

Union Brae and Norham Practice

Quality Report

Union Brae, Tweedmouth, Berwick upon Tweed,
Northumberland, TD15 2HB
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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	
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Are services safe?	Good	
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Are services effective?	Good	
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Are services caring?	Good	
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Are services responsive to people's needs?	Good	
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Are services well-led?	Good	
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Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of Union Brae and Norham Practice on 14 October 2014. We inspected the main surgery at Union Brae and also inspected the branch surgery at Norham.

Our inspection team was led by a CQC Inspector and included a GP specialist advisor and a practice manager specialist advisor. We have rated the practice overall as good.

Comments we received from patients were overwhelmingly positive about the care and treatment they had received. Patients told us they are treated with dignity and respect and involved in making decisions about their treatment options.

Our key findings were as follows:

- The practice covered a large geographical and rural area, services had been designed to meet the needs of the local population.

- Staff reported feeling supported and were able to voice any concerns or make suggestions for improvement.
- There was a range of qualified staff to meet patients' needs and keep them safe.
- The practice was clean and well maintained.
- Data showed us patient outcomes were at or above average for the locality. People's needs were assessed and care was planned and delivered in line with current legislation.
- The practice worked with other health and social care providers to achieve the best outcomes for patients

We saw an area of outstanding practice:

- The provision of services for young people. Significant time and effort had been taken to engage with young people. Services were specifically designed to meet local young people's needs.

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?

The practice was rated as good for safe. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep people safe.

Good



Are services effective?

The practice was rated as good for effective. Data showed patient outcomes were at or above average for the locality. National Institute for Health and Care Excellence (NICE) guidance was referenced and used routinely. People's needs were assessed and care was planned and delivered in line with current legislation. This included assessment of capacity and the promotion of good health. Staff had received training appropriate to their roles and further training needs had been identified and planned. The practice had a system of appraisal and development for all staff. The practice worked with other healthcare professionals to share information. Care and support for young people was outstanding.

Good



Are services caring?

The practice was rated as good for caring. Data 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 care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Good



Are services responsive to people's needs?

The practice was rated as good for responsive. The practice reviewed the needs of their local population and engaged with the NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice and continuity of care, with urgent appointments available the same day. We found the practice had initiated positive service improvements for their patient population, particularly for young people which we found to be outstanding.

Good



Summary of findings

The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and other stakeholders.

Are services well-led?

The practice was rated as good for well-led. The practice had a clear vision and strategy to deliver this. 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 regular governance meetings had taken place. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and this had been acted upon. The practice had an active patient participation group (PPG). Staff had received inductions, regular performance reviews and attended staff meetings and events.

Good



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

The practice was rated as good for the care of older people. Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example in dementia and end of life care. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those who needed them.

Good



People with long term conditions

The practice was rated as good for the population group of people with long term conditions. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. When needed longer appointments and home visits were available. There were structured annual reviews to check their health and medication needs were being met. For those people with the most complex needs the practice worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Good



Families, children and young people

The practice was rated as outstanding for the population group of families, children and young people

An example of outstanding practice was how the practice had conducted a survey of local young people as they felt this patient group was hard to reach and they worked together with the local youth project to gain their views on the practice and make improvements based on the results.

Systems were in place for identifying and following-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. Patients told us and we saw evidence that children and young people were treated in an age appropriate way and recognised as individuals. Appointments were available outside of school hours and the premises was suitable for children and babies. We were provided with good examples of joint working with midwives, health visitors and school nurses. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health.

Outstanding



Summary of findings

Working age people (including those recently retired and students)

Good



The practice was rated as good for the population group of the 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 services as well as a full range of health promotion and screening which reflected the needs for this age group.

People whose circumstances may make them vulnerable

Good



The practice was rated as good for the population group of people whose circumstances may make them vulnerable. The practice held a register of patients with learning disabilities. The practice had carried out annual health checks for people with learning disabilities. The practice offered longer appointments for people with learning disabilities.

The practice discussed vulnerable patients regularly at weekly clinical meetings to ensure they received the best care. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The practice had sign-posted vulnerable patients to various support groups and third sector 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 and out of hours.

People experiencing poor mental health (including people with dementia)

Good



The practice was rated as good for the population group of people experiencing poor mental health (including people with dementia). People experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice had in place advance care planning for patients with dementia.

Summary of findings

What people who use the service say

We spoke with two members of the practice Patient Participation Group (PPG) in advance of the inspection. During the inspection we spoke with seven patients of which one patient was also a member of the PPG.

Patients were overwhelmingly positive about the services they received at the practice. The patients we spoke with reported they felt safe and had no concerns when using the service. They told us that all staff treated them with dignity and respect and had time for them. Patients were satisfied with the appointment system.

We reviewed four CQC comment cards completed by patients prior to the inspection. All but one were complimentary about the practice, staff who worked there and the quality of service and care provided. Words used by patients we spoke with and by those who completed comment cards to describe the practice included exceptional, helpful, very satisfied and clean. We did not find evidence to support the negative comments.

The latest GP Patient Survey completed in 2013/14 showed the large majority of patients were satisfied with the services the practice offered. The results were:

- Percentage of patients rating their practice as good or very good – 95.1%
- Percentage of patients rating their ability to get through on the phone as very easy or easy – 86.3 %
- GP Patient Survey score for opening hours – 85.2%

The practice carried out its own survey in 2013. Results were positive and the analysis of the survey stated that there were less negative comments or comments regarding improvement needed than the previous year. 97% of patients said in the survey they would recommend their GP/nurse to family and friends. 88% of patients at Union Brae and 100% of patients at Norham said they found it easy to make an appointment with a GP.

Areas for improvement

Action the service **SHOULD** take to improve

- The practice should improve the way it audits the medication held in the GP's emergency bags.
- The practice should reconsider its decision not to hold oxygen at the Norham branch surgery, in line with National Resuscitation Council guidelines.

Outstanding practice

We saw an area of outstanding practice which was:

- The identification of services young people wanted to see at the practice. Significant time and effort had been taken to engage with young people. Services were specifically designed to meet local young people's needs.

Union Brae and Norham 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, and a specialist advisor with experience of GP practice management.

Background to Union Brae and Norham Practice

The area covered by Union Brae and Norham Practice extends for around five miles to the north and south of Berwick upon Tweed and for 12 miles to the west. This is a cross-border practice and around 400 of practice patients live in Scotland. The practice population is made up of residents of Berwick upon Tweed and inhabitants of surrounding villages and rural areas.

Union Brae surgery is situated on Union Brae in Tweedmouth which is on the south side of the River Tweed. Berwick upon Tweed is a coastal market town with a mixed population, increasing numbers of ethnic minority residents and has one of the lowest paid populations in England. The surgery is situated on a hill with a car park next to the building. All consulting rooms are on the ground floor.

The branch surgery is situated in the middle of Norham village next to the village green. The building is converted from a former residential property the surgery is fully accessible - all rooms and patients services are on the ground floor. Parking spaces are available directly outside the surgery.

Both the main and branch surgery are dispensing practices. This means under certain criteria they can supply eligible patients with medicines directly.

The provider is a partnership of three doctors, Dr Sarah Ruffe, Dr Neil Forster and Dr Richard Fowles. There is also a salaried GP.

The practice provides services to approximately 7,200 patients of all ages. All patients registered can access services at the main surgery or the branch surgery. The practice is commissioned to provide services within a Personal Medical Services (PMS) Agreement with NHS England.

The practice has four GPs, two male and two female, a locum GP, nurse practitioner, four practice nurses and a health care assistant. There is a practice manager, assistant practice manager and 11 reception and administrative staff.

The service for patients requiring urgent medical attention out of hours is provided by Northern Doctors Urgent Care Ltd and the 111 service.

The addresses of the main and branch surgeries are;

- Main – Union Brae, Tweedmouth, Berwick upon Tweed, TD15 2HB
- Branch – Pedwell Way Surgery, Norham, Berwick upon Tweed, TD15 2LD

Opening times at Union Brae main branch are 8.30am to 6pm Monday to Friday with additional pre bookable appointments on Wednesday evenings from 6.30pm to 8pm. The Norham branch surgery is open Monday, Wednesday and Friday 8.30am to 12.30pm and 1.30pm until 6pm. Then Tuesday and Thursday 8.30 until 12 noon.

Detailed findings

We inspected both the main and branch surgery.

Why we carried out this inspection

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

This provider had not been inspected before and that was why we included them.

How we carried out this inspection

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

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

- Is it well-led?

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

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. This included the local Clinical Commissioning Group (CCG) and the NHS Local Area Team (LAT). We spoke with three members of the practice's Patient Participation Group (PPG).

We carried out an announced visit on 14 October 2014. During our visit we spoke with a range of staff. This included GPs, Practice Nurses, Healthcare Assistants, Dispensers, Reception and Administrative staff. We also spoke with 7 patients who used the service. We reviewed four CQC comment cards where patients and members of the public shared their views and experiences of the service.

Are services safe?

Our findings

Safe Track Record

As part of our planning we looked at a range of information available about the practice as part of our Intelligence Monitoring. This included information from the General Practice High Level Indicators (GPHLI) tool, the General Practice Outcome Standards (GPOS) and the Quality Outcomes Framework (QOF). The latest information available to us indicated there were no areas of concern in relation to patient safety.

Patients we spoke with said they felt safe when they came into the practice to attend their appointments. Comments from patients who completed CQC comment cards reflected this.

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

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

Learning and improvement from safety incidents

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

Norham branch surgery and the cold chain broke down. Learning outcomes from this incident were discussed and an action plan put in place to minimise the risk of this happening again.

The practice was open and transparent when there were near misses or when things went wrong. We saw there were quarterly meetings to specifically discuss any such events. Any which needed discussion earlier would be discussed at the weekly clinical meeting. Each event was recorded on a designated incident form. This recorded details of the incident and how any improvement could be made and actions following the review.

National patient safety alerts were disseminated by the practice manager to practice staff. Staff we spoke with were able to give examples of recent alerts relevant to the care they were responsible for. They also told us alerts were discussed in the various practice meetings which were held.

The practice manager told us she carried out a patient safety walk about every month. She would discuss with staff if there was anything that had “fell through the net” or if there were things they could do to make care safer. The results of this would be discussed at practice meetings to learn and improve patient safety.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records we looked at showed that all staff had received relevant role specific training on safeguarding. Staff we spoke with knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Contact details were easily accessible. Staff were able to give us a good example of where they gave good care in relation to the safeguarding of a vulnerable child.

The practice had a dedicated GP appointed as the lead for both safeguarding vulnerable adults and children. All of the GPs working in the practice been trained to level 3 for safeguarding for vulnerable adults and children.

The practice had a chaperone policy. A notice was displayed in the patient waiting areas to inform patients of their right to request a chaperone. Staff we spoke with told

Are services safe?

us that normally a practice nurse or healthcare assistant undertook this role. Staff were clear about the requirements of the role. Records we looked at confirmed and staff told us staff who undertook chaperone duties had received training and had received disclosure and barring checks (DBS).

The practice had a process to highlight vulnerable patients on their computerised records system. This information would be flagged up on patient records when they attended any appointments so that staff were aware of any issues.

Medicines Management

We checked medicines stored in the treatment rooms and medicine refrigerators and found all medicines were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring medicines were kept at the required temperatures. This was being followed by the practice staff and there was guidance to staff of the action or staff were able to describe the action

There were some processes in place to check medicines were within their expiry date and suitable for use. All the medicines we checked within the surgeries were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. However we checked one of the GPs emergency bags which carried stocks of medicines. The GPs were responsible for the check of medicines in their own emergency bags. In one of the bags we found two medicines to be out of date, one which had expired in July 2013 and the other had expired in April 2014. Before leaving the practice we were assured these medicines would be destroyed and the practice would look at the way they ensured the medication in the GPs emergency bags was up to date.

Vaccines were administered by nurses using protocols that had been produced in line with legal requirements and national guidance. The health care assistant also administered vaccines under directions which had been reviewed and approved in line with national guidance and legal requirements. A member of the nursing staff was qualified as an independent prescriber and she received regular supervision and support in her role from a GP.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. We saw an example of the

process that was followed when a patient's medication had been changed following a visit to hospital. This helped to ensure that patient's repeat prescriptions were still appropriate and necessary.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Dispensing staff we spoke with confirmed they were aware prescriptions should be signed before being dispensed. For those prescriptions not signed before they were dispensed they were able to demonstrate these were risk assessed and a process was followed to minimise risk.

As a dispensing practice there were stocks of medicines which were held in line with appropriate medicines legislation. Practice staff could demonstrate they were following these procedures. There were suitable arrangements in place for the destruction of medicines which were no longer used. The practice had a system in place to assess the quality of the dispensing process and had signed up to the Dispensing Services Quality Scheme, this rewards practices for providing high quality services to

patients who use their dispensary. Arrangements were in place to learn from dispensing errors. Errors affecting dispensed medicines were recorded and reviewed at dispensary and practice meetings to reduce the risk of them happening again.

We saw records showing all members of staff involved in the dispensing process had received appropriate training and had regular checks of their competence. A GP was the lead for medicines management.

As well as being a dispensing practice there was an established service for people to pick up their dispensed prescriptions at five pharmacy locations in Berwick upon Tweed. They also had arrangements in place to ensure people collecting medicines from these locations were given all the relevant information they required.

Cleanliness & Infection Control

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

Are services safe?

domestic staff, one at each surgery. We saw there were cleaning schedules for staff to follow. The practice manager checked on a regular basis that these were followed.

The practice had a nominated infection control lead who was one of the practice nurses. We saw there was an up to date infection control policy and detailed guidance for staff about specific issues. All of the staff we spoke with about infection control said they knew how to access the practice's infection control policies. There were yearly audits of infection control. The audit for 2014 looked at hand washing.

The risk of the spread of infection was reduced as all instruments used to examine or treat patients were single use, and personal protective equipment (PPE) such as aprons and gloves were available for staff to use. The treatment room had walls and flooring that was impermeable, and easy to clean. Hand washing instructions were also displayed by hand basins and there was a supply of liquid soap and paper hand towels. The privacy curtains in the consultation rooms were disposable. The practice had identified that the carpets in the GPs surgeries were not easy to wash and keep clean and these were in a refurbishment plan for both surgeries.

The practice should check the arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades. We looked at some of the practice's clinical waste and sharps bins located in the consultation rooms. We saw only some of the clinical waste bins had the appropriately coloured bin liners in place. We brought this to the attention of the GP whose room this was in. All but one of the sharps bins we saw had been signed and dated as required, we brought this to the attention of the practice manager.

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

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we

saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. We saw evidence of calibration of relevant equipment such as weighing scales. The practice had specific contracts for the maintenance of the spirometer, a machine used to test the lungs, and the electrocardiogram (ECG) machine, which is used to measure electrical activity of the heart.

Staffing & Recruitment

We saw the practice had recruitment policies in place that outlined the process for appointing staff. These included processes to follow before and after a member of staff was appointed. For example, applicants would be invited to attend an interview and satisfactory references would be sought prior to a firm job offer and start date being agreed. There was a comprehensive locum induction pack for locums coming to work at the practice.

The practice had carried out a Disclosure and Barring Service (DBS) check for all clinical staff members and we saw evidence of this. Non-clinical staff had not had a DBS check carried out. The practice could consider a clear rationale as to why they had decided not to carry out DBS checks on non clinical staff. This was not detailed in their recruitment policy.

The practice employed sufficient numbers of suitably qualified, skilled and experienced staff for the purposes of carrying on the regulated activities. We saw there were systems in place to check that the registrations of the GPs with the General Medical Council (GMC) and for the nurses with the Nursing and Midwifery Council (NMC) were up to date. There were arrangements in place to ensure cover for staff absences.

Monitoring Safety & Responding to Risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy and an annual risk assessment. Health and safety information was displayed for staff to see.

Are services safe?

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support. Emergency equipment was available. This included a defibrillator (used to attempt to restart a person's heart in an emergency). All staff asked knew the location of this equipment and records we saw confirmed these were checked regularly. There was access to oxygen at the Union Brae surgery. A decision had been made not to have oxygen at the Norham branch surgery. The National Resuscitation Council states that 'Current resuscitation guidelines emphasize the use of oxygen, and this should be available whenever possible'. The practice should risk assess this decision and consider the rurality of branch surgery in this decision.

Emergency medicines were available in secure areas of the practice. However at the Union Brae surgery all of the emergency medicines were not kept on the emergency trolley. Some of the medicines were in a different treatment room and there was initially some confusion as to where

they were stored when we asked to see them. This meant there was a risk to the effectiveness of the practice being able to treat a patient if there was a medical emergency. We brought this to the attention of the practice manager and a GP partner who said they would review this. All of the medicines we saw were in date and fit for use

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. The plan was comprehensive and current and identified risks such as power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact in the event of failure of the heating system.

A fire risk assessment had been undertaken that included actions required to maintain fire safety. We saw records that showed staff were up to date with fire training and that annual fire drills were undertaken.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance, accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate.

The GPs told us they lead in specialist clinical areas such as hypertension and diabetes and the practice nurses supported this work which allowed the practice to focus on specific conditions. We spoke with staff about how the practice helped people with long term conditions manage their health. They told us that there were regular clinics where people were booked in for recall appointments. We were told that the number of asthma reviews had not been at the rate expected recently. This had been discussed with the clinical staff and as a result they decided to introduce telephone reviews for well patients, which was working well.

There was a pathway of care for frail and elderly patients. They all have a named GP. There were three care homes in the area the practice covered and each care home had a nominated GP who would always try to be the GP who visited to see patients.

We reviewed the most recent Quality and Outcomes Framework (QOF) results for the practice for the year 2012 / 2013. The QOF is part of the General Medical Services (GMS) contract for general practices. Practices are rewarded for the provision of quality care. We saw the practice had scored well on clinical indicators within the QOF. They achieved 99.8%, which was above the average in England of 95.4%.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

A GP partner had the lead role for clinical audit. The practice showed us a yearly schedule of clinical audits. There were various audits which were carried out at different intervals during the year depending upon the type of audit. For example, every year an audit was carried out of patients over 45 who had not had their blood pressure taken in the last five years.

A GP explained to us an example of an audit which was for patients with a single kidney. It had been carried out for the last three years and had a positive effect on patient care. The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF).

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. Staff spoke positively about the culture in the practice around audit and quality improvement.

Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and the latest prescribing guidance was being used. The practice tried to limit the amount of time between the number of repeat prescriptions and medication review. The IT system flagged up relevant medicines alerts when the GP went to prescribe medicines. We were shown evidence to confirm that following the receipt of an alert the GPs had reviewed the use of the medicine in question and where they continued to prescribe it outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

We saw from the minutes of weekly clinical meetings that the most vulnerable patients, for example, those with learning disabilities, children with complex needs or those receiving palliative care were discussed to ensure they received the best care.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff had received annual training such as annual basic life support, fire and safeguarding training. All

Are services effective?

(for example, treatment is effective)

GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

All staff undertook annual appraisals which identified learning needs from which action plans were documented. Staff told us that the practice was proactive in providing staff development which included training. For example one reception member of staff told us they had been on a course for the care of the elderly as a result of this being identified in her professional development plan.

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, nurses giving family planning advice had received training in emergency contraception. Those with extended roles involving seeing patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease were also able to demonstrate they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked closely with other health and social care providers, to co-ordinate care and meet people's needs. We saw meetings were arranged to discuss those patients at high risk or living in vulnerable circumstances.

The multidisciplinary team included community nurses, school nurse, social work and health visitors teams, who would attend along with Marie Curie and Macmillan nurses. The practice also had links with the local hospice and met with the consultant there annually to discuss changes to protocol.

Staff told us they engaged in regular meetings with other practice staff from across the locality to discuss issues and share good practice. Staff met with the local mental health team every three months to discuss those patients experiencing poor mental health.

We found appropriate and effective end of life care arrangements were in place. The practice maintained a palliative care register updated monthly and the terminally unwell were visited at home. We saw there were

procedures in place to inform external organisations about any patients on a palliative care pathway. This included identifying such patients to the local out of hours provider, Northern Doctors Urgent Care (NDUC).

Correspondence from other services such as test results and letters from hospitals were received either electronically or via the post. All correspondence was scanned and passed to the patient's referring GP and the duty doctor. We saw the practice computer system was used effectively to log and progress any necessary actions.

Information Sharing

The practice had systems in place for recording information from other health care providers. This included out of hours services and secondary care providers, such as hospitals.

We spoke with clinical staff about the how information was shared with the Out of Hours services in the local area, 111 and Northern Doctors Urgent Care Ltd. Staff told us that patient information received from the out of hours service was received before 8am. The practice manager confirmed that all faxed information from the out of hours provider, was passed to the GP to review. The GP then identified any action needed and passed the information to the administrator to scan and attach to the electronic clinical patient notes. Staff told us that this normally happened on the same day the information was received.

Consent to care and treatment

We found, before patients received any care or treatment they were asked for their consent and the practice acted in accordance with their wishes. Staff we spoke with told us how they ensured they obtained patients' consent to treatment. Staff were able to give examples of how they obtained verbal or implied consent. We also saw a consent to treatment form which the practice used for consent to investigations or treatment.

A GP we spoke with showed they were knowledgeable of Gillick competency assessments of children and young people. Gillick competence is a term used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

Decisions about or on behalf of people who lacked mental capacity to consent to what was proposed were made in the person's best interests and in line with the Mental Capacity Act (MCA). We found the GPs were aware of the MCA and used it appropriately. The GPs described the

Are services effective?

(for example, treatment is effective)

procedures they would follow where people lacked capacity to make an informed decision about their treatment. They gave us some examples where patients did not have capacity to consent. The GPs told us an assessment of the person's capacity would be carried out first. If the person was assessed as lacking capacity then a "best interest" discussion needed to be held. They knew these discussions needed to include people who knew and understood the patient, or had legal powers to act on their behalf.

Health Promotion & Prevention

The practice offered all new patients a consultation to assess their past medical and social histories, care needs and assessment of risk. These were completed by the GP or nursing staff employed by the practice. Patients with long term conditions were recalled at least yearly, to check on their health and review their medications for effectiveness. Processes were also in place to ensure the regular screening of patients was completed, for example, cervical screening.

The practice identified patients who needed additional support, for example, they kept a register of all patients with a learning disability and those who experienced poor mental health. Staff told us that vulnerable patients were identified via a screen message on their practice records system, these patients were usually seen by the same GP where possible. Leaflets on help with regards to domestic violence were available in the waiting room and the practice had links to local support groups.

We saw a number of leaflets were displayed in the waiting room for patients to access. This included information about common conditions and their symptoms, promotion of healthy lifestyles and prevention of ill health. Test kits for chlamydia and gonorrhoea were available for young people under the age of 25.

There was a range of information for patients on the practice website. This included a section for young people which highlighted to them the services provided including sexual health advice, contraception, pregnancy testing and counselling.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey and a survey of 126 patients undertaken by the practice using completed patient satisfaction questionnaires in 2013. The evidence from these sources showed patients were satisfied that they were treated with compassion, dignity and respect. Data from the national patient survey showed the practice was rated 'among the best' for patients rating the practice as good or very good. Scores were consistently above the national average.

We reviewed four CQC comment cards completed by patients prior to the inspection. All but one were complimentary about the practices, staff who worked there and the quality of service and care provided. Words used by patients we spoke with and by those who completed comment cards to describe the practice included exceptional, helpful, clean and very satisfied. We spoke with two members of the practice PPG in advance of the inspection. During the inspection we spoke with seven patients, one patient was also a member of the PPG. Patients were overwhelmingly positive about the services they received at the practice. They told us that all staff treated them with dignity and respect and had time for them.

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

Staff were aware of the need to keep records secure. We saw patient records were mainly computerised and systems were in place to keep them safe in line with data protection legislation. There was a practice leaflet available to patients explaining about confidentiality of the information the practice kept about them.

The practice had policies in place to ensure patients and other people were protected from disrespectful, discriminatory or abusive behaviour. The staff we spoke with were able to describe how they put this into practice.

Care planning and involvement in decisions about care and treatment

Patients told us they felt they had been involved in decisions about their care and treatment. They said the clinical staff gave them plenty of time to ask questions and responded in a way they could understand. They were satisfied with the level of information they had been given.

The results of the national GP survey showed 88% of patients surveyed rated the question 'Rating of GP involving you in decisions about your care' as good or very good. This was higher than the national average. The results of the practice survey from 2013 showed that between 89 and 95% at Union Brae and 90-100% of patients at Norham branch rated their satisfaction of the quality of the consultation with a GP or nurse as a 4 or a 5, with 5 being the highest level of satisfaction.

We asked staff how they made sure that people who did not have English as a first language were kept informed about their treatment. Staff told us they had access to an interpretation service. Because of geographical constraints this was usually always by telephone however staff felt it worked well.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke to on the day told us staff responded compassionately when they needed help and provided support when required. We saw there was a variety of patient information on display throughout the practice. This included information on health conditions, health promotion and support groups. The practice manager told us they had been involved in a pilot to promote support to carers with the local carers support group and had been coding carers for some time so they could be identified and given appropriate support.

Support was provided to patients during times of bereavement. There was evidence of sharing information for those patients who were reaching the end of their life with other healthcare professionals. Support was tailored

Are services caring?

to the needs of individuals, with consideration given to their preferences at all times. Staff we spoke with in the practice recognised the importance of being sensitive to people's wishes at these times.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the PPG. The group had suggested a handrail outside of the Norham branch surgery would assist patients with mobility difficulties. It was suggested by patients at the group that it would assist parking in the car park at Union Brae surgery if the lines marking the parking bays were re painted. The practice acted on both suggestions and changes were made.

The practice manager told us that the biggest challenge in terms of patient demographics was the rural nature of the practice boundaries. Some of the outlying villages had infrequent bus services, which made travelling by public transport difficult. They believed they provided a much higher amount of home visits compared to other practices to meet the needs of patients.

The practice manager told us that they kept abreast of changes in the local population to plan the future delivery of services. They conducted a survey of local young people in 2014 as they felt this patient group was hard to reach and they worked together with the local youth project to gain their views on the practice. The results were positive and the survey found that access to information was the main issue for young people. As a result of this a section of the practice website was created for young people and a poster advertising the practices services was displayed in the youth project.

Extended opening hours at the practice assisted those at school and work to access appointments. There had been a small turnover of staff during the last three years which enabled good continuity of care.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. In particular the number of patients whose first language was not English was

increasing. The practice were conscious of this and ensured double appointments were made where interpreter services were needed and that there was access to interpreter services.

The practice had made arrangements so that people with physical disabilities were able to access the service. There was parking outside of both surgeries, at Union Brae there were marked bays for patients with mobility difficulties and a bell to ring outside the practice if assistance was needed. All of the consulting and treatment rooms were on the ground floor.

Access to the service

Appointments were available at Union Brae main branch between 8.30am to 6pm Monday to Friday with additional pre bookable appointments on Wednesday evenings from 6.30pm to 8pm. The Norham branch surgery was open Monday, Wednesday and Friday 8.30am to 12.30pm then 1.30pm until 6pm. Then Tuesday and Thursday 8.30 until 12 noon.

Comprehensive information was available to patients about appointments on the practice website and practice leaflet. This included how to arrange urgent appointments and home visits and how to book appointments through the website. Appointments could be booked up to six weeks in advance. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

All patients who needed to be seen urgently were offered same-day appointments and there was an effective triage system in place. Staff told us where patients were identified as needing more flexibility with appointments, such as always having double appointments booked, this was noted on their medical records so staff could make suitable arrangements when an appointment was requested.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

Are services responsive to people's needs?

(for example, to feedback?)

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice at Union Brae. At the Norham branch the premises had been adapted as far as the building would allow.

The most recent GP Survey 2013/14 showed that most patients surveyed were satisfied with how easy it was to contact the practice by phone. 85.2% said it was easy to get through, which compared with an England average of 75%. Patients were also satisfied with the opening times of the practice, with 85.2% saying they were very or fairly satisfied with the opening times. This compared with the England average of 79.8%.

Listening and learning from concerns & complaints

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

We saw that information was available to help patients understand the complaints system. A comprehensive leaflet was available from the reception staff and information was on the practice website. This set out what the patients options were for complaints. However, there was no notice in the waiting rooms about how to complain or signposting patients to the practice leaflet. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had ever needed to make a complaint about the practice.

We looked at two complaints received in the last twelve months and found these were satisfactorily handled and dealt with in a timely way.

The practice reviewed complaints on an annual basis to detect themes or trends. We looked at the report for the last review and no themes had been identified, however lessons learnt from individual complaints had been acted upon.

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 quality care and promote good outcomes for patients. The website and statement of purpose stated the practice aimed to provide the best possible treatment and advice at all times and to help keep patients healthy and work hard to provide the highest standards of care for their patients.

We saw the practice's development plan, which covered 2013/14 and had forward planning for 2014/15. The plan included a review of the development, changes and issues over the last year. The document summarised what the practice saw as its major challenge for 2014 which was managing patient demand and improving access for patients, which included plans for the recruitment of a further salaried GP. Practice objectives were also set out including how they were to be achieved, which member of staff was the lead and the timescale for achievement. For example, the practice wished to move towards being a training practice which they hoped would improve GP recruitment and retention.

We spoke with five members of staff about the vision and values and they understood their responsibilities in relation to these.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via a shared computer drive on any computer within the practice. We looked at five of these policies and procedures, all had been reviewed annually and were up to date.

The practice held regular meetings where governance, quality and risk were discussed. We saw the most recent notes of these to confirm this.

The practice used the QOF to measure their performance. The QOF data for this practice showed it was performing in line with national standards. We saw that the clinical team regularly discussed QOF data and the quality of service delivered at team meetings.

The practice had completed a number of clinical audits. Audits which had been undertaken in the last year were

documented in the practice development plan. There was also schedule of each year's audits. We saw that the full audit process was completed and the audits resulted in improvements.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us their risk management policy which addressed a wide range of potential issues, such as fire equipment and the safety of medicines.

Leadership, openness and transparency

We were shown a clear leadership structure which had named members of staff in lead roles. For example, there was a lead nurse for infection control and one of the partner GPs was the lead for safeguarding and another for medicines management. We spoke with five members of staff and they were all clear about their own roles and responsibilities. They all told us that felt valued, well supported and knew who to go to in the practice with any concerns.

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

The practice had gathered feedback from patients through patient surveys, including the recent young person's survey. There were also thank you cards, positive comments forms and complaints received. We looked at the results of the latest patient survey and saw that the practice had worked with the PPG to make the survey practice specific particularly in relation to access to appointments and contact with the practice. The results of the survey were discussed with the GP partners and the PPG. Following this an action plan was drawn up to review current appointments and telephone systems, then introduce new systems and monitor progress. Progress on these issues were discussed at the PPG meetings. Results of the survey were available on the practice website.

The practice had active PPGs with separate groups at both the main and branch surgeries. The groups met three times a year, with a joint meeting held annually in August. We were shown examples of action the practice had taken following suggestions by the PPG, this included a hand rail being added outside the Norham branch. Minutes of the PPG groups were available on the practice website.

Feedback left by patients on the website "NHS choices" where members of the public can post their views on the practice had not been responded to. There had been three

Are services well-led?

Good 

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

reviews left in total for the practice in 2014. All three were negative, however there was no common theme from these. We asked the practice manager about this who said it was one of the GP partners responsibilities to respond to these, however this had not been carried out.

We saw the practice had a newsletter produced three times a year. The latest newsletter gave updates on booking appointments and bank holiday closures.

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at two staff files and saw staff were supported to develop through regular training,

supervision and appraisal. Staff told us that the practice was very supportive of their training needs and they were provided with staff away days where guest speakers and trainers attended.

We saw practice staff met on a regular basis. Minutes from these meetings showed the team discussed clinical care, audit results, significant events and areas for improvement. Staff from the practice also attended the Clinical Commissioning Group (CCG) protected learning time (PLT) initiative. This provided staff with dedicated time for learning and development. Staff particularly told us that they felt that good communication was a strong point for the practice.

We saw that significant events and incidents were used as a learning opportunity and shared with staff during meetings.