myocardial infarctions before 2007 for device therapy. The number and quality of audits showed the practice proactively used audits to improve care and treatment and people's outcomes and that improvement was checked and monitored. All six audits we looked at demonstrated this.

The practice demonstrated that it responded to a wide variety of information that was either made available to them or sourced by the practice. They used such information to examine their performance and look for areas where they could improve outcomes for patients. For example, the practice had carried out a detailed asthma audit following a published national asthma deaths report in 2014 'Why asthma still kills'. They had looked at the twelve action points from the audit and compared the practice's performance against these actions with a date for follow up recorded against identified actions.

Opportunities to participate in benchmarking, peer review and accreditation was proactively pursued. The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. The practice was aware of their performance when compared to other practices in the CCG.

The practice used the information collected for the Quality Outcomes Framework (QOF) and performance against national screening programmes and local and national data to monitor outcomes for patients. The data showed positive outcomes for patients in all categories as the practice had scored 100% in the previous year. Examples of this from the QOF data showed that patients with diabetes, CHD and asthma were managed in such a way that minimised risk. The team was making use of clinical audit tools, intelligence monitoring tools, appraisals, clinical supervision, staff meetings to assess the performance of the practice and its staff. The staff we spoke with discussed how, either within the practice or at external meetings they reflected on the outcomes being achieved and areas where this could be improved.

The practice was committed to working collaboratively with other partners to ensure that patients received coordinated care. An example of this is how the practice managed patients who were at end of life. The practice was following the gold standards framework for end of life care. It had a palliative care register and held regular meetings that were attended by external partners such as palliative care nurses. One GP had completed and the other had almost completed their Diploma in Palliative Care. As part of this diploma the GP attended 10 sessions working with palliative care teams. They told us this training had led to an improved outcome for patients as they made better use of medicines and were clearer on when and how to liaise

with specialist care teams. We saw feedback received from a member of the palliative care team. This feedback was extremely complimentary about the level of clinical care provided by the practice and how they often went over and above what was required of them. They said they were excellent at collaborative working. In January 2011 the practice published an article in the local newspaper about making advanced decisions in response to the find your 1% campaign. The Dying Matters Coalition campaign was part of the government's Quality, Innovation, Productivity and Prevention (QIPP) agenda. Around 1% of the population dies each year and the 'Find Your 1%' campaign aimed to get GPs talking to patients likely to die within the year 'as early as possible' about wishes for palliative care. It sought to persuade GPs to discuss end-of-life care with patients who were likely to die in the next 6-12 months, in order to increase the number of people dying in their usual place of residence. We were told the GPs felt that the palliative care diploma improved their confidence at both identifying those nearing the end of life and initiating discussion about people's wishes. As a result, 1.5% of the practice list currently had an advanced directive or community do not resuscitate order in place.

Effective staffing

Practice staffing included medical, nursing, dispensing, managerial and administrative staff. We noted a good skill mix among the clinical staff; both male and female. GPs had additional qualifications in a range of areas; examples of which were Diploma in Mountain Medicine, Certificate in Pain Management, Pre-hospital Emergency Care Certificate (Advanced), Certificate in Practical Palliative and Certificate in Diabetes Management. The nurse also had a range of additional qualifications, which included BSc Honours in Community Nursing (district nursing) Dip in Higher Ed (adult nursing). The continuing development of staff skills, competence and knowledge was recognised as integral to ensuring high-quality care. For example, we saw evidence that as part of the asthma plan the practice had put in place an identified GP to undertake a respiratory medicine course as they were the named clinician for asthma services. This was in addition to the practice nurse who carried out the majority of asthma reviews and had postgraduate training in asthma. Another example included the Diplomas in Palliative Care the GPs had or was working towards. Records showed staff were qualified and had the skills required to enable them to carry out their roles effectively and in line with best practice. The practice had systems in place for ensuring staff training was relevant and up to date.

All GPs were up to date with their yearly continuing professional development requirements and had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England). All staff had an annual and mid-year appraisal and the learning needs of staff were identified and training put in place to meet their learning needs.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those of patients with complex needs. The practice provided a local enhanced service of providing paramedic support. When a paramedic attends a patient and they assess that the individual may not require transport to hospital they can contact the practice. Response to the paramedic is given high priority and after discussion with the GP, the patient is either taken to hospital, taken to the practice or a home visit arranged. We were provided with a recent example where a patient had fallen in the community and sustained a head injury. The paramedic called the practice for advice. The patient was brought to see the GP where they carried out minor surgery. This saved ambulance transport, A&E attendance and inconvenience to the patient.

Blood test results, x ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service were sent both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. All staff we spoke with understood their roles and felt the system in place worked well.

Records showed the practice held multidisciplinary team meetings on a regular basis to discuss the needs of complex patients. Other services were available for patients at the practice. For example visiting mental health workers, health visitor, physiotherapist and podiatrist.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Information sharing

The systems to manage and share the information that was needed to deliver effective care were coordinated across services. The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. For example, immediately following multidisciplinary meetings the out of hours' record for patients on an end of life pathway was updated by the practice. District nursing teams and the out of hours' service were supplied with a map of the patient's home address if they lived in a remote area. Electronic systems were also in place for making referrals to secondary care. The practice had other polices in place to ensure seamless sharing of information with other providers. For example, a protocol had been put in place following the death of a patient to ensure that any service that patient was involved in was informed of their death.

The practice had systems to provide staff with the information they needed, clinical and non-clinical. Staff used an electronic patient record, to coordinate, document and manage patients' care. Staff were trained to use the system and spoke positively about the benefits. The software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. The practice also used an intelligence monitoring tool to help co-ordinate patient care. For example, the practice used the data from this tool to identify high risk patients.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. The clinical staff we spoke with understood the key parts of the legislation and was able to describe how they implemented it in their practice. The practice had policies in place relating to consent.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated an understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures.

Health promotion and prevention

The practice consistently supported people to live healthier lives through a targeted proactive approach to health promotion and prevention of ill health. The practice published a monthly article in the local newspaper; recent subjects entitled 'Improving your health', 'Falls prevention scheme' and 'Check your pulse'. The practice was also represented at various forums within the area to raise awareness of health issues and the challenges facing people in the community. Staff provided us with examples to demonstrate they were acutely aware that social isolation was an issue in the area and offered support and advice to patients on how to avoid this. For example, we were told that patients were made aware of luncheon clubs that were running that patients could attend.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for the childhood immunisation programme was 100% which was above the national average. There was a clear policy for following up non-attenders in place. We saw evidence the practice engaged with the local community to increase the uptake of immunisations. For example the practice had run a flu immunisation clinic at a local mothers and toddlers group.

The data we looked at showed the practice performed well in the areas relating to health prevention. The general practice high level indicators (GPHLI) showed the practice's performance in a wide range of health prevention areas was above the national average and did not present a risk. For example Flu Vaccination (at risk) rates, diabetes and CHD cholesterol monitoring and health checks for mental illness. The data also showed that admission rates to secondary care for patients with conditions such as CHD, asthma and diabetes was below the national average.

The practice offered NHS Health Checks to all its patients aged 40 to 75 years. The practice data showed that out of these checks two patients had currently been identified as at risk and referred on to secondary care. The practice carried out patient checks opportunistically. For example,

Outstanding ☆

Are services effective?

(for example, treatment is effective)

when patients attended the practice, staff checked whether other areas such as blood pressure or pulse needed checking. They also carried out other opportunistic screening such as prostate checks.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. The practice kept a register of all patients with a learning disability and mental ill health. Records showed the percentage of patients with mental ill health that had received a health check was 100%. All patients on the learning disability register were offered a care plan and an annual health check and where agreed, this took place.

Data for the practice's performance for cervical smear uptake was equal to the national average. The practice had a protocol for managing patients who did not attend for their smear in the last five years and actively tried to encourage them to attend. The practice had similar mechanisms in place for other programmes.

Outstanding ☆

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included results from the national GP patient survey published on 8 January 2015, 40 CQC comment cards, 360 degree feedback from patients, peers and healthcare professionals and the results of the friends and family test for January, February and March 2015. The evidence from all these sources showed an overwhelming satisfaction with the way patients were treated and that this was with compassion, dignity and respect. The national GP patient survey showed 96% of respondent patients described their overall experience of the surgery as good compared to the national average of 68%. 97% of patients said the GP and 96% said the last nurse they saw or spoke to was good at giving them enough time compared to the national averages of 85% for the GP and 79% for the nurse. 92% of patients said the reception staff were helpful compared to the national average of 87%. All but one of these figures was above the CCG and national average. The results of the Friends and Family Test for January, February and March 2015 showed that of the 35 responses received during this time, 34 were extremely likely to recommend the practice and one was likely.

Patients completed CQC comment cards to tell us what they thought about the practice. All the comments were positive about the care patients experienced. Staff were described as outstanding, excellent, caring, understanding and thorough. The CQC comment cards and feedback from patients showed patients were satisfied with the care provided by the practice and that their dignity and privacy was respected.

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

We saw staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so confidential information was kept private. Staff told us if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected; they would raise these with the practice manager. The practice advertised the practice's zero tolerance for abusive behaviour.

Care planning and involvement in decisions about care and treatment

Feedback from patient sources showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and rated the practice well in these areas. For example, data from the national patient survey showed the proportion of respondents to the GP patient survey who stated the GP was good or very good at involving them in decisions about their care was above the national average; 95% compared to 82% and 88% compared to 85% nationally in respect of the nurse. This was aligned to feedback we received.

Patients we spoke with on the day of our inspection told us health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the CQC comment cards we received was extremely positive and aligned with these views.

Translation services were available for patients who did not have English as a first language.

Patient/carer support to cope emotionally with care and treatment

Discussions with staff and feedback from patients demonstrated staff were highly motivated and were inspired to offer care that was kind, caring and supportive and that met the needs of the population. A large proportion of the patients told us that staff went over and above their responsibilities. For example a member of the administration team delivered second hand books to an isolated patient at home once a month. We observed person centred interactions between staff and patients on the day of our inspection. Patients visited the practice specifically to share their positive experiences with us about the care and support they received.

The practice had comprehensive systems in place for supporting patients and their family who were bereaved

Outstanding ☆

Are services caring?

which was managed by a member of the administration team. When a patient died the GP was identified, who made initial contact with the family via the telephone, a condolence card sent and a follow up visit diarised.

Data from the national GP survey showed 99% said the last GP and 93% said the last nurse they saw or spoke to was good at treating them with care and concern. This was above the national average of 85% for GPs and 90% for nurses. 99% also said the GP and 95% said the nurse was good at listening to them which was above the national average.

We were provided with at least five examples that demonstrated staff actively tried to improve outcomes for patients. They demonstrated they were acutely aware of their population and rural area and consciously supported patients emotional and social needs. They recognised they were as important as patients physical needs. Staff talked about isolation being an issue in the rural area and how they always considered this. Examples of how the practice supported patients included; the GP had contacted a patient to enquire about their wellbeing as a member of their family had been admitted to hospital, the practice offered cakes and coffee to raise money for charity and offered a social gathering when it ran their flu clinics. We heard how patients wellbeing was checked on who lived in isolated areas. The examples clearly demonstrated staff had taken into account patients cultural, social and religious needs.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The NHS England Area Team and clinical commissioning group (CCG) told us the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw numerous examples which demonstrated the involvement of other organisations and the local community was integral to how the practice planned their services to meet people's needs. We were told by a member of UDAP how the practice had suggested it became an associate member of the UDAP as they felt it likely that there would be issues of common interest and concern between all different community groups. The meetings allow an exchange of information, compliments, comments and concerns between members of the public, community groups and locally elected representatives.

The practice had taken numerous locally available opportunities to implement service improvements and manage delivery challenges to its population. An example of this was the practice had been the only practice to secure funding from the CCG following submission of a comprehensive bid to run a multifactorial proactive series of interventions for fall and injury prevention in the over 75 year olds. The practice recognised that patients living in the community were at risk and calculated based on International studies that a large proportion of their patients were at risk of fall related injuries. The practice had put in place a comprehensive plan to address this matter as a community rather than individual approach. An example of the first intervention we saw was an advert shortly to be placed in the local newspaper informing the community of seminars being held in the villages which would include presentations from a GP and physiotherapist as well as practical workshops on falls recovery. Other interventions in the plan included medication reviews, in particular withdrawal support for a certain medicine known to increase the risk of hip fracture and night falls, postural blood pressure checks, eye tests and walking aid reviews.

The practice also provided numerous in house services and tests that would normally be undertaken in hospital. For example, in house blood tests for warfarin monitoring using INR Star, acute retention catheterisation and DVT diagnosis management. These services meant patients could be treated closer to home and this was of significant benefit due to the population of the area in their rural location. The practice also provided other in house procedures including minor surgery and minor injury which was again particularly useful as the practice saw transient patients due to its location on the Coast to Coast cycle route.

Tackling inequity and promoting equality

Staff could access a translation service for patients whose first language was not English.

The practice was situated on the ground floor. Consulting rooms and corridors were accessible to all patients which made movement around the practice easy and helped to maintain patients' independence. We saw the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. An audio loop was available for patients who were hard of hearing and a portable audio loop was available to take on home visits. Accessible toilet facilities were available for all patients and records showed regular tests were carried out on the emergency call bell facilities. Parking was available for all patients.

Access to the service

The practice offered a mixture of 'sit and wait' and booked appointments daily. Sit and wait appointments were available every morning from 08:30 to 10:00, bookable appointments at 11:30 which were normally booked by the GP and booked appointments from 16:00 to 17:30 daily. Emergency appointments are available between the hours of 08:00 and 18:00 daily. Appointments with the nurse were by booked appointment only. The dispensary was open on a Monday 08:30-13:00 and 16:00-18:00, Tuesday 08:30-13:00, Wednesday 08:30-13:00 and 16:00-18:00, Thursday 08:30-13:00 and Fri 08:30-13:00 and 16:00-18:00. Between 08:00 and 08:30 there was a GP on site to answer any telephone queries or see any urgent cases presenting before the morning clinic began. Between 18:00-18:30hrs the service was covered by the out of hours service. The out of hours is accessed through the 111 service and is provided by Harrogate District Hospital Foundation Trust.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

The data we reviewed and the feedback from patients about the appointment system showed a generally high level of satisfaction. Patients could make their appointments in different ways, either by telephone, face to face or online, via the practice website. Consultations were provided face-to-face at the practice, by telephone, by e-mail or by means of a home visit by the GP. All patients said they could book appointments in advance and could get an emergency appointment if needed.

Patients told us the experience of making an appointment was positive. They said staff were friendly. The national GP survey results were aligned to this. 89.9% of respondents described their experience of making an appointment as good; which was significantly higher than the national average of 73.8% and slightly higher than the CCG average. 90.7% found it easy to get through to the surgery by phone which was significantly higher than the national average of 71.8% and higher than the CCG average of 86.9%.

Patients told us they could always get an appointment but waiting times could be lengthy at times. The national GP survey results were aligned to this. 92.7% of respondents said they were able to get an appointment to see or speak to someone the last time they tried, which was higher than the national average of 85.4% and the CCG average of 91.9%. Whilst some patients said they may have to wait a period of time to see the GP if they attended a sit and wait appointment they said this was a crucial service and benefited patients. 40.4% of respondents to the national GP patient survey said they usually waited 15 minutes or less after their appointment time to be seen which was significantly lower than the national average of 65.2% and the CCG average of 70.7%. The practice saw a number of non-registered patients; transient patients due to the geography and the sit and wait service worked well for managing these patients.

The practice provided multiple examples of working with other organisations and the local community to demonstrate how the practice offered additional services. For example the practice had provided unfunded voluntary support to the Yorkshire Ambulance Service since 2007. This worked by the ambulance service sending a text message to the GP if they required emergency assistance. The message was sent from the alternate response desk and the GP contacted the desk dispatcher to notify them if they were able to attend. This could involve anybody experiencing a medical emergency within the practice area. Incidents attended included road traffic accidents, a drowning, hypothermia, severe sepsis and heart attacks. The practice had also provided medical support for the Tour de France.

Appointments were open to patients to book in advance. We heard evidence that no patient was ever turned away from the practice and the practice staff were flexible and proactive in managing appointments. The practice coordinated their appointments to reduce the number of times a patient had to visit the practice. The practice had a policy in place for managing longer appointments and visits were made to patients' homes when assessed as being required.

Information was available to patients about making appointments and what action patients should take if they required attention outside of practice opening hours or in an emergency. This was available on the practice website and in the practice leaflet. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances.

Listening and learning from concerns and complaints

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

Information on how patients could make a complaint was available to patients in a number of areas; including the practice website and practice leaflet.

The practice had received one complaint in the last twelve months. Records showed complaints had been dealt with in a timely way and were open and transparent. There was an active review of complaints and where appropriate improvements made as a result. Positive feedback from patients was also shared and celebrated among the staff.

Are services well-led?

Outstanding ☆

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

Our findings

Vision and strategy

The practice mission statement was; to provide high-quality, personalised care to their patients. Their ethos was to provide excellent clinical care and a personalised and professional service to all their patients. They aimed to go the extra mile, be part of the community and to bring care as close to home as possible. We spoke with eleven patients, one member of the community nursing team and reviewed information received from two members of the UDAP. We reviewed forty completed CQC comment cards, the results of the Friends and Family Test and 360 degree feedback from patients, peers and other professionals. All the information reviewed was aligned to Reeth Medical Centre delivering its vision and strategy. We spoke with eight members of staff and they all aimed to provide high quality care and could provide clear examples of how this had been achieved.

Governance arrangements

The practice had a wide range of policies and procedures in place to govern activities and these were available to staff via any computer within the practice. We looked at a sample of these policies and procedures and the system the practice manager had in place for ensuring these were reviewed and were up to date.

We saw evidence that the governance and performance management arrangements were proactively reviewed and reflected best practice. The practice held regular governance meetings where matters such as performance, quality and risks were discussed. The practice demonstrated how they took a systematic, proactive and innovative approach to working with other organisations to improve care outcomes for patients, how they worked to tackle health inequalities and how they also considered the financial aspects for the practice and the NHS.

The practice had comprehensive quality assurance and risk management arrangements in place. Examples of these included the use of a bespoke intelligent monitoring tool, QOF, National and International studies, staff supervision, peer review (internal and external) to the practice and effective systems and processes for recalls and medicine management. Staff had lead roles in managing QOF and performance was closely monitored. Comprehensive arrangements were in place for identifying, recording and managing risks, internal and external to the practice.

We saw evidence that succession planning was regularly discussed and the practice was acutely aware of the NHS Five Year Forward View and considered it in aspects of their work.

Leadership, openness and transparency

A clear leadership structure was in place which demonstrated a commitment in driving improvement in the quality of care and patients experiences. We were told there was an open and transparent culture at the practice and all staff were engaged in the direction of the practice. Staff told us they had the opportunity and were happy and encouraged to raise issues. UDAP told us Reeth Medical Centre was extremely supportive of local healthcare issues the Partnership had tried to address. They provided us with examples where the lead GP had attended and spoke at a 'Rural Summit' about the need to keep and access healthcare services and the importance of doing so for young people and young families in isolated communities.

The practice manager was responsible for human resource policies and procedures and had systems in place to ensure these were reviewed and read by staff. We reviewed a range of policies to support staff in their role, for example disciplinary procedures, induction policy, bullying and harassment and the management of sickness) which were in place to support staff. Staff could access these on any computer at the practice.

Seeking and acting on feedback from patients, public and staff

There were high levels of constructive staff engagement and all staff were actively encouraged to raise concerns. The practice had gathered feedback from patients through patient surveys, comment cards and complaints and compliments received. The practice also made the Friends and Family Test available for patients in the practice, on their website and also provided a link to complete the test on every electronic message that was sent from the practice. The practice used 360 degree feedback to obtain feedback; in this instance the lead GP had gained feedback from patients, peers and a clinician from a secondary care service (360 degree feedback is a process where not just your superior but your peers and direct reports and sometimes even customers evaluate you. You receive an analysis of how you perceive yourself and how others perceive you). The evidence we saw showed the practice acted on any feedback received and kept the informant informed of any actions taken.

Are services well-led?

Outstanding ☆

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

Innovative approaches were used to gather feedback from patients who used services and the public. The practice did not have a PPG in place. Their attempts at setting up a group had been unsuccessful due to a lack of interest. The practice told us how they had explored other means of engaging with patients such as a blog but this did not generate interest. The practice described how they considered integration into the wider community in line with the NHS England Five Year Forward View and in 2012 had joined the UDAP as they felt this was an ideal way of engaging and working with patients and the wider community. The group met five times a year and was made up of County, District and Parish Councillors, public sector representatives such as the Police, voluntary sector, business people and members of the public living and working in the Upper Dales.

The practice had gathered feedback from staff through staff away days and generally through staff meetings, protected learning time appraisals and discussions. Staff told us they gave feedback and discussed any concerns or issues with colleagues and the management team. Our discussions with staff demonstrated a high level of staff satisfaction and a confidence that their views were listened to.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at staff files and saw that regular appraisals took place. We were told and were provided examples where staff had been supported to complete additional training to support them in their professional development and also enhance the service offered to patients.

The practice demonstrated a strong collaboration and support across all staff and a common focus on improving quality of care and people's experiences. The practice had embedded a wide range of systems to ensure the practice was continually learning and improving. The practice had comprehensive systems in place for reporting, recording and monitoring significant events, incidents and accidents. We saw evidence that not only did the practice review incidents that occurred within other practices within their CCG area but also from practices and Out of Hours services in other CCGs.

The leadership drove continuous improvement using a wide range of International, National, regional, local and practice information, such as studies and audits. The practice provided considerable evidence of how they closely monitored their performance against the findings of the various sources detailed above. Evidence showed there was a clear proactive approach to seeking out and embedding new ways of providing care and treatment to improve outcomes for their patients. This was evidenced by the practices comprehensive study and subsequent successful bid for funding to run a population intervention for fall and injury prevention in the over 75 year olds.

Everyone we spoke to was committed to high standard professional practice and to working with one another to make effective use of every resource for delivering organised and co-ordinated services to meet current patients' needs; They took every opportunity for learning from current experience and used it towards developing better care provision for the future. For example the practice was exploring the possibility of being able to provide chemotherapy for patients in their own homes. They demonstrated a determined attitude to overcome barriers the practice and the population faced. The leadership demonstrated and evidenced its commitment and drive to continually move forward to improve outcomes for patients.