The Rothbury 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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Rothbury Practice on 11 February 2016. Overall the practice is rated as good.

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

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- Risks to patients were assessed and well managed.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had the skills, knowledge and experience to deliver effective care and treatment.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which they acted on.
- The provider was aware of and complied with the requirements of the Duty of Candour.

We saw some areas of outstanding practice:

- The practice responded quickly to provide care to approximately 450 extra patients from a nearby practice, which was closed down at short notice last autumn. This represented an 8% increase in the patient list size of the practice. Both clinical and administration staff worked extra hours to ensure that all of these patients were registered quickly and that nobody was overlooked. Extra staff were recruited to

Summary of findings

ensure medical records and prescriptions were transferred correctly. The practice has managed this task without negatively impacting on the 450 patients or their existing patient population.

- The practice provided end-of-life care, in conjunction with the local palliative care team, which had a strong, visible, person-centred approach. Patients were assigned to a named GP who oversaw their care, while another GP was assigned to offer support to family members. The practice had also developed a template to improve communication between services involved in managing the end-of-life care of their patients. We saw evidence and received feedback from patients to show that this end-of-life service was greatly appreciated.

The areas where the provider should make improvement are:

- Provide appropriate training to staff who act as chaperones to assist them to perform this role.

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.

- There was an effective system in place for reporting and recording significant events
- Lessons were shared to make sure action was taken to improve safety in the practice.
- When there were unintended or unexpected safety incidents, patients received reasonable support, truthful information, a verbal and written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- Risks to patients were assessed and well managed.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework showed patient outcomes were at or above average for the locality and compared to the national average.
- The practice was the lowest prescriber of antibiotics in the county in quarter two of 2015/16. They also achieved the highest uptake of influenza vaccinations among learning disability patients in the county.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of ongoing appraisals and personal development plans for all staff.
- Staff worked with multidisciplinary teams to understand and meet the range and complexity of patients' needs.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the National GP Patient Survey showed patients rated the practice higher than others for several aspects of care.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.

Summary of findings

- Information for patients about the services available was easy to understand and accessible.
- We observed a strong patient-centred culture. We were given multiple examples by staff and patients of occasions when staff had gone out of their way to help patients in need.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- A former GP from the surgery had formed a local bereavement visiting service which was run jointly by the practice and local churches.

Are services responsive to people's needs?

Outstanding 

The practice is rated as good for providing responsive services.

- The practice had responded quickly to successfully register approximately 450 patients (an 8% increase on their list size) from another surgery which had closed down at short notice. This required additional staff to be employed, as well as requiring existing staff to work extra hours to ensure patients were registered and reviewed.
- Practice staff reviewed the needs of their local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified.
- 100% found it easy to get through to this surgery by phone compared to a CCG average of 76.8% and a national average of 73.3%.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- Services were tailored to particularly suit the rural population served by the practice. For example they offered a "complex care" clinic to remove the need for patients with long-term conditions to book multiple appointments, reducing their need to travel to the practice.
- 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 and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good 

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

Summary of findings

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to this.
- There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings.
- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- The provider was aware of and complied with the requirements of the Duty of Candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for knowing about notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken
- The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active.
- There was a strong focus on continuous learning and improvement at all levels.

Summary of findings

The six population groups and what we found

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

Older people

Good

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

- 79% of the practice population is over 65 years old, with almost double the number of patients between the ages of 60 and 69 than the national average. The practice offered proactive, personalised care to meet the needs of this group.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- In the 30 months prior to March 2015 the practice had screened 69% of patients aged 60-69 for bowel cancer, (clinical commissioning group average 64.3%, national average 58.3%).
- The practice provided their own end-of-life care in conjunction with the palliative care team.
- The practice had a higher-than-average prevalence of cancer, due in part to the higher prevalence of cancer among older people. The practice had managed to achieve a rate of 54.3% of new cancers being treated following diagnosis via two week wait referrals (local average 44.4%, national average 48.8%).

People with long term conditions

Good

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

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- Performance for diabetes related indicators was better than the CCG and national average. For example, the percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c was 64 mmol/mol or less in the preceding 12 months (1 April 2014 to 31 March 2015) was 90.2%, compared to the national average of 77.5%. IFCC-HbA1c is a test to measure blood glucose levels.
- The practice ran a “complex clinic” to review patients with more than one diagnosis at one appointment, to save them having to visit the practice multiple times.
- Longer appointments and home visits were available when needed.

Summary of findings

- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

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

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw positive examples of joint working with midwives, health visitors and school nurses.

Working age people (including those recently retired and students)

Good

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

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.
- Cervical screening uptake was 83.1%, which was comparable to the national average of 81.9%.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.

Summary of findings

- The practice had achieved the highest uptake of influenza vaccinations in the county among patients with a learning disability.
- The practice offered longer appointments for patients who needed them.
- The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people.
- The practice informed 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)

Good

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

- Performance for mental health related indicators was similar to the national average. For example, the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption had been recorded in the preceding 12 months (1 April 2014 to 31 March 2015) was 93.3%, compared to the national average of 89.6%.
- 76% of patients diagnosed with dementia had had their care reviewed in a face to face meeting in the last 12 months, which is below the national average of 84%.
- The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.
- The practice carried out advance care planning for patients with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results published in July 2015 showed the practice was performing above local and national averages. 254 survey forms were distributed and 141 were returned. This represented a response rate of 55.5%, and 2.7% of the practice's patient list.

- 100% found it easy to get through to this surgery by phone compared to a clinical commissioning group (CCG) average of 76.8% and a national average of 73.3%.
- 93.3% were able to get an appointment to see or speak to someone the last time they tried (CCG average 85.9%, national average 85.2%).
- 94.7% described the overall experience of their GP surgery as fairly good or very good (CCG average 87.1%, national average 84.8%).
- 93.5% said they would definitely or probably recommend their GP surgery to someone who has just moved to the local area (CCG average 81.2%, national average 77.5%).

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received nine comment cards, eight of which were positive about the standard of care received. Patients told us that they were always treated with compassion and respect by staff, that they felt listened to and involved in their care, and that it was easy to make appointments.

We spoke with eight patients during the inspection. All the patients said they were happy with the care they received and thought staff were approachable, committed and caring. The results of the practice's Friends and Family Test for the six months prior to our inspection showed 96% of patients were extremely likely or likely to recommend the practice.

Areas for improvement

Action the service SHOULD take to improve

- Provide appropriate training to staff who act as chaperones to assist them to perform this role.

Outstanding practice

- The practice responded quickly to provide care to approximately 450 extra patients from a nearby practice, which was closed down at short notice last autumn. This represented an 8% increase in the patient list size of the practice. Both clinical and administration staff worked extra hours to ensure that all of these patients were registered quickly and that nobody was overlooked. Extra staff were recruited to ensure medical records and prescriptions were transferred correctly. The practice has managed this task without negatively impacting on the 450 patients or their existing patient population.
- The practice provided end-of-life care, in conjunction with the local palliative care team, which had a strong, visible, person-centred approach. Patients were assigned to a named GP who oversaw their care, while another GP was assigned to offer support to family members. The practice had also developed a template to improve communication between services involved in managing end of life care of their patients. We saw evidence and received feedback from patients to show that this end-of-life service was greatly appreciated.

The Rothbury Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist adviser, a practice manager specialist adviser and a CQC Inspection Manager.

Background to The Rothbury Practice

The Rothbury Practice is registered with the Care Quality Commission to provide primary care services.

The practice provides services to approximately 5,500 patients from two locations:

- 3 Market Place, Rothbury, Northumberland, NE65 7UW.
- Longframlington, Morpeth, Northumberland, NE65 8AD.

These are the locations we visited on the day of our inspection. The practice has also recently taken over the contract to provide two sessions a week at Harbottle Surgery, Harbottle, Northumberland, NE65 7DG. We did not visit these premises on the day of our inspection, as this location was recently inspected whilst under a different provider.

The practice in Rothbury is based in a converted listed building in the centre of the village. Part of the building is owned and managed by the practice, part is rented. Consulting rooms where patients are seen are located on the ground floor and first floor. Due to the age and layout of the building there is no lift to the first floor, and all services for patients who are unable to manage stairs are offered on the ground floor. On-street parking was available outside the practice building. The branch practice at Longframlington is in a purpose built, single storey building owned by the practice. There is a car park for patients to use and level entry access.

There are 24 members of staff, comprising four GP Partners (two female, two male), one salaried GP (female), one GP registrar (male), one nurse practitioner (female), three practice nurses (all female), one healthcare assistant (female), a medicines manager, practice manager and 10 admin/reception staff.

The Rothbury Practice is part of Northumberland clinical commissioning group (CCG). Information taken from Public Health England placed the area in which the practice was located in the third least deprived decile. In general, people living in more deprived areas tend to have greater need for health services.

The practice at Rothbury is open between 8am and 6.30pm Monday to Friday, with extended opening hours offered until 8pm on every third Thursday of the month, and from 7.15am to 8am on Wednesdays. The branch surgery at Longframlington is open from 8.30am to 12pm from Monday to Friday, as well as from 2.30pm to 5.30pm on Wednesday afternoons. Harbottle Surgery is open from 9am to 11am on Tuesdays and 9.30am to 11.30am on Thursdays. The telephone lines operate at all times during the opening hours of the main surgery at Rothbury. Outside of these times, a message on the surgery phone line directs patients to out of hours care, NHS 111 or 999 emergency services as appropriate.

The practice provides services to patients of all ages based on a Personal Medical Services (PMS) contract agreement for general practice. The practice population differs greatly from national averages, with a much higher than average patient population over the age of 50 (especially between

the ages of 60 and 64) and a lower number of patients aged under 40. The service for patients requiring urgent medical attention out of hours is provided by the NHS 111 service and Northern Doctors Urgent Care Limited.

Why we carried out this inspection

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

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

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 11 February 2016. During our visit we:

- Reviewed information available to us from other organisations, for example, NHS England.
- Reviewed information from CQC intelligent monitoring systems.
- Spoke to staff and patients, including members of the Patient Participation Group (PPG).
- Looked at documents and information about how the practice was managed.
- Reviewed patient survey information, including the NHS GP Patient Survey.
- Reviewed the practice's policies and procedures.

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.

Good

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system.
- The practice carried out a thorough analysis of the significant events.

We reviewed safety records, incident reports, national patient safety alerts and minutes of meetings where these were discussed. Lessons were shared to make sure action was taken to improve safety in the practice. For example, patient confidentiality procedures were reviewed following analysis of a significant event.

When there were unintended or unexpected safety incidents, patients received reasonable support, truthful information, a verbal and written apology and were told about any actions to improve processes to prevent the same thing happening again.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training relevant to their role. GPs were trained to Safeguarding Children Level three. Children who did not attend for appointments were followed up and the non-attendance was coded on the practice's computer system.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones had received a Disclosure and Barring Service check (DBS check). (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). Not all staff who acted as chaperone had undergone training for the role but were able to correctly describe their duties.
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.
- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Prescription pads were securely stored and there were systems in place to monitor their use. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. The practice had a system for production of Patient Specific Directions to enable Health Care Assistants to administer vaccinations after specific training when a doctor or nurse were on the premises.
- We reviewed four personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.
- There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a

Good

Are services safe?

health and safety policy available with a poster in the reception office which identified local health and safety representatives. The practice had up to date fire risk assessments and carried out regular fire drills. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).

- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises, and oxygen with adult and children's masks was available from the community hospital located close to the practice. The decision to not keep oxygen on the premises had been risk assessed. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met peoples' needs.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 99.2% of the total number of points available (clinical commissioning group (CCG) average was 97.4%, national average 94.7%), with 9.3% exception reporting (this was the same as CCG average, 0.1% above national average). (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014/15 showed;

- Performance for diabetes related indicators was better than the CCG and national average. For example, the percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c was 64 mmol/mol or less in the preceding 12 months (1 April 2014 to 31 March 2015) was 90.2%, compared to the national average of 77.5%. IFCC-HbA1c is a test to measure blood glucose levels.
- The results for patients with hypertension were similar to the national average. 80.9% of patients with hypertension had a blood pressure reading of 150/99mmHg or less in the 12 months between 1 April 2014 and 31 March 2015, compared to a national average of 83.7%.
- Performance for mental health related indicators was similar to the national average. For example, the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption had been recorded in the preceding 12 months (1 April 2014 to 31 March 2015) was 93.3%, compared to the national average of 89.6%.

Clinical audits demonstrated quality improvement.

- There had been five clinical audits completed in the last two years, two of these were completed audits where the improvements made were implemented and monitored.
- The practice participated in local audits, national benchmarking, accreditation, peer review and research.
- Findings were used by the practice to improve services. For example, an audit into diabetes diagnoses had found that some patients who should have received a diagnosis had been missed. The practice therefore increased their efforts to identify high-risk patients, and as a result the second cycle of the audit found that diagnosis rates had improved and more patients were receiving the treatment they needed.

Information relating to patient outcomes was monitored and used to drive improvement. The practice used various sources, such as RAIDR and the National Cancer Intelligence Network (NCIN) to monitor outcomes. For example, the practice was aware that cancer prevalence among their practice population was 3.6%, which was higher than both the local and national averages of 2.7% and 2.1% respectively. They had examined ways to improve practice performance relating to cancer. 54.3% of new cancers were treated following diagnosis via two week wait referrals, which was better than the local average of 44.4% and the national average of 48.8%. The practice was also the lowest prescriber of antibiotics in the CCG area for the second quarter of 2015/16.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. It covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff, for

Good

Are services effective?

(for example, treatment is effective)

example for those reviewing patients with long-term conditions. Staff administering vaccinations and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccinations could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.

- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support during sessions, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. Not all staff had had an appraisal within the last 12 months due to the extra workload incurred when the practice took over the patient list at Harbottle Surgery, which was closed suddenly. However, all staff told us that they felt supported and could approach management with concerns or training requests. We also saw an updated appraisal schedule which showed that staff who had missed their appraisal would receive one in the coming months.
- Staff received training that included: safeguarding, fire procedures, basic life support and information governance awareness. Staff had access to and made use of e-learning training modules and in-house training. The practice was actively seeking to increase the number of training opportunities available to staff, and all medical staff had one week of training leave per year to pursue training interests.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results. Information such as NHS patient information leaflets were also available.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care services to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, when they were referred, or after they were discharged from hospital. We saw evidence that multi-disciplinary team (MDT) meetings took place on a weekly basis and that care plans were routinely reviewed and updated.

The practice was also piloting an unplanned admissions register, to monitor patients who were at high risk of being admitted to hospital. These patients, which included patients with dementia or receiving palliative care, were monitored as part of a High Risk Pathway and discussed at practice and MDT meetings. The care plans of these patients were reviewed every three months and doctors completed them together with patients and other professionals, at the patient's home if the patient was unable to travel to the surgery. The register was operated in conjunction with the carer's register to ensure care was delivered holistically. At the time of inspection the practice had approximately 130 patients on the register, which roughly equalled 2.4% of the practice list.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and recorded the outcome of the assessment.
- The process for seeking consent was monitored through regular audits of patient records.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support.

Good

Are services effective?

(for example, treatment is effective)

- These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were then signposted to the relevant service.
- Support for people suffering from issues related to alcohol and smoking cessation advice were available from local support groups.

The practice's uptake for the cervical screening programme was 83.1%, which was comparable to the national average of 81.9%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available. They were also part of the CCG "Pink Letter" programme, in which patients who did not attend were sent a more personal and informal letter encouraging them to attend. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. In the 30 months prior to March 2015 they had screened 69% of patients aged 60-69 for bowel cancer, which was higher than the CCG average of 64.3% and national average of 58.3%.

Childhood immunisation rates for the vaccinations given were comparable to CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 92.3% to 100% (CCG average 95.3% to 98.1%) and five year olds from 91.5% to 100% (CCG average 94.9% to 98.5%).

Flu vaccination rates for the over 65s were 77.1%, and at risk groups 53.9%. For the over 65s these results were above CCG and national averages, while for at risk groups these were slightly lower. However, more recent data from 2015/16 showed the practice did manage the highest uptake in influenza vaccinations among learning disability patients in the CCG area (76.3%, CCG average 48.9%)

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

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

Eight of the nine patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with two members of the patient participation group. They also told us they were satisfied with the care provided by the practice and said that when they visited as patients their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was in line with or above averages for their satisfaction scores on consultations with GPs and nurses. For example:

- 97.3% said they had confidence and trust in the last GP they saw compared to the clinical commissioning group (CCG) average of 96.1% and national average of 95.2%.
- 88.1% said the GP gave them enough time (CCG average 88.8%, national average 88.6%).
- 87.8% said the GP was good at listening to them (CCG average 90.6%, national average 88.6%).
- 90.3% said the last GP they spoke to was good at treating them with care and concern (CCG average 88.2%, national average 85.1%).
- 92.1% said the last nurse they spoke to was good at treating them with care and concern (CCG average 92.9%, national average 90.4%).
- 97.9% said they found the receptionists at the practice helpful (CCG average 88.6%, national average 86.8%).

Care planning and involvement in decisions about care and treatment

Patients told us 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 available to them. Patient feedback on the comment cards we received was also positive and aligned with these views.

Results from the National GP Patient Survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages. For example:

- 88.4% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 89.3% and national average of 86%.
- 86% said the last GP they saw was good at involving them in decisions about their care (CCG average 85.7% , national average 81.4%)
- 86.7% said the last nurse they saw was good at involving them in decisions about their care (CCG average 87.3% , national average 84.8%)

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified approximately 4.1% of the practice list as carers. Written information was available to direct carers to the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by a

Good

Are services caring?

patient consultation at a flexible time and location to meet the family's needs, and/or by giving them advice on how to find a support service. Patients were also contacted six weeks after a bereavement to offer further support if required. A bereavement visiting service had been set up by a former GP from the surgery, and was operated jointly between the practice and local churches.

The practice provided end-of-life care, in conjunction with the local palliative care team, to patients who had been diagnosed with a terminal illness. Patients and their families were assigned to a named GP who oversaw their care. The practice developed a template for planning the care of the patients, and shared this with the local palliative care team. This included information about the patient's wishes regarding their care. They had also developed a checklist of administrative tasks to be performed in the event of a patient dying, in order to ensure appointments were cancelled and family's did not receive correspondence in error which would cause them distress. The practice also managed 12 beds at the local community hospital which were used for step-up, step-down care, but which could also be used for palliative patients to provide additional care or respite.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of their local population and engaged with the NHS England Area Team and clinical commissioning group (CCG) to secure improvements to services where these were identified. This was particularly evident when the practice responded quickly to register approximately 450 extra patients from a nearby practice which was closed down at short notice. This represented an 8% increase in the patient list size, and required the practice to undertake rapid, proactive measures to ensure the needs of these patients, as well as the needs of their existing patients, were well met. These measures included:

- Both clinical and admin staff worked extra hours to ensure that all of these patients were registered quickly and that nobody was overlooked.
- Due to the incompatibility of the computer systems of the two practices the patient records from the other practice had to be inputted manually, which required additional staff.
- The practice had also employed a pharmacist and medicines manager to undertake medication reviews of the new patients.
- Further to the 450 extra patients, the practice was temporarily managing another small group of patients who fell outside of their boundary but who had not yet registered with another surgery.

As well as responding quickly to change to ensure patient needs were met, the practice was also proactive in offering services which were of particular benefit to patients in a rural area with relatively low access to services.

- The practice ran a "complex clinic" for patients with multiple diagnoses. This allowed patients to be reviewed in one appointment, rather than having to visit the practice multiple times.
- We were told of a number of occasions where the practice had offered emergency medical assistance to patients and people in the local area. The closest Accident and Emergency department to the main surgery was approximately 30 miles away (approximately a 45 minute drive).
- Home visits were available for older patients and patients who would benefit from these. Patients told us that doctors were always happy to visit them at home, in spite of the large geographical area covered by the practice.
- The practice was proactive in offering online services. The practice website was very comprehensive, offering a wealth of information about the practice as well as various health conditions and support groups. Policies and practice performance data were available to patients, as well as minutes from the Patient Participation Group (PPG) meetings. The website also contained information about local walk-in centres, pharmacies, out of hours GP and dental services, as well as health promotion material such as an "exercise menu" which listed venues for exercising in the local area. Online services offered through the website included booking appointments and ordering prescriptions.
- The practice offered a 'Commuter's Clinic' every third Thursday evening until 7.30pm for working patients who could not attend during normal opening hours. Appointments were also offered from 7am to 7.30am on a Wednesday.
- There were longer appointments available for patients who needed them.
- Same day appointments were available for children and those with serious medical conditions.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately.
- There were disabled facilities, a hearing loop and translation services available.
- The practice was unable to install a lift as the practice building was Grade 2 listed. However, all patients who were unable to climb stairs were seen in consulting/ treatment rooms on the ground floor.
- A blood pressure monitor was available for use in the waiting room. Patients could record their own blood pressure on a form provided to save time in an appointment, or they could come to the practice to use the equipment without an appointment and leave their result to be checked by a clinician later.
- The surgery could offer patients who were prescribed warfarin appointments at the INR clinic at

the nearby community hospital. INR (International Normalised Ratio) is a blood test which needs to be performed regularly on patients who are taking warfarin to determine their required dose. By being able to go to the clinic, patients did not have to travel outside of the village for the test.

Access to the service

The practice at Rothbury was open between 8am and 6.30pm Monday to Friday. The branch surgery at Longframlington was open 9am to 12pm on Mondays and Thursdays, 8.30am to 12pm on Tuesdays and Fridays, and 2.30pm to 5.30pm on Wednesdays. Harbottle Surgery was open from 9am to 11am on Tuesdays and 9.30am to 11.30am on Thursdays.

Appointments were available during all opening hours at Rothbury and Harbottle. At Longframlington appointments were available during all opening hours except Wednesdays, when they began at 3pm, and Thursdays, when they began at 9.30am. Phone lines were open for booking appointments at any of the practice sites from 8am to 6.30pm. Outside of these time the telephone lines were redirected to NHS 111 and local out-of-hours providers.

Extended surgery hours were offered at Rothbury until 8pm every third Thursday of the month, and from 7.15am to 8am on Wednesdays. In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for people that needed them.

Despite the increased demand as a result of taking over part of the Harbottle Surgery patient list, results from the national GP patient survey showed that patient's satisfaction with access to care and treatment was above local and national averages, with telephone access scoring particularly highly.

- 100% patients said they could get through easily to the surgery by phone compared to the CCG average of 76.8% and national average of 73.3%.
- 80.8% of patients were satisfied with the practice's opening hours (CCG average 76.6%, national average 74.9%).
- 62.8% patients said they always or almost always see or speak to the GP they prefer (CCG average 62.1%, national average 60%).

People told us on the day of the inspection that they were able to get appointments when they needed them. They also told us that the practice was flexible in offering appointments that met the needs of the patient. For example, one patient told us that the practice had brought their appointment forward to give them time to take their prescription to the village pharmacy before it closed.

Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns.

- Their 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.
- We saw that information was available to help patients understand the complaints system, for example on posters displayed at the practice, on the practice's patient leaflet, and on the practice website.

We looked at six complaints received in the last 12 months and found these were satisfactorily handled and dealt with in a timely way. There was openness and transparency with dealing with the complaint. Lessons were learnt from concerns and complaints and action was taken as a result to improve the quality of care. For example, following a complaint that fewer surgeries were being offered from the branch practice the number of sessions there was increased. A rota system was put in place to ensure a GP was available there at least four days a week and access to nurse appointments was available from Monday to Friday.

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.

- The practice had a mission statement which was displayed in the waiting areas and staff knew and understood the values.
- The practice had a strategy and supporting business plans which reflected the vision and values and were regularly monitored.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff.
- A comprehensive understanding of the performance of the practice was maintained.
- A programme of continuous clinical and internal audit which was used to monitor quality and to make improvements.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

The strong governance arrangements the practice had in place had allowed them to take on approximately 450 extra patients from the nearby Harbottle Surgery, which was closed down at short notice last autumn. Despite the strength of feeling about the closure of the Harbottle Surgery, the practice had been able to register and review these patients without any negative feedback or complaints from either the Harbottle patients or the practice's existing patient group. There had also been no identified negative impact on care and outcomes for patients. At the time of inspection, the practice was working closely with patients and with NHS England to achieve a viable long-term solution for these patients.

Leadership and culture

The partners in the practice had the experience, capacity and capability to run the practice and ensure high quality care. They prioritise safe, high quality and compassionate care. The partners were visible in the practice and staff told us they were approachable and always took the time to listen to all members of staff.

The provider was aware of and complied with the requirements of the Duty of Candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for knowing about notifiable safety incidents

When there were unexpected or unintended safety incidents:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.
- They kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure in place and staff felt supported by management.

- Staff told us the practice held regular team meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident in doing so and felt supported if they did. We noted team training was held for one half day each month, while team meetings were held twice a month.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.
- Staff told us they were happy to work the additional hours that had been involved in registering and reviewing the 450 patients transferred from Harbottle Surgery, and that they felt this has added to the strong team spirit at the practice.

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

The practice encouraged and valued feedback from patients, the public and staff. They proactively sought patients' feedback and engaged patients in the delivery of the service.

Are services well-led?

Good

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

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. There was an active PPG which met regularly, carried out patient surveys and submitted proposals for improvements to the practice management team. For example, the system of triaging appointments used by the practice was suggested by the PPG.
- The practice had gathered feedback from staff through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.
- At the time of our inspection the practice was applying to move premises to the local community hospital in the village. The practice had written to every patient and held discussion events in order to gather feedback from patients about the move and to discuss any concerns they have had.

Continuous improvement

There was a strong focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. The practice was also proactive in offering online services and introducing new technology.