The Border Practice

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

This was a comprehensive inspection of the Border Practice and was carried out on 1 October 2014.

The practice was well led by the GP partners and the practice manager. We rated this practice as good overall. We found outstanding practice in the way the practice responded to the needs of people with long term conditions, providing them with effective care and treatment. The practice had responded to the needs of working patients and those patients who had barriers to accessing GP services.

Our key findings were as follows:

- The practice was rated highly by patients for the respect they were shown, their confidence in the ability of the doctor or nurse and their ability to listen.
- The practice provided GP appointments at times that met the needs of their patients.
- The practice was able to offer specialist clinics to patients to avoid the need to attend hospital.
- There were effective infection control procedures in place and the practice building appeared clean and tidy.

We saw areas of outstanding practice including:

- The effective care of patients diagnosed with hypertension went beyond best practice by reviewing that diagnosis. This entailed monitoring their blood pressure for a full twenty four hour period with a view to confirming or refuting their diagnosis of hypertension so their treatment could be improved.
- The practice had a flexible approach to providing care for patients with a learning disability to ensure they received care and treatment in a way that met their needs. The practice carried annual health checks in the patient's own home or during quiet times to ensure the patient felt as relaxed as possible, were supported by their carer or were in familiar surroundings.

However the provider should:

Summary of findings

- Have a written policy for maintenance of the cold chain for temperature sensitive medicines including action to take in the event of a potential failure.
- Have a mercury spillage kit available to safely dispose of any mercury if their blood pressure machine were to break.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for safe. There were systems in place to protect patients from avoidable harm and abuse. Staff understood their responsibilities to raise concerns about safety. Reports of incidents and significant events were reviewed and lessons learnt to support improvement.

Staff had received up to date training in safeguarding and were focused on early identification and referral to local safeguarding teams.

There was evidence of the safe management and auditing of infection control within a clean and well maintained building.

Arrangements were in place to deal with emergencies and major incidents. Staff were trained and there was appropriate equipment and medicines available to deal with a medical emergency. A detailed business continuity plan was in place to deal with any event which may cause disruption to the service.

Are services effective?

Good

The practice is rated as good for effective. Our findings at inspection showed the practice delivered care and treatment in line with recognised best practice. They worked with other health professionals to ensure a complete service with the right treatment outcomes for their patients. The provider had systems and processes in place to ensure that standards of care were effectively monitored and maintained. Clinical audit cycles had been completed, which had resulted in improvements to patient care and treatment.

The practice used proactive methods to improve patient outcomes and had links with other local providers to share best practice. Patients were supported to manage their own health and were treated by appropriately well trained staff. Staff received the necessary support, training and development for their role and extended duties.

Are services caring?

Good

The practice is rated as good for caring. Patients we spoke with were complimentary about the caring compassionate attitude of staff. They said they were treated with dignity and respect and were involved in care and treatment decisions. Staff gave patients the information they required about their treatment to ensure they were able to make informed choices.

Summary of findings

We also saw that staff treated patients with kindness and respect. Staff provided privacy during all consultations and reception staff maintained patient confidentiality when registering or booking in patients.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. We found the practice had initiated many positive service improvements for their patient population that were over and above their contractual obligations, particularly for people in vulnerable circumstances. The practice had worked with commissioners to provide GP access for patients who were not able to receive care elsewhere.

Patients reported good access to the practice and a GP of choice, with continuity of care. Urgent appointments available the same day. Clear details of the appointment system were available in the practice leaflet and on the practice website. The practice had an 'on call' doctor available every day and an 'overflow' clinic with unlimited capacity to ensure that any patient who felt they need to see a GP could do so. The practice had good facilities and was well equipped to treat patients and meet their needs.

The practice understood the needs of their practice population and had made changes to the practice building and systems to meet the needs of their patients.

Complaints were managed swiftly and openly as part of the system of patient feedback. There was evidence of shared learning from complaints with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for well-led. The practice had a clear vision to deliver high quality care and promote good outcomes for patients. Their ethos was to promote an open culture and teamwork where each person's role was valued. Staff were clear about their responsibilities in relation to this.

There was a clear leadership structure and staff felt supported by the GPs and practice management. The practice had an established staff team and a culture of openness and honesty was encouraged. The quality, performance and effectiveness of the service were monitored with GPs having a collective responsibility for making decisions about clinical practice.

The practice had a number of policies and procedures to govern activity which were regularly reviewed. The practice actively sought

Summary of findings

feedback from patients and this had been acted upon. The practice had an active patient participation group (PPG). Staff had received induction, regular performance reviews and felt communication throughout the practice was good.

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The six population groups and what we found

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

Older people

Good

The practice was rated good for the care of older people. Each patient over 75 years of age had a named GP but were able to see any GP of their choice for continuity of care when necessary or specialised care and treatment if needed. We saw that the practice responded to the needs of this population group by improving access to the services they needed.

The practice had a number of older patients who lived in residential care. If these patients required a GP they were visited in their home. The GPs used these visits to speak with or monitor the health of any of their other patients who lived in the same residential care. The practice nurse also visited the patients in residential care and the housebound to administer flu vaccinations.

The practice worked closely with the community nursing team and palliative care team to ensure good provision of end of life care.

People with long term conditions

Good

The practice was rated good for the treatment of patients with long term conditions. The practice had a higher than average number of diabetic patients. They had put in place longer combined appointments with the health care assistant, to undertake a focused diabetic check including lifestyle advice, followed by time with the GP.

Staff at the practice had been supported to gain further relevant qualifications and skills to improve the treatment and monitoring of long term conditions. The health care assistant and phlebotomist (a person who has been trained to take blood samples) at the practice were able to carry out anticoagulant monitoring by specific blood tests for patients. Patients did not have to travel to the hospital clinic to be monitored.

Patients with long term conditions were invited into the surgery for health checks.

One of the GP partners who had a special interest in cardiology ran a weekly monitoring clinic for palpitations and blood pressure monitoring.

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Families, children and young people

Good

The practice was rated good for the care of families, children and young people. The practice had a GP partner with an interest in family planning and child health and they were the lead for child safeguarding.

The practice offered a full range of immunisations for children and data showed that the practice had vaccinated a high percentage of eligible children. There was a system in place to encourage the uptake of vaccination for five year old children. A member of reception staff worked closely with the senior nurse to repeatedly contact parents to offer vaccinations.

The practice worked closely with midwives and health visitors who used the practice premises to meet with their patients. Health visitors attended the practice's clinical meetings each month to share information and best practice.

Working age people (including those recently retired and students)

Good

The practice was rated good for the care of working age people (including those recently retired and students). The practice had a high percentage of patients of working age. Early morning, late evening and Saturday morning appointments were available for patients. This increased the accessibility of their service to people who were unable to attend during the day due to work commitments.

There was a lunchtime gynaecology and contraception clinic. This had been put in place to help maintain confidentiality for patients who did not wish to share with their employer or colleagues that they were attending the practice.

There was capacity within the appointment system for all patients to be seen the same day if necessary for an emergency.

People whose circumstances may make them vulnerable

Good

The practice was rated good for people living in vulnerable circumstances. The practice provided health checks for their patients who had a learning disability and lived in the community. It had been identified that these patients were more relaxed in a familiar environment so GPs and nurses made arrangements to carry out these checks in their home. Staff told us that they planned appointments carefully for certain patients with a learning disability to ensure they did not wait for a long time and become agitated or planned appointments at lunch time when the surgery was quiet. All patients with a learning disability were offered a physical health

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check and all had received a check up in the last 12 months. The practice carried out some of these health checks in the patient's own home to ensure the patient felt as relaxed as possible and were supported by their carer in familiar surroundings.

The practice provided GP access for patients from Hampshire and Surrey who other GPs had refused to see.

People experiencing poor mental health (including people with dementia)

Good

The practice was rated good for the care of people experiencing poor mental health. All practice staff were aware of those patients who were suffering from poor mental health. Reception staff were able to offer immediate appointments to those patients with a known diagnosis of poor mental health. A counsellor from a local support group worked at the surgery. The counsellor was able to see referrals from the GPs and patients were able to self-refer to use their service.

The practice worked with local mental health services to ensure patients were well supported. Staff were educated and informed about local support services and provided information to patients.

Summary of findings

What people who use the service say

We spoke with five patients and a representative of the patient participation group (PPG). We reviewed 25 comment cards which had been completed by patients in the two weeks leading up to our inspection.

Without exception patients were very complimentary about the practice staff who they said were patient, understanding and friendly. All the patients we spoke with praised the caring attitude of the GPs and their ability to respond to their patients' needs promptly with compassion and understanding. Patients commented positively on the way GPs and nurses listened to them and the way they explained their diagnosis or medicines in a way they could understand.

We spoke with patients from a number of population groups. These included mothers and children, people of working age, people with long term conditions and people aged over 75 years of age.

Patients told us that staff had a caring attitude and they felt safe with the care they received. Patients were satisfied with the appointment system and the ability to get appointments to suit their needs. We were told by patients that the on line booking system for appointments worked well and that extended opening times helped to fit around work or caring responsibilities. Patients appreciated the ability to have certain blood tests done at the practice, which in the past had meant a journey to the general hospital.

There had been 200 responses to the 'Improving Practice Questionnaire' that the practice had conducted in July 2014. This survey showed that 90% of the patients who responded rated the practice as good, very good or excellent. The practice was rated highly by patients for the respect they were shown, their confidence in the ability of the doctor or nurse and their ability to listen.

Areas for improvement

Action the service SHOULD take to improve

- The practice should have a written policy for the maintenance of the cold chain for temperature sensitive medicines including action to take in the event of a potential failure.
- The practice should have a mercury spillage kit available to safely dispose of any mercury if their blood pressure machine were to break.

Outstanding practice

- The effective care of patients diagnosed with hypertension went beyond best practice by reviewing that diagnosis. This entailed monitoring their blood pressure for a full twenty four hour period with a view to confirming or refuting their diagnosis of hypertension so their treatment could be improved.
- The practice had a flexible approach to providing care for patients with a learning disability to ensure they received care and treatment in a way that met their needs. The practice carried annual health checks in the patient's own home or during quiet times to ensure the patient felt as relaxed as possible, were supported by their carer or were in familiar surroundings.

The Border 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 second CQC inspector.

Background to The Border Practice

The Border Practice is located in Blackwater Way, Aldershot, Hampshire. The practice is operated from a spacious surgery purpose built in 2005 which is owned by the GP partners. The practice building has six consulting rooms and four treatment rooms. There is space for allied clinical services to use the consulting rooms. A physiotherapist, local counselling services, community pulmonary and cardiac rehabilitation teams and health visitors also use the building.

The practice does not provide an out of hours service for their patients. Outside normal surgery hours patients are able to access urgent care from an alternative Out of Hours provider.

The practice provides a range of primary medical services to approximately 8,600 patients. Patients are supported by two male and one female GP partners and a female salaried GP, providing 34 GP sessions per week. Further support is provided by a practice manager, practice nursing staff, a health care assistant, a phlebotomist and administrative and reception staff. The practice is a member of the North East Hampshire and Farnham Clinical Commissioning Group (CCG).

The Border Practice has a Personal Medical Services (PMS) contract. These contracts enable providers to develop services to meet local needs. PMS practices can develop bespoke models of service delivery tailored to specific needs of groups who may not have their needs met otherwise. This includes GP services for vulnerable groups or specialist services.

North East Hampshire and Farnham CCG covers a significantly less deprived area than the average for England. However The Border Practice is situated in the urban area of Aldershot where the levels of deprivation are among the highest for practices within this CCG area.

Why we carried out this inspection

We inspected this practice as part of our new comprehensive inspection programme.

We carried out a comprehensive inspection of this practice 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 practice, and to provide a rating for the service under the Care Act 2014.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations such as; local Healthwatch, NHS England and North East Hampshire and Farnham Clinical Commissioning Group (CCG), to share what they knew.

We carried out an announced visit on 1 October 2014. During our visit we spoke with a range of staff including all the GPs, practice nursing staff, the practice manager and reception and administrative staff. We spoke with patients who used the service. We observed how people were being cared for and reviewed some of the practice's policies and procedures. We also reviewed 25 comment cards where patients and members of the public had shared their views and experiences of the service.

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)

The Border Practice has a low percentage of their patients in the over 65 age group compared with the average for England. The practice population of people between the ages of 30 and 64 is higher than the average for England. The practice population ratio is almost 50:50 male to female.

Good

Are services safe?

Our findings

Safe Track Record

We reviewed the significant events that had been recorded by the practice over the last 12 months. There were no recorded medication errors. Potential safety incidents had been acted on promptly and cascaded to practice staff to mitigate future risks. There was evidence that significant events had been handled appropriately to protect the safety and well-being of patients. Staff had reacted appropriately to a medical emergency at the practice but had made changes to medical emergency training to familiarise staff with the practice's own defibrillator.

Weekly clinical meetings were used to highlight and discuss any patient safety or drug alerts which had been received to ensure verbal and written information was passed to appropriate staff, GPs and nurses.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. We saw the reports of these events and discussed with the practice manager and GPs the process for recording incidents.

The practice kept records of significant events that have occurred. The records for the last 12 months were made available to us. Time was allocated to significant events on the weekly practice meeting agenda; this provided senior staff with the opportunity to discuss any incident and to record any learning points. There was an annual review of all significant events. We saw an example where a specific incident had been investigated and suggestions had been sought about how to prevent the incident reoccurring. Systems within the practice had been changed to minimise future risks. There was evidence that appropriate learning had taken place where necessary and that the findings were disseminated to relevant staff. For example when an unsheathed needle was found in a treatment room this had been discussed with visiting hospital midwives and nursing staff and the practice sharps policy had been reinforced. Staff including receptionists, administrators and nursing staff were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so.

Reliable safety systems and processes including safeguarding

All staff had received relevant training on safeguarding. The provider's training needs assessment was made available to us which showed that all staff had received training in child and adult protection. All the partner GPs and the senior practice nurse had received level three training. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Contact details were posted throughout the practice and were easily accessible for all staff.

Systems were in place for alerting local safeguarding teams when repeated requests for children to attend for immunisation were not responded to by parents. Staff were confident that they would be able to identify possible signs of abuse especially in relation to child protection.

A chaperone policy was in place and visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who accompanies another person during treatment or examination). If nursing staff were not available to act as a chaperone, eight reception and administration staff had undertaken training and understood their responsibilities when acting as chaperones. Clinicians documented that a chaperone had been offered and either accepted, recording the name of the chaperone, or declined by the patient, in the patient record.

The practice's chaperone policy clearly documented the guidelines for chaperones, including confidentiality and recording. There was a detailed procedure for those people acting as chaperones.

Medicines Management

We checked medicines stored in the fridges. Staff we spoke with told us about the checks they made of fridge temperatures and were clear about the need to maintain the cold chain in relation to temperature sensitive medicines and vaccines and the actions they would take if the cold chain had been broken. However there was no written policy for maintenance of the cold chain and action to take in the event of a potential failure. Emergency medicines for cardiac arrest, anaphylaxis and hypoglycaemia were available and all staff knew their location.

We attended a clinical meeting where a drug safety alert was discussed by the GPs and nurses. Information from the North East Hampshire and Farnham Clinical

Good

Are services safe?

Commissioning Group (CCG) medicines management pharmacist was cascaded to staff in relation to the procedure for reporting adverse reactions to prescribed medicines. The CCG medicines management pharmacist met with the GP lead for prescribing on a weekly basis and attended a practice clinical meeting every six months. The GP lead for prescribing attended a medicines management forum every two months to ensure they kept up to date with current guidance.

When nurses or Health Care Assistants (HCAs) administered Prescription Only Medicines e.g. vaccines, Patient Group Directions or Patient Specific Directions were in place in line with relevant legislation.

Patients were able to request repeat prescriptions at the practice or online, patients we spoke with did not have any concerns about the process. The practice had a protocol for repeat prescribing which was in line with GMC guidance. This covered how changes to patients' repeat medications were managed and the system for reviewing patients' repeat medications to ensure the medication was still safe and necessary. Blank prescriptions were stored securely.

Cleanliness & Infection Control

The practice had a lead for infection control, who had undertaken training in November 2012 for this role, to enable them to provide advice on the practice infection control policy and carry out staff training.

A lead nurse was responsible for infection control procedures at the practice. There were appropriate policies and procedures in place to reduce the risk and spread of infection. Infection control procedures were subject to an annual audit and an annual risk assessment. With guidelines in place to update the risk assessment if there is any change to the purpose of a treatment room. The most recent check had taken place in July 2014.

Improvements identified for action at the most recent infection control audit in July 2014 had been completed in the time frame set by the provider. For example the steam cleaning of treatment room curtains and rips and tears to examination couches had been identified and steps taken for their repair. There had been no reported incidents from sharps injuries or spillage. All staff had received induction training about infection control that was specific to their role.

We observed the premises to be clean and tidy. We noted that the infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures and to comply with relevant legislation.

Occupational health was outsourced through a contract with the local general hospital. We did not look at results but noted that staff had been referred for pre-employment checks on immunisation and Hep B status. The practice checked the Hep B status of all their GPs and nurses annually.

The practice had tested their water supply for the presence of Legionella. (Legionella is a bacterium found in water storage systems which can cause illness in people.) The practice had been identified as being low risk as there were no water storage systems in the building.

Patients we spoke with commented positively on the standard of cleanliness at the practice. The premises were visibly clean and well maintained. Work surfaces could be cleaned easily and were clutter free.

Equipment

Staff we spoke with did not raise any concerns about the safety, suitability or availability of equipment. We saw that medical equipment had been calibrated in September 2014, there had been no action necessary at that time as all equipment was functioning correctly and accurately. (Calibration is a means of testing that equipment is accurate). Electrical items had been portable appliance tested (PAT tested) and were deemed safe to use. This provided assurances that the equipment was in efficient working order and in good repair.

We saw in one of the treatment rooms a blood pressure machine which contained mercury. Although safe to use the practice did not have a mercury spillage kit which would be needed to safely deal with any mercury if the machine were to break.

Staffing & Recruitment

There was an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave; the staff we spoke with told us they were happy with this arrangement. The majority of staff had worked at the practice for a number of years, the practice manager and GPs told us they felt the stable work force provided a safe environment for their patients.

Good

Are services safe?

The staff recruitment policy showed that appropriate checks had been carried out on staff before starting work at the practice. The practice policy was that all staff had criminal records checks via the Disclosure and Barring Service (DBS). GPs and nursing staff had enhanced DBS checks.

The patient to GP session ratio at this practice was higher than average for England. We spoke with all the GPs at the practice who told us that the use of locum GPs was very rare. The GPs told us they covered each other's leave and sickness absence and did not feel that their workload was excessive. Three GPs had shared the work of a recently returned colleague who had been on maternity leave. Patients we spoke with did not report any difficulty in accessing a GP consultation. This was confirmed by the reception staff who had not experienced difficulty meeting patients' needs for GP consultations.

Monitoring Safety & Responding to Risk

The practice had appropriate equipment, emergency medicines and oxygen to enable them to respond to an emergency should it arise. The practice had an automated external defibrillator (AED) which could be used in the emergency treatment of a person having a cardiac arrest. We were told that the emergency equipment, oxygen and emergency medicines were checked monthly by a practice nurse to ensure the equipment was working and the medicines were in date to ensure they would be safe to use should an emergency arise. There was a record of the monthly checks.

Arrangements to deal with emergencies and major incidents

We saw records that all staff had received training in Basic Life Support and GPs had taken part in Immediate Life Support training (which is at a more advanced level) within the last 12 months. Two members of staff were due for updates. All staff asked, including reception and administration staff knew the location of the AED, oxygen, and emergency medicines. Significant event analysis documentation included that a medical emergency concerning a patient had been discussed and appropriate learning taken place.

The practice had a business continuity plan which included what the practice would do in an emergency which caused a disruption to the service, such as a loss of computer systems, power or telephones. The practice had established relationships, and formal arrangements were in place, with neighbouring practices to ensure that patient care could continue at a 'buddy practice' in an emergency.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

We spoke with all the GPs at this practice. They were able to describe how they accessed guidelines from both the National Institute for Health and Care Excellence (NICE) and from North East Hampshire and Farnham Clinical Commissioning Group (CCG).

We attended a clinical meeting on the day of our inspection. All clinical meetings were minuted by the practice manager. We saw minutes of previous meetings where new guidelines were disseminated and patients were discussed. GPs and nurses were required through their partnership agreement or contract of employment to remain up-to-date with registrations, qualifications and training. The practice manager kept a log of training in subjects such as infection control, child and adult protection and equality and diversity and tracked renewal dates for appraisals and registrations. All the GPs interviewed were aware of their professional responsibilities to maintain their professional knowledge.

Patients had their needs assessed and care planned in accordance to best practice. We saw evidence of complete clinical audit cycles which showed that patients prescribed medicines for anxiety and depression were prescribed appropriate doses and their treatment was under regular review. Also that the prescribing of medicines for diabetes followed current best practice guidelines. We saw evidence to show that patients who attended with a diagnosis of hypertension had their previous diagnosis of hypertension challenged and reassessed by a 24 hour blood pressure review with a view to improving treatment.

All new patients to the practice were offered a health assessment carried out by the practice nurse or health care assistant to ensure the practice was aware of their health needs. Patients who relied on long term medication were regularly assessed and their medication needs reviewed. There were systems in place to ensure that the GPs reviewed the diagnostic and blood test results of their patients. The practice ran a number of specialised clinics to meet the needs of patients. These included a diabetic clinic where related health checks were carried out by the health care assistant or practice nurses such as foot checks and retinal screening, a GP with special interest in diabetes then carried out a consultation with the patient immediately afterwards, when any issues or queries could be discussed.

The practice referred patients appropriately to hospital and other community care services. National data showed the practice is in line with national standards on referral rates for all conditions. We saw evidence of appropriate use of two week wait referrals. Two week wait oncology referrals had been the subject of an audit by one of the GP partners. This audited the practice to ensure that the standard of referring patients within two or fewer primary care appointments and within 24 hours had been met. Clinical meeting minutes showed that there was a regular review of elective and urgent referrals and that improvements to practise were shared with all clinical staff.

The practice was aware of those patients at risk of frequent hospital admission. Care plans had been produced for each of these patients. The practice policy was that a GP must telephone the patient within three days of their discharge from any hospital admission.

All GPs and nursing staff were aware of their responsibility to stay updated regarding NICE guidelines. Additionally GPs had their own areas of interest and used clinical meetings and journal club to share information with colleagues.

The practice was aware of its performance against standards for prescribing antibiotics agreed with the CCG.

Management, monitoring and improving outcomes for people

The practice routinely collected information about patients' care and outcomes. The practice undertook regular clinical audits and the Quality and Outcomes Framework (QOF) was used to assess the practice's performance (QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice in their surgeries). We were present at one of the weekly clinical meetings where one of the GPs presented the findings of their most recent medicines management audit. This included discussion of the learning from the audit the timescale for re audit.

The practice regularly reviewed their achievements against QOF. The practice manager was a regular attender at locality practice meetings where representatives from neighbouring practices met to discuss ways of improving outcomes for their patients. The QOF data was actively

Good

Are services effective?

(for example, treatment is effective)

monitored at the practice and GPs were made aware of any shortfalls that needed to be addressed. Administration staff were responsible for tracking certain streams of information such as asthma and chronic obstructive pulmonary disease (COPD) and calling patients into the surgery for health checks. One of the GP partners had a special interest in cardiology ran a weekly cardiac monitoring clinic for palpitations and BP monitoring for patients attending practices within the CCG. The GP was supported by a health care assistant who was trained to perform 12 lead ECG recording and to fit and remove 24 hour blood pressure monitors.

QOF data showed the practice performed well in comparison to local practices. For example, the blood pressure reading in the previous nine months for patients with hypertension was 150/90 mmHg or less. The practice showed us six clinical audits that had been undertaken in the last 12 months three of these were completed audits where the practice was able to show what actions had been taken since the initial audit and these were recorded. Completed audit cycles included prescribing for anxiety and depression, prescribing of medicines for diabetes and an audit of 'two week rule' oncology referrals.

The practice GPs told us they all had responsibility for keeping up to date with recent guidance. Updates in guidance from the NICE were discussed at the weekly clinical meetings. One of the GPs was the joint lead for maternity and child health for the CCG and shared recent guidance and best practice with the GPs and nurses.

Effective staffing

All the staff we spoke with in both clinical and administrative roles told us they were well supported by the GPs and the practice manager. There was a system of induction in place for newly recruited staff. All staff as part of their induction received the practice's induction handbook which had been regularly reviewed to ensure it contained relevant up to date guidance.

There was an annual appraisal system in place for staff. Staff we spoke with confirmed they had taken part in an annual appraisal and had been able to use the protected time to discuss any concerns they may have, around patient care or practice management, and their own personal development. Staff told us the practice organised staff training in a number of areas and supported staff to attend relevant training. The practice manager told us that wherever possible they organised face to face training as a more effective alternative to e learning. Nursing staff had taken part in a range of training courses to improve patient care such as diabetes, flu updates and yellow fever. All practice staff had received training in basic life support, information governance and child and adult protection. GPs took part in a peer review appraisal; these appraisals would form part of their future revalidation with the General Medical Committee (GMC). All GPs were aware of the appraisal schedule and revalidation dates for their colleagues. One GP had completed their revalidation in February 2014 with the other GPs due for revalidation in 2015.

During our inspection we spoke with five patients and reviewed 25 comment cards. They all commented positively on the availability of appointments, how quickly their telephone calls were answered and waiting times once they were at the practice. There was sufficient staff available to meet their needs.

Working with colleagues and other services

The practice worked with others to improve the service and care of their patients. There were arrangements in place for other health professionals to use the practice premises to provide services to patients. These included a physiotherapist, a counsellor, a clinical psychologist, health visitors and community pulmonary and cardiac rehabilitation teams. Antenatal and postnatal care was provided by visiting midwives and health visitors. One of the GP partners who had a special interest in women's health and obstetrics was a point of contact for midwives to liaise about cases or concerns. GPs and nurses worked closely with health visitors, community nurses and the community mental health team (CHMT).

The practice held weekly clinical meetings to which other health care professionals were invited to attend when appropriate. We attended a clinical meeting on the day of our inspection. This meeting was attended by all the GPs, practice nurses and the practice business manager. This gave the GPs and nurses the opportunity to discuss specific concerns to ensure the best treatment outcomes for patients. The practice had adopted the principles of the Gold Standards Framework in relation to end of life care. We saw meeting minutes that showed palliative care nurses attended clinical meetings once a month to discuss the care needs of specific patients.

There were systems in place to ensure that the GPs reviewed the diagnostic and blood test results, received

Good

Are services effective?

(for example, treatment is effective)

from other health care providers, for their patients. Administration staff collated information in a variety of formats from the Out of Hours provider or from other organisations. Any information relating to patients was highlighted to the GPs for checking. They were then able to take immediate action if required.

Information Sharing

Patient information was stored securely on the practice's electronic record system. Patient records could be accessed by appropriate staff in order to plan and deliver patient care. The practice had historic paper patient records which were used if necessary to review medical histories.

Reception and administration staff had systems in place to add to patient records information that was received from other healthcare providers. We saw that information was transferred to patient records promptly following out of hours or hospital care.

The practice ensured that the out of hours and ambulance service were aware of any relevant information relating to their patients. For example care plans that were in place for patients with complex medical needs were shared with the out of hours and ambulance services. These services were also made aware of any patient whose end of life was being managed at their home

The weekly clinical meetings had time set aside for information sharing with multidisciplinary input for discussions of complex patients, these meetings were minuted.

Consent to care and treatment

When patients did not have capacity for decision making the staff we spoke with gave us examples of how the patient's best interest was taken into account. For example discussions had taken place with the CMHT in relation to one patient who had temporary loss of capacity.

GPs we spoke with demonstrated a clear understanding of Gillick competencies for under 16 year olds making decisions and were familiar with using the assessment.

We found that staff were aware of the principles of the Mental Capacity Act 2005 (MCA). GPs had attended specific training and provided guidance for other staff. All practice staff had attended protection of children and vulnerable adults training which had included reference to the MCA and Children's Act 2004.

We saw how consent to treatment, or when treatment was declined, this was recorded. For example child immunisations or where a patient declined the offer of a chaperone for an examination.

The practice had surveyed their patients about the proposal to make their own health records accessible on line for their personal use, as they do with appointments and prescriptions, and the future use of summary care records for patients. The practice had given patients information on their website to ensure they understood how to opt out if they did not want their medical information used in this way.

Health Promotion & Prevention

All new patients to the practice were offered a health assessment to ensure the practice was aware of their health needs.

The practice had a range of health promotion leaflets in their waiting rooms and other areas. Noticeboards were used to signpost patients to relevant support organisations such as hospice care. The practice leaflet was available at the practice and was also available on their website. The practice leaflet gave useful contact details for national support organisations and community drug services.

Practice nurses had specialist training and skills, for example in the treatment of asthma, diabetes and travel vaccinations. The practice offered a full travel vaccination service and is one of four yellow fever centres in the CCG area. This enabled nurses to advise patients about the management of their own health in these specialist areas.

The practice offered NHS Health Checks to all its patients aged over 40. These were carried out by the practice nurses and health care assistants who would discuss the findings with patients and refer to a GP if a medical opinion or diagnosis was required.

All patients with learning disability were offered a physical health check and all had received a check up in the last 12 months. The practice carried out some of these health checks in the patient's own home to ensure the patient felt as relaxed as possible and were supported by their carer in familiar surroundings. Appointments for other patients with a learning disability were carefully planned by the practice to ensure they did not wait for a long time and become agitated or arranged at lunch time when the practice was quiet.

Good

Are services effective?

(for example, treatment is effective)

The practice offered a full range of immunisations for children and data showed that the practice had vaccinated a high percentage of eligible children. The percentage of children receiving booster vaccinations at the age of five was slightly lower. This had been identified by the practice. There was a system in place to encourage the uptake of vaccination for five year old children. A member of reception staff worked closely with the senior nurse to repeatedly contact parents to offer the vaccination. Patient records recorded if a parent declined their child's vaccination.

The practice had taken part in a health education initiative lead by the CCG. This campaign was aimed at educating patients and signposting them to the correct NHS services.

The practice recognised that it there was a high level of obese patients in their area and ran a weight loss clinic, run by the senior practice nurse as a slimming coach, to address this. The practice also made referral to weight management programmes or to a local community based healthy living group for exercise.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

During our inspection we spoke with five patients, reviewed 25 comment cards and spoke with a representative from the practice's patient participation group (PPG). Everybody was complementary about the care that they, or the patients they represented, received from all the practice staff. We spoke with patients of varying ages. They all said that they had been dealt with courteously by all staff. We observed staff interacting with patients and we saw that patients were treated with dignity and respect.

We reviewed the most recent data available for the practice on patient satisfaction. This included their own improving practice report, practice information from the NHS England GP patient survey and NHS Choices. The evidence from all these sources showed patients were satisfied with how they were treated and this was with compassion, dignity and respect.

One of the GP partners held a lunchtime gynaecology and contraception clinic at lunchtime. This had been put in place to help maintain confidentiality for patients who did not wish to share with their employer of colleagues that they were attending the practice.

Staff told us how they respected patients' confidentiality and privacy. The majority of telephone calls were answered by staff that were not sitting at the reception desk and ensured that confidential information could not be overheard. We saw this in operation during our inspection and noted that it was effective in maintaining confidentiality. There was a private room available for patients beside the reception area where private conversations could take place. All staff had taken part in information governance training and those we asked were able to demonstrate how they ensured patients privacy and confidentiality was maintained.

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 and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the practice's satisfaction survey (Improving Practice Questionnaire) showed 88% of practice respondents said the GP explained their treatment well, with 85 % responding that the GP or nurse took into consideration their personal situation when discussing or advising on care decisions. Both these results were above average when compared with other practices of a similar size that had completed the survey.

Patients we spoke with on the day of our inspection told us that their GP explained their treatment and all commented that there was enough time to discuss their needs. They also told us they felt listened to and supported by staff that ensured they understood what had been said in order to make an informed decision about the choice of treatment they wished to receive. The comment cards we received were also positive and praised the informative, respectful attitude of the GPs and nurses.

Staff told us that translation services were available for patients who did not have English as a first language. Some staff at the practice were bilingual and could be called on to communicate to patients, if necessary, in seven languages other than English.

Patient/carer support to cope emotionally with care and treatment

On the day of our inspection we attended the practice's weekly clinical meeting. GPs discussed bereaved families and the support they may need. Other patients were discussed including the emotional and practical support that their carer may need. GPs told us that they involved families and carers in end of life care. They ensured that the Out of Hours service was aware of any information regarding patients' end of life needs. One of the patients who provided feedback told us of the support they had received during a recent bereavement and praised the caring attitude of all the practice staff.

The practice ensured the Out of Hours service received specific patient health records. This included individualised information about patients' complex health, social care or end of life needs.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Whenever possible patients were offered the GP of their choice or were directed to the GP who, through a special interest or extended training, was best able to meet their needs. All patients over 75 had a named GP in line with current recommendations. The practice felt this ensured continuity of care when necessary or specialised care and treatment if needed.

The practice and all the staff we spoke with were aware of the practice population in respect of age, ethnic origin and number of patients with long term conditions. The practice had responded to the needs of the practice population. The practice had a high percentage of patients of working age. Early morning, late evening and Saturday morning appointments were available for patients who could not attend during weekdays due to work commitments. In total the practice offered 4.5 hours of extended hours surgeries per week. The practice had a large number of diabetic patients and had a system of longer combined appointments with the health care assistant to make general heath checks and followed by time with the GP. The health care assistant and phlebotomist (a person who has been trained to take blood samples) at the practice were able to carry out INR blood tests for patients (this is a measurement used to determine the effects of medicines to slow down blood clotting, such as warfarin, on the body's blood) a tool could then be used to calculate the correct dose for. This service meant that patients did not have to travel long distances to the hospital INR clinic.

The practice staff including those in reception were aware of those patients who had poor mental health. Reception staff were able to offer immediate appointments to those patients known to them and told us that some patients felt comfortable telling them if they were in crisis.

The practice had a patient participation group (PPG). The group had been consulted about the questions for the annual patient survey carried out between December 2013 and January 2014. Most of the questions for that survey were aimed at gaining patients' opinions on the appointment system and access to appointments. Following the survey the PPG had agreed a plan of action with the practice for changes and in response to the outcome of the survey. The practice manager told us that the practice was constantly reviewing the appointment system following feedback from patients. The practice manager attended a monthly meeting of practice managers from the North East Hampshire and Farnham Clinical Commissioning Group (CCG). This forum had been used to share best practice ideas for improving the appointments system for patients.

A member of the PPG made themselves available to the inspection team and were keen to promote and compliment the responsiveness of the practice. They explained how they worked with the practice for the benefit of patients. There was evidence of regular PPG meetings; some were attended by the practice manager and some by a GP, the PPG representative told us that some were only held for PPG members for private discussion with the ability to feedback to the practice afterwards.

There had been a low turnover of staff at the practice in recent years which enabled good continuity of care and accessibility to appointments with a GP of choice. All patients needing to be seen urgently were offered same-day appointments. There was the choice of a telephone consultation and GPs operated an 'overflow' clinic where those patients who could not be given specific appointments were seen at the end of a morning session.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services, e.g. those with a learning disability, the elderly living in care homes, the under-fives, patients who had work commitments, patients with carers who also worked and those with long term conditions. The practice provided GP access for patients from Hampshire and Surrey who other GPs had refused to see at other practices. The appointments were longer than usual and where appropriate a security guard was present.

The practice provided health checks for some of their patients who had a learning disability and lived in the community. It had been identified that these patients were more relaxed in a familiar environment so GPs and nurses made arrangements to carry out these checks in their home. Staff told us that they plan appointments carefully for certain patients with a learning disability to ensure they do not wait for a long time and become agitated or plan appointments at lunch time when the surgery is quiet. The practice had a number of older patients who lived in residential care. If these patients required a GP they were visited in their care home. The GPs used these visits to

Good

Are services responsive to people's needs?

(for example, to feedback?)

speak with or monitor the health of any other of their patients who lived in the same residential care. Practice nurses visited housebound patients to administer flu vaccinations.

The majority of staff had also undertaken training in equality and diversity and could demonstrate that they promoted equality in the practice.

The premises were purpose built and had been designed to meet the needs of people with disabilities. The premises were accessible to patients who used wheelchairs. The practice had facilities for patients with a disability and an area of the reception desk was at a lower level for patients who may use a wheelchair. However this area was used for the touchscreen booking system so was no longer of use to patients who may use a wheelchair. There was a lift that provided access to first floor.

Access to the service

Information relating to the practice opening hours was available on the practice website and in the practice leaflet. These gave information for patients on how they could book appointments and organise repeat prescriptions online. Patients could also make appointments by telephone and in person to ensure they were able to access the practice at times and in ways that were convenient to them. Opening hours were from 8 am to 6.30 pm with appointments available between 9 am and 11.30 am and 3.30 pm and 5.30 pm. Specialist clinics were held outside these times. Extended hours were available as a minimum two Saturday mornings and two early morning/late evening surgeries per month. We were told that early morning surgeries started at 7 am.

Patients we spoke with told us they had not encountered any problems making appointments when they needed them. They told us that they were able to get emergency appointments on the day they needed but sometimes had to wait a few days to get a routine appointment or to see the GP of their choice. Patients did not have a named GP but those we spoke with were happy with this arrangement and usually saw the GP of their choice. We spoke with five patients, a representative of the PPG, looked at feedback that had been left on NHS choices and reviewed 25 comment cards. Most patients felt that they could access a GP when they needed to. The patients we spoke with were clear about how the practice operated their appointment system.

Reception staff explained the appointment booking system. Patients could telephone the practice or book routine appointments on line. Telephone consultations were also available to enable patients to speak with a GP. Clear details of the appointment system were available in the practice leaflet and on the practice website. The practice had an 'on call' GP available every day and an 'overflow' clinic with unlimited capacity to ensure that any patient who felt they need to see a GP could do so.

There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. This was provided by an Out of Hours service. 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 about the Out of Hours service was also provided to patients in the practice leaflet and on the website.

We saw a copy of a completed audit which showed that the practice had monitored their own performance in relation to responding quickly to patients needs when referring to secondary care within recommended time frames. The audit had included analysing the response rate of secondary care in providing appointments and starting active treatment.

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 the practice manager was the designated responsible person who handled all complaints in the practice.

Accessible information was provided to help patients understand the complaints system this was set out in the practice leaflet, on the practice website and displayed in the practice. Patients were asked to put complaints in writing. Information on the practice website and in the practice leaflet did not give guidance about making a verbal complaint or how people could be supported if they wanted to make a complaint.

Evidence seen from reviewing a range of feedback about the service, including complaint information and supporting operational policies for complaints and whistleblowing, showed that the practice responded quickly to issues raised. The record of complaints showed

Good

Are services responsive to people's needs?

(for example, to feedback?)

that all complaints had been responded to in a courteous manner by the practice manager. Any comments made about the practice on the NHS Choices website had been responded to by the practice manager, either thanking the patient for their positive comments or encouraging the patient to approach the practice to allow them to address their concerns.

The practice regularly analysed complaints to ensure that any themes or trends were identified and to improve the service patients received as a result of feedback.

There was evidence of shared learning from complaints with staff. We noted from minutes of meetings and by talking with staff that complaints were discussed to ensure all staff were able to learn and contribute to improvements at the practice.

Are services well-led?

Good

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

Our findings

Vision and Strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. Their ethos was to promote an open culture and teamwork where each person played their role. Decisions were made democratically and patient care was frequently shared by GPs.

We spoke with four GPs, two practice nurses, the practice manager and a number of reception and administration staff. They all knew and understood the practice values and knew what their responsibilities were in relation to these.

All staff felt able to make suggestions to improve outcomes for patients for example in relation to appointment systems or from personal research or learning. GP and nursing staff used weekly clinical meetings, clinical audit and journal club (GPs meet to discuss recent scientific articles) to share and discuss information to improve effective patient care.

The practice had worked with other practices towards providing improved services for their patients. Patients described the practice as caring and friendly.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff.

The practice held annual governance meetings; additionally governance was a regular agenda item for weekly clinical meetings. We attended a meeting and looked at minutes from meetings. We found that performance, quality and risks were discussed.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance and to monitor the effectiveness of some aspects of the practice, for example the identification of disease and unplanned hospital admissions. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was discussed at weekly meetings and regularly monitored and reviewed to maintain or improve outcomes.

The practice manager told us that they met with other practice managers from the North East Hampshire and Farnham Clinical Commissioning Group (CCG) each month. This gave the practice the opportunity to measure their service against others and work collaboratively to identify best practice.

Clinical audits were regularly undertaken by the practice GPs. We saw evidence of completed audit cycles.

Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. For example in relation to the provision of care for patients who had a history of violence or inappropriate behaviour, to assess the risk to the safety of the practice staff.

The practice manager and GPs demonstrated leadership in their governance arrangements as they used the information from incidents and significant events to minimise risk by identifying trends and themes that may affect care and service quality.

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 partners was the lead for prescribing and was the practice's Caldecott Guardian. The weekly clinical meetings were used for GPs to cascade information to colleagues. The GPs all felt they had a collective responsibility for making decisions and monitoring the effectiveness of clinical practice through audits or specialist training. The practice manager was responsible for the day to day running of the service and assessing, monitoring and developing non-clinical staff whose roles were in reception or administration.

The leadership was established at the practice as GP partners and the practice manager had been in their roles for a number of years. All the staff we spoke with told us they felt supported by the practice manager and GPs. All staff confirmed there was an open culture and felt that they could question each other about their working practices. Staff we spoke with felt able to go to any senior staff member with any problems, concerns or ideas. All staff were clear about their roles and responsibilities and that they were provided with opportunities for development and training. Appraisals were carried out annually and training was supported by the GP partners and practice management. We saw that serious events were reported and discussed at weekly GP meetings for learning and not to apportion blame. Staff informed us that communication within teams and across the service was good with information shared appropriately.

Are services well-led?

Good

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

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example anti-discrimination/equal opportunities policy, flexible working policy and disciplinary procedure, which were in place to support staff. We were shown a copy of the staff induction handbook that was available to all staff, this included operational procedures and protocols such as first aid and data protection.

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

The practice had gathered feedback from patients through an Improving Practice questionnaire, a survey carried out with the patient participation group (PPG), the NHS Choices website and patient compliments and complaints.

We looked at the results of the annual patient survey and 90% of the responses had been good, very good or excellent. Areas achieving lower satisfaction scores, although above national average, related to telephone access. The practice manager and reception staff were able to tell us of the changes to the appointment systems that they continued to make to improve this service to patients. The practice used sections of the patient survey to specifically get feedback on the GPs' interpersonal skills. All surveys had been analysed and an action plan was in place to address any areas for improvement.

The practice had an active PPG however it did not contain representatives from all ages of the patient population. We spoke with a representative of the PPG who explained how they and the practice had actively tried to recruit to the group. PPG members spent time in the practice, introduced themselves to patients in the waiting room and encouraged feedback. We saw minutes of three PPG meetings when the practice manager had attended and the actions taken by the practice in response to patient feedback, such as reception staff communicating to patients if GPs were running late.

There had been 154 responses in the patient survey which was conducted between December 2013 and January 2014. The survey questions had been developed collaboratively with the PPG and sent to the patient reference group, (the patient reference group is a group of patients who have agreed to be contacted once or twice a year for their views thoughts and opinions of the practice) and other patients who visited the practice at that time. Questions were focused on the access to GP consultations for patients and to assess patient views about the trialling of 8am opening. Other questions were used to gauge patient responses to proposed changes in the appointment system. The practice manager showed us the analysis of the survey which had been developed and discussed with the PPG. The results and actions of the survey were available for patients on the practice website.

Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. The practice had a whistle blowing policy which was available to all staff in the staff handbook and electronically.

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We saw that regular appraisals took place and there was an appraisal plan for the coming year. Staff told us that the practice was very supportive of training and where possible training took place at the practice.

The practice had completed reviews of significant events and other incidents and shared these with staff at meetings or discussed informally as appropriate to ensure the practice improved outcomes for patients. For example staff had the opportunity to reflect on a medical emergency that had taken place. All staff were able to contribute to the learning process and to make suggestions for future training. The practice had supported staff following the incident and had acknowledged their professional and efficient actions.