Bellingham Practice

Inspection report

Bellingham
Hexham
Northumberland
NE48 2HE

Date of inspection visit: 19 November 2018
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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 location	Outstanding
Are services safe?	Good
Are services effective?	Good
Are services caring?	Outstanding
Are services responsive?	Outstanding
Are services well-led?	Outstanding

Overall summary

This practice is rated as outstanding overall. (Previous inspection – 2 October 2014 – rating – good).

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Outstanding

Are services responsive? – Outstanding

Are services well-led? - Outstanding

We carried out an announced comprehensive inspection at Bellingham Surgery on 19 November 2018, as part of our inspection programme.

At this inspection we found:

- The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.
- Feedback from patients who use the service was continually positive about the way that staff treated them. The practice provided an exceptional service where patients were truly respected and valued as individuals and were empowered as partners in their care. Staff were very good at involving patients in decisions about their care and treatment and treated them with compassion, kindness, dignity and respect. This was reflected in the very positive feedback the practice received from the national GP patient survey.
- The practice routinely reviewed the effectiveness and appropriateness of the care and treatment they provided. Staff ensured that care and treatment was delivered in line with evidence-based guidelines.
- Services were tailored to meet the needs of individual patients and were delivered in a way that ensured flexibility, choice and continuity of care.
- The practice encouraged learning and improvement, and staff had the skills, knowledge and experience to carry out their roles.
- The leadership, governance and culture within the practice were central to driving and improving the delivery of high-quality, person-centred care. The practice had a very clear vision to deliver high quality care and promote good outcomes for patients. This was supported by a highly effective business plan and business planning process. High standards were promoted and owned by all practice staff.
- Governance processes and systems for risk management, performance and quality improvement operated effectively.

We rated the practice outstanding for providing caring, responsive and well led services because:

- Patients' individual needs and preferences were central to the practice's delivery of tailored services. For example, leaders had reduced the risk of avoidable hospital admissions by actively engaging with a local scheme to give direct access to the local community hospital for people with an emergency healthcare plan. They had streamlined the recall process for annual health checks for patients with long term conditions (LTCs), which had lowered the number of missed appointments and increased the efficiency of the service. They had reinvested savings in clinician time to improve access to general appointments. This had supported an improved customer experience as reflected in the very positive feedback patients gave the service. The practice understood the challenges faced by patients living in a rural area. They had identified areas where there were gaps in the service locally and had taken steps to address these, by negotiating improved access for their patients. Staff actively engaged with the local community, to help ensure the surgery could stay open in adverse weather conditions and, so that vulnerable patients living in outlying rural areas could continue to receive a care and treatment.
- Patients could access services and appointments in a way and at a time that suited them. The practice's performance on the National GP Patient survey was higher than both local and national averages, across all indicators relating to the responsiveness and timeliness of the service. For some of these, the performance was much higher than average and demonstrated a positive variation when compared to local and national averages. They had improved access for young people by providing targeted out-of-hours appointments at a clinic on a Thursday evening and implementing online consultations aimed at young people. They had attained the 'You're Welcome' accreditation, which is a set of quality criteria aimed at supporting primary care to deliver young people friendly health services.

Overall summary

Professor Steve Field CBE FRCP FFPH FRCGPChief
Inspector of General Practice

Population group ratings

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

Our inspection team

Our inspection team was led by a CQC lead inspector and included a GP specialist adviser. A CQC member of staff shadowed the inspection.

Background to Bellingham Practice

The Bellingham Practice is located in the village of Bellingham in Northumberland and provides care and treatment to 3,555 patients of all ages, based on a Personal Medical Services (PMS) contract. The practice is part of the NHS Northumberland clinical commissioning group (CCG). We visited the following location as part of the inspection:

- The Bellingham Practice, Hexham, Northumberland, NE48 2HE.

The practice serves an area where deprivation is lower than the England average. In general, people living in more deprived areas tend to have a greater need for health services. The Bellingham Practice has fewer patients aged under 18 years of age, and more patients over 65 years, than the England averages. The percentage of people with a long-standing health condition is below the England average. Life expectancy for women and men is similar to the England averages. National data showed that 0.5% of the population are Asian and 0.7% are from other non-white ethnic groups.

The main practice is located in a two-storey building. All consultation and treatment rooms are on the ground floor. Disabled access is provided throughout and the car park has dedicated parking bays for patients with disabilities.

The practice has three GP partners (one male and two female), a nurse practitioner (female), a practice nurse (female), a treatment room nurse (female), two healthcare assistants (female), a practice manager, an IT/HR/ medicines manager, and a team of administrative and reception staff. The practice provides teaching sessions for 1st, 2nd, 3rd and 5th year medical students and 1st year nursing students. Training placements were also provided for trainee GPs. A GP registrar, (female, trainee doctor), was on placement at the time of our visit.

When the practice is closed patients can access out-of-hours care via Vocare, known locally as Northern Doctors, and the NHS 111 service.

Good

Are services safe?

We rated the practice the practice as good for providing safe services.

Safety systems and processes

The practice had clear systems to keep people safe and safeguarded from abuse. However, although they had arrangements in place for sharing relevant patient information with out-of-hours services, this did not include a prompt to share safeguarding information. (The practice told us they would address this immediately following the inspection.)

- Overall, the practice had appropriate systems to safeguard children and vulnerable adults from abuse. Most staff had received up-to-date safeguarding and health and safety training appropriate to their role. Plans were in place to provide this to recently appointed staff. Staff knew how to identify and report concerns. Safeguarding contact information could be easily accessed. Regular Supporting Families meetings were held in conjunction with the health visitor and school nurse, to help keep vulnerable patients safe and share information about risk.
- Staff who acted as chaperones were trained for their role and had received a 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.)
- Staff took steps, including working with other agencies, to protect patients from abuse.
- The practice carried out appropriate checks on staff when they were recruited.
- There was an effective system to manage infection prevention and control.
- The practice had arrangements to ensure that facilities and equipment were safe and in good working order.
- Arrangements for managing waste and clinical specimens kept people safe.

Risks to patients

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

- Arrangements were in place for planning and monitoring the number and mix of staff required to meet patients' needs, including planning for holidays, sickness, and busy periods. The practice told us they had experienced some difficulties in relation to the provision of healthcare assistant cover during the last year, but had 'buddied' with another local practice to share resources, until appropriate staff could be recruited. Locum GP cover was not used as the partners preferred to provide cover for each other. This helped to provide better continuity of care for patients.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections, including sepsis.
- When there were changes to how the service was delivered, the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

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

- The care records we saw showed that information needed to deliver safe care and treatment was available to staff. There was a clear documented approach to managing test results.
- The clinical systems templates used by the practice highlighted patients' vulnerabilities and areas of risk. The templates linked to relevant information leaflets that could be handed out to patients during a consultation.
- The practice had systems for sharing information with staff and other agencies, including out-of-hours, to enable them to deliver safe care and treatment.
- There was a protocol to help ensure incoming patient information was handled in a safe and effective manner.
- Clinicians made timely referrals in line with protocols. Appropriate arrangements were in place for 'safety-netting' patients, to help make sure referrals were received by secondary care services and patients received their test results.

Appropriate and safe use of medicines

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

- The systems for managing and storing medicines including vaccines, medical gases, emergency medicines and equipment, minimised risks.

Good

Are services safe?

- Staff prescribed and administered or supplied medicines to patients and gave advice on medicines in line with current national guidance. The practice had reviewed its antibiotic prescribing and taken action to support good antimicrobial stewardship in line with local and national guidance. The practice's prescribing of co-amoxiclav, cephalosporins and quinolones (antibiotics) was much better than the local clinical commissioning group and national averages. Good antimicrobial stewardship for broad-spectrum antibiotics like these, is important to ensure they are used appropriately.
- The health of patients was monitored in relation to their use of medicines and followed up appropriately. Patients were involved in regular reviews of their medicines.

Track record on safety

The practice had a good track record on safety.

- Risk assessments had been completed to help assure patient safety.
- The practice monitored and reviewed the arrangements they had in place to promote patient safety. This helped to give staff a clear, accurate and current picture of safety issues and any risks, which helped them to identify and implement any improvements that were needed.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were safe and effective systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and acted to improve safety.
- The practice acted on and learned from external safety events, as well as patient and medicine safety alerts.

Please refer to the Evidence Tables for further information.

Good

Are services effective?

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

(Please note: Any Quality Outcomes (QOF) data relates to 2017/18. The QOF is a system intended to improve the quality of general practice and reward good practice.)

Effective needs assessment, care and treatment

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

- Patients' immediate and ongoing needs were fully assessed.
- We saw no evidence of discrimination when clinicians made decisions about patients' care and treatment.
- Staff used technology to help them provide a better service to their patients. For example, mobile blood pressure monitors had been purchased, so patients could undergo monitoring in their own home, rather than having to go to hospital.

Older people:

- The practice maintained a register of their frail elderly patients. Staff had actively focussed on the identification and management of older patients living with frailty. Staff used an electronic frailty tool to help them identify those at greatest risk.
- A weekly multi-disciplinary meeting was held to review the needs of patients with complex needs, including those at risk of admission into hospital.
- Arrangements had been put in place to support care planning. Emergency health care plans had been completed for those patients considered to be most at risk. These had been shared with the attached paramedic service the out-of-hours service, the North East Ambulance Service and the attached paramedic service.

People with long-term conditions (LTCs):

- Housebound patients could receive an influenza vaccination in their own home.
- Practice leads had been identified for the key LTCs, to help promote leadership and expertise.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions such as diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation (AF) and hypertension. One of the LTCs clinical indicators relating to the treatment of patients with COPD, used by the CQC in the accompanying evidence table, shows the practice performed better than the local CCG and national averages.

Families, children and young people:

- The practice had a designated safeguarding lead who provided expertise and leadership, to help ensure there was a co-ordinated response to concerns about vulnerable patients at risk of harm.
- Childhood immunisations were carried out in line with the national childhood vaccination programme. The childhood immunisation indicator for vaccines given to children aged one, used by the CQC in the accompanying evidence table, shows the practice's uptake rate was above the World Health Organisation (WHO) target.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. The practice also had arrangements in place to follow up children who failed to attend appointments.

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

- The practice's uptake for cervical screening was 82.9%, which was above the 80% coverage target of the national screening programme.
- The practice's uptake for breast screening and bowel cancer screening were above the national averages.
- The practice had systems to inform eligible patients, such as students attending university for the first time, to have the meningitis vaccine.
- Patients had access to appropriate health assessments and checks, including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks, where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

- End-of-life care was delivered in a coordinated way, which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances, including those patients who have a learning disability. The practice offered annual health checks to patients with a learning disability.

Good

Are services effective?

- The practice had arrangements in place for vaccinating patients who had an underlying medical condition in line with the recommended schedule. As part of the practice's preparation for the influenza season, searches were carried out to identify and then target 'at-risk' patients.

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

- The practice's performance in relation to the mental health indicators was comparable to the local CCG and national averages.
- The practice assessed and monitored the physical health of people with mental illness, by providing access to an annual mental health review. Patients could access smoking cessation services at the local pharmacy.
- Patients at risk of dementia were identified and offered an assessment, to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis. Where the practice was made aware that a patient had a Lasting Power of Attorney, this was coded in their medical records, as were any Advanced Directions and Do Not Attempt Cardio Pulmonary Resuscitation agreements.

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.

- The practice had carried out clinical audits, to help them improve outcomes for their patients. The sample of clinical audits we looked at were relevant, showed learning points and evidence of improvement.
- A range of other quality improvements audits had also been completed. These included: a review of the practice's long-term conditions review processes; reviews of the care and treatment of patients with certain conditions, such as those with COPD requiring a 'Rescue Pack'; prescribing audits; and an audit of some of the practice's internal systems and processes using the Productive General Practice Quick Start Programme toolkit.
- Unplanned admissions to hospital and readmissions, were reviewed each week at the practice's multi-disciplinary meetings.
- Clinical staff took part in local and national improvement initiatives. For example, the practice participated in the local CCG's medicines optimisation programme. Also, as part of a local CCG initiative, the practice was collaborating with other local practices to provide patients with access to out-of-hours appointments.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

- Staff whose role included immunisation and taking samples for the cervical screening programme, had received appropriate training. Clinical audits were carried out to help maintain staff competence in cervical screening.
- The practice understood the learning needs of staff and provided protected time and training to meet them. The provider had maintained a training matrix, which they used to monitor their compliance with targets throughout the year. Although this was not up-to-date at the time of our inspection visit, a more up-to-date and complete version was forwarded to us following the inspection.
- The practice provided staff with ongoing support. This included an induction process, appraisals, clinical supervision and support for revalidation. The practice ensured the competence of staff employed in advanced roles, by reviewing their performance.
- There was a clear approach for supporting and managing staff when their performance was poor or variable. The practice manager was clear about how they would handle such concerns.

Coordinating care and treatment

Staff worked together, and with other health and social care professionals, to deliver effective care and treatment.

- We saw records that showed clinical staff were involved in assessing, planning and delivering care and treatment.
- When providing care and treatment for patients with long-term conditions, staff actively collaborated with relevant health and social care professionals.
- Patients received coordinated and person-centred care. This included when they moved between services and when they were referred to, or were discharged from hospital.
- The practice ensured that end-of-life care was delivered in a coordinated way, and staff worked with other healthcare professionals, to help ensure the needs of

different patients were met. A quarterly multi-disciplinary palliative care meeting was held, to review patients' needs. A traffic-light system was used to identify those at greatest risk, so appropriate care could be provided. As part of this meeting, each death of a patient was reviewed, to assess whether better care could have been provided. Support for bereaved relatives was also discussed.

Helping patients to live healthier lives

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

- The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a LTC and patients who were also carers.
- Clinical staff encouraged and supported patients to be involved in monitoring and managing their own health. For example, where appropriate, staff referred patients to relevant social prescribing schemes such as the Age UK LTCs project, a local exercise programme for patients with LTCs and a local community walks group. Practice staff also referred patients to the local social services 'Support Planning' team, to help make sure patients had the social care and support they needed.
- Staff encouraged and supported patients to be involved in monitoring and managing their own health, for example, by encouraging their involvement in their LTCs and medicine reviews.
- Clinical staff told us they discussed any changes to care or treatment with their patients and, where appropriate, their carers.
- The practice supported initiatives to improve the health of their patients, for example, by providing patients with support to access smoking cessation advice.

Consent to care and treatment

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

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- Relevant staff had completed training in the application of the Mental Capacity Act (2005).

Please refer to the Evidence Tables for further information.

Outstanding

Are services caring?

We rated the practice as outstanding for caring.

Kindness, respect and compassion

Patients were truly respected and valued as individuals and were empowered as partners in their care. Staff treated patients with kindness, respect and compassion.

- Feedback from patients was very positive about the way staff treated them.
- Staff told us they tried very hard to look after the needs of their most vulnerable patients, especially those that lived in outlying rural areas. They demonstrated this by, for example, the extra steps they took to provide care and treatment during periods of severe weather. Key staff stayed in the village overnight if a period of bad weather was expected, so the surgery could remain open if some staff could not get into work. Staff worked with community members, and other healthcare professionals, to make sure they could visit vulnerable patients in outlying areas who were housebound.
- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- The national GP Patient survey results for the practice were above local and national averages for questions relating to how staff cared for their patients. In particular, 100% of respondents stated, that during their last GP appointment, they had confidence and trust in the healthcare professional they saw or spoke to. This was higher than local CCG and national averages.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about their care and treatment**.** Leaders were aware of the Accessible Information Standard (AIS) and acted to comply with this. Information about AIS was available on the practice's website. (The AIS requires providers to make sure that patients and their carers can access and understand the information that they are given.) Clinical records contained READ codes and 'pop-ups' that identified patients with known communication needs. The practice's questionnaire for newly registered patients asked patients whether they had any particular communication needs. Hearing loops were available in all the consulting rooms.

- Staff communicated with people in a way that they could understand. For example, staff could access easy-to- read materials for use with patients.
- Staff proactively identified and supported carers and had identified 4.8% of their practice list as patients who were also carers. The practice had a designated carers' champion and most staff had completed carers' awareness training, to help improve the care and support they provided to patients. The practice hosted a local carers' group. This is attended by a representative from the Northumberland Carers Group on a quarterly basis. Patients identified as needing extra support are referred to the local carers organisation. Patients who are also carers are encouraged to self-identify.
- The national GP Patient survey results for the practice were above the local and national averages for the question relating to how staff involved them in making decisions about their care and treatment. Of those who responded, 100% of patients stated that during their last GP appointment they were involved as much as they wanted to be in decisions, about their care and treatment.

Privacy and dignity

The practice respected patients' privacy and dignity.

- Reception staff knew that if patients wanted to discuss sensitive issues, they could offer them a private room to discuss their needs.
- Staff recognised the importance of promoting patient's dignity and respect.

Please refer to the Evidence Tables for further information.

Outstanding

Are services responsive to people's needs?

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

We rated the practice as **outstanding** for providing responsive services because:

- Patients' individual needs and preferences were central to the practice's delivery of tailored services. For example, leaders had reduced the risk of avoidable hospital admissions by actively engaging with a local scheme to give direct access to the local community hospital for people with an emergency healthcare plan. They had streamlined the recall process for annual health checks for patients with long term conditions (LTCs), which had lowered the number of missed appointments and increased the efficiency of the service. They had reinvested savings in clinician time to improve access to general appointments. This had supported an improved customer experience as reflected in the very positive feedback patients gave the service. The practice understood the challenges faced by patients living in a rural area. They had identified areas where there were gaps in the service locally and had taken steps to address these, by negotiating improved access for their patients. Staff actively engaged with the local community, to help ensure the surgery could stay open in adverse weather conditions and, so that vulnerable patients living in outlying rural areas could continue to receive a care and treatment.
- Patients could access services and appointments in a way and at a time that suited them. The practice's performance on the National GP Patient survey was higher than both local and national averages, across all indicators relating to the responsiveness and timeliness of the service. For some of these, the performance was much higher than average and demonstrated a positive variation when compared to local and national averages. They had improved access for young people by providing targeted out-of-hours appointments at a clinic on a Thursday evening and implementing online consultations aimed at young people. They had attained the 'You're Welcome' accreditation, which is a set of quality criteria aimed at supporting primary care to deliver young people friendly health services.

Responding to and meeting people's needs

Patients' individual needs and preferences were central to the practice's delivery of the tailored services. The services provided by the practice were flexible, promote informed choice and helped ensure continuity of care.

- The practice understood the needs of its patient population and their tailored services in response to those needs.
- The facilities and premises were appropriate for the services delivered. The practice was proactive in their planning to help ensure the premises were well maintained, especially in relation to maintaining access during the winter months.
- The practice hosted a range of services on site including, for example, a paramedic ambulance service, physiotherapy, retinal screening, stoma care, podiatry and mental health recovery sessions, to enable access to these services for patients who found it difficult to travel or who did not have transport, because they lived in a rural community.
- The practice made reasonable adjustments when patients found it hard to access services.
- The practice provided very effective care coordination for patients who are more vulnerable, approaching the end-of-life or who have complex needs.

Older people:

- The practice was responsive to the needs of older patients, and offered home visits and urgent access for those with enhanced needs.
- All patients had a named GP, who supported them in whatever setting they lived.
- Patients considered to be 'at-risk' had an emergency healthcare plan in place and staff were very proactive in working with other professionals, to help these patients avoid unnecessary admissions into hospital.
- The practice actively used a locally negotiated 'golden-ticket' arrangement, to provide their frail patients, who were at risk of an emergency hospital admission, with direct access to a local community hospital, to help avoid admission into a regional specialist emergency hospital. Over the last 12 months, five patients had been supported to use this arrangement.

People with long-term conditions:

- The practice had a very effective patient recall system, which helped to ensure patients had their needs

Are services responsive to people's needs?

reviewed on a regular basis. In 2017, the practice undertook a project to improve the quality of care and treatment patients with LTCs received, and to help reduce the level of non-attendance at screening and LTCs review appointments. This led to a number of improvements including:

1. A reduced rate of non-attendance at LTCs reviews. Before the project commenced, the rate of non-attendance for a screening appointment was 14.2% and 8.1% for a follow-up appointment. Following completion of the project, the rates had reduced to 4.8% and 2.1% respectively, thereby resulting in increased appointment availability for the clinical team.
2. An improved system for informing patients with LTCs about the results of any tests they had undergone, which meant they were able to review these before they attended their appointment.
3. Delegation of all medicine reviews for patients with LTCs to the clinical nursing team, which meant that GPs had more time for patient consultations.
4. A more concise LTCs review process, to help create savings in clinical time and provide increased contact with patients. From May to July 2017, there had been a saving equivalent to 15 nurse practitioner/GP appointments of 15 minutes duration. In February to April 2018, the saving of clinical time had risen to an equivalent of 51 nurse practitioner/GP appointments of 15 minutes duration.

- As part of the practice's engagement with the National Diabetes Prevention Programme, leaders were working in collaboration with a key stakeholder, to deliver education sessions within the community, to help avoid patients having to travel long distances.
- A system had been put in place, to help ensure house-bound patients had access to an annual review.
- Clinical staff were proactive in referring patients to appropriate services, to help promote better health outcomes and healthier lifestyles. For example, patients identified as being pre-diabetic were referred to the National Diabetes Prevention Programme. Leaders were working in partnership with the 'Versus Arthritis' peer support group, to help provide patients with advice about exercise, the pros and cons of surgery and how to live well with the condition. The first session, involving six patients, had taken place shortly after the inspection. Further sessions were planned. Leaders envisaged these sessions would provide patients with appropriate support closer to home and would help clinicians reduce referrals to the orthopaedic service.
- The practice had applied for funding from the local Windfarm Committee, to provide an exercise maintenance class in the local community, for people with LTCs.
- Plans were being made to support nursing staff to deliver diabetic training sessions in the local community.

Families, children and young people:

- The practice had gained the 'You're Welcome' accreditation, which is a set of quality criteria aimed at supporting primary care to deliver young people friendly health services.
- The practice maintained close working relationships with community health, educational and social care staff, to help provide more responsive care for younger patients.
- The practice's website included dedicated pages for young people. These provided helpful advice for young people covering such areas as confidentiality. They also included web addresses for sites aimed at improving young people's health.
- Younger patients were able to access out-of-hours appointments on a Thursday evening.
- On-line consultations had been recently introduced specifically for young people. Young people could submit questions on-line and were then contacted by a clinician, so that appropriate advice could be given. This helped to promote increased confidentiality, within a close village community setting.
- The practice actively supported young people to make the transition to adult services. The parents of 14-year-old children, and patients who had reached the age of 16 years, were routinely sent letters informing them about the services available at the practice.
- Flexible appointments were provided for children who were unwell.
- Contraceptive and family planning services were provided for those who needed them. The practice referred patients to another local practice for contraceptive services they did not provide.

Are services responsive to people's needs?

- The practice's website provided a good level of sexual health advice and information, and the practice provided access to Chlamydia Screening and was a C-Card distribution centre. (C-Card is a free service offering condoms and sexual health information.)
- Women could access ante-natal and post-natal care at the practice. Well Baby clinics were held twice a month.
- The practice's premises were suitable for children and babies.

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

- NHS health checks were offered to eligible patients and the practice provided written advice about the results.
- The needs of this population group had been identified and the practice had adjusted the services it offered, to help ensure these were accessible and flexible. Extended opening hours were provided on a Wednesday morning by a female doctor and, on a Thursday evening by a male doctor and a female practice nurse, to offer patients greater flexibility when booking appointments. Patients could access out-of-hours appointments via the local Corbridge Hub, between 6pm and 8pm each weekday evening and on a Saturday between 9am and 5pm. In addition, to the out-of-hours appointments provided by the local Corbridge hub, the practice was trialling a Saturday surgery throughout November, (a sub-hub arrangement), to help them evaluate how well used the extra provision would be used by their patients. This was being staffed internally.
- The practice had put arrangements in place to help them deal with the influx of patients during the tourist season.
- Where appropriate, clinical staff referred recently retired patients to trainee counsellors to help them adjust to their new circumstances.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances, including those with a learning disability.
- The needs of vulnerable patients were discussed at the practice's weekly multi-disciplinary meeting. During periods of bad weather, staff contacted these patients to ask if they needed any extra assistance.
- Patients transitioning to another gender were actively supported to attend a speciality service based in Newcastle, in line with the 'trans-care pathway'.
- Patients with learning disabilities had access to an annual healthcare appointment (including a GP appointment), where their needs were reviewed to ensure they were being met.
- All consultation and treatment rooms were accessible to patients with physical disabilities.
- Staff had access to an interpreter service which provided a face-to-face translation service and interpreters should they be needed.

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

- Staff we interviewed had a good understanding of how to support patients with mental health needs, including those patients living with dementia. The practice had a dementia champion, to help support improvements for patients with dementia and staff had completed dementia awareness training.
- Leaders used a specialist toolkit to help them identify patients with dementia who may require additional support from clinicians. Patients and their carers were then contacted to ensure their needs were being met.
- Nurses from the practice had attended local Women's Institute meetings and provided training sessions, to help provide information about issues that could impact on a patient's wellbeing. For example, a recent training session had covered the role of the Lasting Power of Attorney.
- Patients with dementia were invited to attend for an annual review, to help ensure their needs were being met appropriately.
- Clinical staff actively carried out opportunistic dementia screening, to help ensure patients were receiving the care and support they needed to stay healthy and safe.
- Alerts had been placed on the clinical system to 'flag' patients with dementia, so clinicians could take this into account during a consultation.
- Information about dementia support services was available in the practice.
- Carers of patients with dementia were invited to attend for a health check.

Timely access to care and treatment

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Patients were offered 15-minute appointments as standard.

Outstanding

Are services responsive to people's needs?

- The national GP Patient survey results for the practice were above the local and national averages for questions relating to access to care and treatment. In particular, 100% of respondents stated that their needs were met at their last appointment.
- The practice used an automated appointment text reminder system, to help reduce the number of appointments where patients did not attend.
- Patients could access evening and weekend appointments out-of-hours at a hub provided by a group of local GP practices.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.

Listening and learning from concerns and complaints

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

- Information about how to make a complaint or raise concerns was available in the practice and on their website.
- The complaints policy and procedures were in line with recognised guidance.
- The practice had received three complaints during the previous 12 months. Where appropriate, changes were made to facilitate improvement and an apology was offered.

Please refer to the Evidence Tables for further information.

Outstanding

Are services well-led?

We rated the practice, and all the population groups as outstanding for providing a well-led service.

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels. Leaders demonstrated the high levels of experience, capacity and capability needed to deliver high-quality, person-centred, sustainable care.

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges they faced in delivering primary care within a rural setting, and were actively addressing them by, for example, providing very responsive services tailored to meet the needs of their patients.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future of the practice.

Vision and strategy

The practice's strategy and supporting objectives and plans were stretching and challenging, whilst remaining achievable. The practice had a clear vision and credible strategy to deliver high quality, sustainable care.

- Leaders had a clear vision and set of values. These were underpinned by a very strong supporting business plan and business planning process, to help staff achieve priorities. Leaders were proactive in monitoring their progress in relation to the delivery of their strategy. Leaders had developed their vision and strategy jointly with staff, via practice meetings and through the Productive General Practice Quick Start toolkit they were using to drive improvements.
- Staff were aware of and understood the practice's vision for the future and their role in supporting leaders to deliver high-quality, sustainable care.
- The practice planned their services to meet the needs of their patient population. Leaders actively worked with other healthcare professionals and external stakeholders, to help improve the care and treatment they provided to their patients.

Culture

The practice had a culture of high-quality sustainable care. Leaders had an inspiring shared purpose, and strove to deliver and motivate staff to succeed. There were high levels of satisfaction amongst all staff.

- Staff told us they felt respected, supported and valued. They were proud to work at the practice.
- The practice focused on the needs of patients.
- Openness, honesty and transparency were demonstrated by the practice, when responding to incidents and complaints. The provider was aware of, and had systems to ensure compliance with, the requirements of the duty of candour.
- Staff told us they could raise any concerns they had and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they needed. All staff had received an annual appraisal during the previous 12 months. Staff were supported to meet the requirements of professional revalidation where appropriate.
- Clinical staff were given protected time for professional development.
- There was a strong emphasis on the safety and well-being of all staff. Staff were proud of the organisation as a place to work and spoke highly of the culture within which they worked.
- The practice actively promoted equality and diversity. For example, most staff had received equality and diversity training.
- There were positive working relationships between leaders and staff.

Governance arrangements

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

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective.
- Staff were clear about their roles and accountabilities, including those in relation to safeguarding and infection prevention and control.
- Practice leaders had established effective policies, procedures and activities, to help ensure safety, and to assure themselves they were operating as intended. For example, the practice had effective audit arrangements in place.

Outstanding

Are services well-led?

Managing risks, issues and performance

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

- There was an effective process to identify, understand, monitor and address current and future risks, including those relating to patient safety.
- The practice had processes to manage current and future performance. Leaders had oversight of national and local safety alerts, incidents, and complaints.
- Clinical audit had a positive impact on the quality of care and outcomes for patients. There was clear evidence of action to develop clinical practice and improve patient outcomes.
- The practice had plans in place for handling emergencies and had trained staff in how to implement them.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was considered alongside the views of patients, to help improve the services the practice delivered.
- Where appropriate, performance data and notifications were shared with external bodies, so the practice's performance against local and national priorities could be monitored.
- Quality and sustainability were discussed in relevant meetings.
- Systems were in place that helped ensure the information used to monitor performance and the delivery of quality care was accurate.
- The practice used information technology systems to monitor and improve the quality of care.
- Arrangements had been made to ensure the confidentiality of patient identifiable data and patient records.

Engagement with patients, staff and external partners

The practice actively involved patients, staff and external partners to promote high-quality sustainable services.

- Patients and staff were encouraged to share their views and any concerns they had regarding the services the practice provided. Patients' views were listened to and used to make improvements. There was also an active patient participation group to help the practice achieve this.
- The practice was transparent, collaborative and open with stakeholders about their performance. They were participating in the arrangements made by the local GP Federation, to help improve patient access to appointments out-of-hours. The practice submitted information to the local clinical commissioning group, to help them benchmark the quality of care and treatment offered and to meet targets.

Continuous improvement and innovation

There was evidence of systems and processes which supported learning, continuous improvement and innovation.

- There was a strong focus on continuous learning and improvement and staff knew about improvement methods and had the skills to use them. For example, the practice was taking steps to review and streamline their long-term medication review and appointment processes, using the Productive General Practice Quick Start toolkit.
- Bellingham Practice was a research-ready practice and a training practice. Leaders agreed to participate in research which they judged would benefit their patients and result in safer care. The practice was currently involved in a study aimed at helping them to provide more responsive care to patients at high-risk of exacerbation of their asthma. Training opportunities were provided for trainee doctors, and medical and nursing students.
- Learning was shared and used to make improvements.
- Leaders encouraged staff to take time out to review individual and team objectives, processes and performance, through their attendance at staff meetings and via the practice's appraisal system.

Please refer to the Evidence Tables for further information.