

The Liphook and Liss Surgery

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?

Requires improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Good



Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Liphook and Liss Surgery on 21 July 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing, well-led, effective, caring and responsive services. It was also good for providing services for older people, people with long term conditions, families children and young people, working age people (including those recently retired and students), people whose circumstances may make them vulnerable and people experiencing poor mental health (including people with dementia). It required improvement for providing safe services.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.

- Risks to patients were assessed and well managed, with the exception of those relating to fire safety.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

Summary of findings

- Patients had the facility to attend the practice's other site that had different late night and Saturday opening if this is more convenient for them.
- The practice delivered medicines to housebound patients.
- The practice used photography as a means of diagnosis and comparison of GP diagnostic skills.
- The practice had a very detailed carer's policy which they shared widely. The support they offered carers included, telephone ordering of prescriptions, flexibility and priority of appointment times and home visits to address the carers own health issues. The practice offered support for carers to document a plan for the person they cared for should the carer have a medical emergency. There was an opportunity for carers to get together advertised in the waiting room which was supported by the practice and patient participation group.

- The patient participation group (PPG), supported by the practice GPs organised an information evening, with guest speakers, on the subject of dementia. The event was publicised in the local press and was open to all people in the area.

However there were areas of practice where the provider needs to make improvements.

Importantly the provider must:

- Ensure a full risk assessment is in place for the management of fire safety. Staff must receive training in relation to fire safety.

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 is rated as requires improvement for providing safe services. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. Reviews and investigations were thorough and lessons learned were shared with all staff to support improvement. However we found that risks to patients and staff in relation to fire safety had not been fully assessed. All fire equipment had been tested; a fire procedure was in place for fire safety but this had not been reviewed for a number of years. There were no appointed fire marshals; there was no record of fire training for staff.

Requires improvement



Are services effective?

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet those needs. There was evidence of appraisals for all staff. Staff worked with multidisciplinary teams.

Good



Are services caring?

The practice is rated as good for providing caring services. Patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality. There was a detailed carers' policy with full details of the services the practice could offer to those patients who were also carers.

Good



Are services responsive to people's needs?

The practice is rated as good for providing responsive services. Patients told us it was easy to get an appointment with a named GP or a GP of choice, there was continuity of care and urgent appointments available on the same day. The practice had good facilities and was well equipped to treat patients and meet their

Good



Summary of findings

needs. Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.

The practice acted on suggestions for improvements and changed the way it delivered services in response to feedback from the patient participation group.

Are services well-led?

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. 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 is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. The practice GPs worked on a rota with another practice to provide daily ward rounds in a care home and community hospital for patients recently discharged from an acute hospital. The practice delivered medicines to housebound patients.

Good



People with long term conditions

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medicine needs were being met. There was a pathway of care for patients provided by healthcare assistants and nurses with support and oversight from GPs. For those patients with the most complex needs there was liaison with other relevant health and care professionals and specialist teams to deliver a multidisciplinary package of care.

Good



Families, children and young people

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances or who were at risk. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

Good



Working age people (including those recently retired and students)

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of this group of patients had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services such as; booking appointments and ordering of

Good



Summary of findings

prescriptions. Telephone consultations were available each day which could negate the need for patients to visit the practice. The practice provided a full range of health promotion and screening that reflected the needs of this population group.

People whose circumstances may make them vulnerable

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice carried out annual health checks for people with a learning disability and data for the year ending March 2015 showed that 89% of patients with a learning disability had received an annual health review. The practice supported patients in two local care homes for people with learning difficulties. Care plans were in place for these patients and GPs visited when requested to do so.

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

Good



People experiencing poor mental health (including people with dementia)

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). 92.5% of people experiencing poor mental health had received an annual physical health check in the preceding 12 months. The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia. The practice had produced comprehensive, agreed care plans for over 94% of their patients experiencing poor mental health.

The practice had sign posted patients experiencing poor mental health to appropriate services and had supported them in accessing those services.

There had been a recent information evening organised collaboratively between the practice and the patient participation group on the subject of dementia. Speakers included a dementia consultant and a representative of the Alzheimer's Society.

Good



Summary of findings

What people who use the service say

As part of our inspection process, we asked patients to complete comment cards prior to our inspection.

We received 33 comment cards, spoke with four patients and a member of the Patient Participation Group. All comments received indicated that patients found the reception staff, GPs and nurses helpful, caring and polite and described their care as very good. There were many positive comments from patients about the way in which the GPs and nurses explained their treatment options and the advice they gave. However three patients used the comment cards to describe their poor experience of the practice's appointment system.

Patients' comments were in line with results received from the National GP Patient Survey. For example, the national GP patient survey results for 2014 showed that over 91% of patients described their overall experience of this practice as good.

Results from the National GP Patient Survey also showed that 87% of patients found it easy to get through to the practice by phone and 94.2% said that the last GP they saw or spoke with was good at treating them with care and concern. The survey showed that 100% of patients stated that they had confidence and trust in the last GP they saw or spoke to. These results are significantly higher than the national average.

Areas for improvement

Action the service MUST take to improve

- Ensure a full risk assessment is in place for the management of fire safety and staff receive training in relation to fire safety.

The Liphook and Liss Surgery

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, a specialist advisor in practice management and a CQC Pharmacist Inspector.

Background to The Liphook and Liss Surgery

The Liphook and Liss Surgery is a dispensing practice located at Station Road, Liphook, GU30 7DR. (Dispensing practices have a dispensary with trained staff. This allows the practice to dispense medicines to their patients who live more than one mile, as the crow flies, from their nearest pharmacy).

Liphook is a village popular with people who commute to work in London. The practice has a personal medical services (PMS) contact to provide services to approximately 10,000 patients from these premises and from their other site in the rural village of Liss approximately six miles away. The Liphook and Liss Surgery is part of the South Eastern Hampshire Clinical Commissioning Group. We did not inspect the services provided from the premises in Liss, although we did inspect the dispensary in Liss as all dispensing is coordinated from that site.

The practice has two male and six female GP partners. The GPs in total provide the equivalent of 6.3 full time GPs. Support is also provided by six part time practice nurses, two of whom are nurse prescribers, and three part time health care assistants. The practice is further supported by a practice manager and an assistant practice manager, reception and administrative staff and dispensary staff.

The practice is open Monday to Friday 8am to 6.30pm with extended hours on a Monday between 6.30pm and 7.30 pm. These late evening appointments alternate between the practice's two sites. The practice provides Saturday morning appointments two Saturdays each month these also alternate with their site in Liss.

The GPs at this practice have opted out of providing out of hours services to their patients. When the practice is closed out of hours care and treatment can be accessed through the NHS 111 telephone number.

The Care Quality Commission draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality and Outcomes Framework, the National Patient Survey and data from Public Health England. This data shows that the practice provides care and treatment to a higher than average number of patients who are over the age of 40 compared with the average for England, with a much lower than average number of patients between the ages of 20 and 39.

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.

Detailed findings

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

How we carried out this inspection

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

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

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 the practice we reviewed information we held and asked other organisations and key stakeholders to share what they knew about the practice. We also reviewed policies, procedures and other information the practice provided before the inspection day. We carried out an announced visit on 21 July 2015.

We spoke with a range of staff including three GPs, the practice nurse, a healthcare assistant, reception staff and administration staff, on the day. We sought views from a representative of the patient participation group, looked at comment cards and reviewed survey information.

Are services safe?

Our findings

Safe track record and learning

There was an open and transparent approach and a system in place for reporting and recording significant events. People affected by a significant event received a timely and sincere apology and were told about actions taken to improve care. Staff told us they would inform the practice manager or their assistant of any incidents. All staff had access to the shared drive on the practice computer system where they could record any incidents to be dealt with by the practice manager. The practice carried out an analysis of the significant events. These were discussed at each of the practice sites before being further analysed at practice meetings.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. Lessons were shared to make sure action was taken to improve safety in the practice.

Safety was monitored using information from a range of sources, including National Institute for Health and Care Excellence (NICE) guidance. This enabled staff to understand risks and gave a clear, accurate and current picture of safety. Patient safety alerts were received by the practice directly to the practice manager's email address. The practice had recognised this may represent a risk if the practice manager's emails were not monitored during any absences. The practice was in the process of arranging for these alerts to be received to a generic email address, accessible to a number of staff to ensure any urgent alerts were actioned and recorded without delay.

Overview of safety systems and processes

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

- Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. One of the GP partners was the lead member of staff for safeguarding. The GPs attended safeguarding

meetings when possible and provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training relevant to their role.

- A notice was displayed in the waiting room, advising patients that nurses would act as chaperones, if required. All staff who acted as chaperones were trained for the role and had received a disclosure and barring checks (DBS). (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- There were procedures in place for monitoring and managing risks to patient and staff safety except in relation to fire safety. The practice had conducted a premises risk assessment during which some risks in relation to fire had been assessed. The practice did not have a specific fire risk assessment. We saw there was a fire procedure dated July 2002 and reviewed in 2003. This was brought to the attention of the practice and the procedure was reviewed and updated on the day of our inspection. The procedure did not name trained fire wardens but stated the evacuation was to be coordinated by the practice manager, their assistant or a senior GP. There was no record of training for this role and no recorded fire safety training for staff, the practice staff acknowledged that any training they had received was a number of years ago.
- All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice also had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health, infection control and legionella.
- Appropriate standards of cleanliness and hygiene were followed. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result. However we saw the last audit had recorded that elbow taps were available in all treatment rooms. This had not taken into the consideration that a

Are services safe?

consulting room was currently being used as a treatment room by the health care assistant. A premises audit in May 2015 had prioritised the need to change the hand wash sink taps and remove the carpets in that room.

- Medicines kept for emergency use and for use within the practice were kept safely and at the correct temperatures for optimum effectiveness. There were processes in place to check that medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates.

Systems were followed to manage medicines kept at the practice to ensure safety. There were written protocols to give instructions to staff on these systems. Records were kept of the fridge temperatures. This included the recording of minimum and maximum temperatures reached and the records showed that temperatures were within the required range.

Vaccines were administered by nurses using patient group directions that had been produced in line with legal requirements and national guidance. All patient group directions we looked at were in date and signed by a doctor and the nurse practitioners using these protocols. Some medicines were given against patient specific directions and these were produced in line with legal guidance and ensured safe practices were followed.

Repeat prescription systems in place were effective and allowed for continuity of prescribed treatment. Repeat prescriptions for high risk medicines were only issued following authorisation by the doctor through internal communication to confirm required monitoring was in place. Routine repeat prescriptions for medicines which were within their review date and did not require monitoring were dispensed and handed to patients without being signed by a doctor. These were signed by the GP within 24 hours of collection by the patient which is not in accordance with current best practice guidance. This was raised with the practice at feedback and they have confirmed that they have changed this system. Blank prescription forms and prescription pads were handled in accordance with national guidance and kept securely at all times.

Medicine alerts were cascaded to relevant staff by the practice manager and confirmation received that action had been taken. There was a governance process in place for all near misses and significant events to be logged and corrective action taken to prevent similar incidents happening again.

- Recruitment checks were carried out and the files we reviewed showed that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring (DBS). We also carried out spot checks of a further four files to ensure DBS checks had been carried out and recorded for all staff.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for the different staffing groups to ensure that enough staff were on duty.

Arrangements to deal with emergencies and major incidents

There was an instant messaging system and emergency alert on the computers in all the consultation and treatment rooms which alerted other staff to any emergency. All staff received annual basic life support training and there were emergency medicines available in the treatment room. The practice had a defibrillator available on the premises and oxygen with adult and children's masks. There was also a first aid kit and accident book available. Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use.

The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice carried out assessments and treatment in line relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice had systems in place to ensure all clinical staff remained up to date. The practice had access to guidelines from NICE and used this information to develop how care and treatment was delivered to meet patients' needs.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF). (This is a system intended to improve the quality of general practice and reward good practice). The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. Current results were 98.9% of the total number of points available, with 11.3% exception reporting. This practice was not an outlier for any national or QOF (or other national) clinical targets. Data from 2013 to 2014 showed;

- Performance for diabetes related indicators was better (99.7%) than the clinical commissioning group (CCG) (92.5%) and national average (90.1%)
- The percentage of patients with hypertension intervention related indicators was better (92.4%) than the CCG (92.1%) and national average (88.4%).
- Performance for mental health related indicators was better (100%) than to the CCG (82.1%) and national average (90.4%).
- The percentage of patients diagnosed with dementia whose care had been reviewed in a face to face review in the preceding 12 months was (81.82%) which was lower than the CCG average (85.8%) and the national average (83.82%)

Clinical audits were carried out to demonstrate quality improvement and all relevant staff were involved to improve care and treatment and patients' outcomes. There had been a number of single cycle clinical audits completed in the last two years. We also saw examples of six completed audit cycles where the improvements made were implemented and monitored. The practice participated in applicable local audits, national benchmarking, accreditation, peer review and research.

Findings were used by the practice to improve services. For example, an audit had been carried out of patients being treated for asthma and other breathing difficulties and the medicines they were receiving. Recognised guidance including that from National Institute of Care Excellence (NICE) is that regular or prolonged use of steroids posed a risk to patients of osteoporosis. The learning from the first audit was that all patients should be made aware of the risk of osteoporosis with their treatment and that appropriate preventative measures should be taken. The second cycle of the audit showed a clear improvement in the number of patients with a record of the advice they had been given and the number of patients who were taking appropriate medicines to reduce the risk of osteoporosis.

The practice had worked with a consultant dermatologist to improve the outcomes for patients presenting at the practice with skin lesions. The practice used a dermatoscope to take magnified images of the patient's skin lesion; any lesions causing concern were referred directly to the consultant. Other lesions were discussed with the dermatology consultant and the photographic record was kept as a reference tool for the practice GPs when diagnosing any unidentified skin lesions.

An audit of dermatoscope pictures showed that of 36 patients sent on to secondary care 20 received the same diagnosis as that taken from the photograph alone. The other 16 patients had a diagnosis of a less significant nature. There was a single audit of dermatoscope pictures which had been unable to assess the number of referrals to secondary care that the system had prevented. However GPs told us the audit had confirmed their increased confidence in their diagnosis skills and continued to improve the quality of the dermatoscope images with a view to sharing them online with the consultant. Dermatoscopy was routine for all patients attending the practice with any type of skin lesion to allow GPs to discuss with their peers for early diagnosis and further monitoring.

Effective staffing

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

- The practice had an induction programme for newly appointed non-clinical members of staff that covered such topics as health and safety and confidentiality. There was no reference to staff requiring training in fire safety apart from ensuring they were aware of exits, fire extinguishers and assembly points.

Are services effective?

(for example, treatment is effective)

- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet these learning needs and to cover the scope of their work. This included ongoing support during sessions, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and facilitation and support for the revalidation of GPs. All staff had taken part in an appraisal within the last 12 months.
- Staff received training that included: safeguarding, basic life support and information governance awareness. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system. This included care and risk assessments, care plans, medical records and test results. Information such as NHS patient information leaflets were also available. All relevant information was shared with other services in a timely way, for example when patients were referred to other services. Care plans that were developed for those patients with complex needs were shared through the Hampshire Health Record. (The Hampshire Health Record takes information directly from many of the health record systems within Hampshire and creates a combined health record, to give health professionals quick and easy access to patient records).

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

Consent to care and treatment

Patients' consent to care and treatment was always sought in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act

2005. When providing care and treatment for children and young people, assessments of capacity to consent were also carried out in line with relevant guidance. Where a patient's mental capacity to consent to care or treatment was unclear the GP assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment. We saw good examples of capacity assessments clearly documented in the patient records. This ensured that any GP continuing care for that patient had a clear understanding of their needs.

Health promotion and prevention

Patients who may be in need of extra support were identified by the practice. These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. The practice coded any patients at risk of diabetes. These patients were invited into the practice annually for a health check and advice. Patients were signposted to relevant support services. Smoking cessation advice was available from a local support group. Patients who may be in need of extra support were identified by the practice.

The practice had a comprehensive screening programme. The practice's uptake for the cervical screening programme was 79.23% which was comparable to the CCG average of 81.88% and the national average of 78.3%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

Childhood immunisation rates for the vaccinations given to under two year olds ranged from 93.6% to 98.2% which was comparable to the CCG average. The immunisation rates for five year olds ranged from 92% to 97% which was comparable to the CCG average. Flu vaccination rates for the over 65s were 72%, and at risk groups 74.05%. These were above national averages.

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

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed throughout the inspection that members of staff were courteous and very helpful to patients both attending at the reception desk and on the telephone and that people were treated with dignity and respect. Curtains were provided in consulting 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. Reception staff told us they felt able to assess when patients wanted to discuss sensitive issues or appeared distressed, they could offer them a private room to discuss their needs. The practice had centralised the telephone system for the two premises. All calls to the practice were taken in an upstairs room where conversations could not be overheard.

Thirty of the 33 Care Quality Commission comment cards we received from patients were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. Three patients commented on their difficulties accessing appointments. We also spoke with a member of the patient participation group (PPG) on the day of our inspection. They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed patients were happy with how they were treated and that this was with compassion, dignity and respect. The practice was well above average for its satisfaction scores on consultations with GPs. Satisfaction with the receptionists was broadly in line with clinical commissioning group (CCG) and national averages however satisfaction with the practice nurses was below CCG and national figures. For example:

- 91.9% said the GP was good at listening to them compared to the CCG average of 90.1% and national average of 88.6%.
- 93.1% said the GP gave them enough time compared to the CCG average of 89.3% and national average of 86.8%.

- 100% said they had confidence and trust in the last GP they saw or spoke with compared to the CCG average of 97% and national average of 95.3%.
- 94.2% said the last GP they spoke with was good at treating them with care and concern compared to the CCG average of 88.9% and national average of 85.1%.
- 85.1% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 91% and national average of 90.4%.
- 94.5% said they had confidence and trust in the last nurse they saw or spoke with compared to the CCG average of 97% and national average of 97.2%.
- 88.7% of patients said they found the receptionists at the practice helpful compared to the CCG average of 89.7% and national average of 86.9%.

Care planning and involvement in decisions about care and treatment

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

Results from the national GP patient survey we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were above or in line with local and national averages. For example:

- 90.8% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 88.4% and national average of 86.3%.
- 84.8% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 85% and national average of 81.5%.

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

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was

Are services caring?

also a carer. There was a practice register of all patients who were carers and those patients were being supported by the practice, for example, by offering health checks, greater flexibility with appointments, prescription ordering and collection, and referral for social services support. Written information was available for adult carers and young carers on the practice website to ensure they understood the various avenues of support available to them. The practice leaflet requested all carers make themselves known to the practice and to view the carer's policy. A copy of the carer's policy was also available in the waiting room.

Staff told us that if families had suffered bereavement, the senior GP partner or their usual GP visited the bereaved family. This gave the family the opportunity to discuss the family's needs, the GP was able to give them medical advice or support them to find a support service if necessary. During our inspection we observed one of the practice GPs making a number of home visits to a person at the end of life and saw how they did everything they could to make that person comfortable including arranging to personally collect and deliver medicines.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice worked with the local clinical commissioning group (CCG) to plan services and to improve outcomes for patients in the area. For example, one of the GP partners was the chair of the CCG. The practice regularly met with the CCG to discuss and improve services to Patients such as elective referrals to secondary care, A & E referrals and pathology.

Services were planned and delivered to take into account the needs of different patient groups and to help ensure flexibility, choice and continuity of care. For example;

- The practice offered extended hours opening until 7.30pm each Monday and two Saturdays each month. These extended hours alternated between the practice's two sites and provided bookable appointments for patients who could not attend during normal opening hours.
- There were longer appointments available for people with a learning disability.
- Home visits were available for older patients or any patient who would benefit from these. The practice provided regular home visits to patients in 17 care homes in the area.
- Urgent access appointments were available for all people who required them with children and patients with serious medical conditions prioritised.
- There were disabled facilities and translation services available.
- The patient participation group (PPG) had designed a directory of activities and services for patients. This was available in the waiting room and was regularly updated by a PPG member. This included information about activities such as walking football, tea dances and chairbics. (Chairbics are a series of exercises which can be done by people sitting down).

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday. Appointments were from 8.20am until 5.20pm some of these were pre bookable and others were made as a result of the triage system in operation at the practice. Extended hours surgeries were offered at the following times; every Monday until 7.30pm and alternate Saturday mornings, these extended opening hours were alternated

between the two practice premises. In addition to pre-bookable appointments that could be booked up to four weeks in advance, urgent appointments were also available each day for patients who needed them.

Results from the national GP patient survey showed that patients' satisfaction with how they could access care and treatment was better than or comparable to local and national averages and people we spoke with on the day of our inspection were able to get appointments when they needed them. For example:

- 77% of patients were satisfied with the practice's opening hours compared to the CCG average of 77.1% and national average of 75.7%.
- 87.1% of patients said they could get through easily to the practice by phone compared to the CCG average of 84.3% and national average of 74.4%.
- 85.5% of patients described their experience of making an appointment as good compared to the CCG average of 79.8% and national average of 73.8%.
- 69.8% of patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 61.5% and national average of 65.2%.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system, this was available in the practice leaflet and on the practice website. Patients we spoke with were aware of the process to follow if they wished to make a complaint.

We looked at complaints received in the last 12 months and found these had been satisfactorily handled and dealt with in a timely way.

Lessons were learnt from concerns and complaints and action was taken as a result to improve the quality of care. For example, a complaint about the quality of a trainee GP's consultation had been investigated and discussed with the GP. The feedback and learning from this complaint was used as part of the trainee's regular tutorial and reflected on as part of their personal development.

Are services well-led?

Good 

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The practice described their vision and values as good patient outcomes, continuity of care, good record keeping and team working. The practice had a robust strategy and supporting business plans which reflected the vision and values and were regularly monitored.

Governance arrangements

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

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

Leadership, openness and transparency

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

Staff told us that regular team meetings were held. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and confident in doing so and felt supported if they did. Staff said they felt respected, valued and supported, particularly by the partners and the practice management at the practice. All staff were involved in

discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

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

The practice encouraged and valued feedback from patients, proactively gaining patients' feedback and engaging patients in the delivery of the service. It had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. There was an active PPG which met on a regular basis, carried out patient surveys and submitted proposals for improvements to the practice management team. For example, the PPG had suggested a practice newsletter to encourage communication from the practice. This had been put in place and was a collaborate project between the PPG and the practice. An action from the patient survey 2014/15 had been to improve confidentiality at reception desks. The practice had invested in a new telephone system which centralised all calls which were taken by staff in a dedicated telephony room.

The results of the latest friends and family test showed that 93% of patients were extremely likely or likely to recommend the practice.

The practice had also gathered feedback from staff generally through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run. The health care assistant told us how they were involved in the interviews for a phlebotomist who the practice had decided to employ to reduce their workload.

Innovation

There was a strong focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area as the practice was part of the East Hampshire Vanguard Group

The patient participation group (PPG) had recently, supported by the practice GPs, organised an information evening, with guest speakers, on the subject of dementia. The event was publicised in the local press and was open

Are services well-led?

Good 

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

to all people in the area. This event followed the success of a similar event they organised last year on stroke. The

organisation was led by the PPG and the practice paid any costs. The event had been advertised in the local press and care homes contacted. The evening was well supported with over 60 people attending and a hand-out produced.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>There was no risk assessment in place in relation to fire safety and staff had not received training in fire safety.</p> <p>How the regulation was not being met</p> <p>The practice did not have appropriate systems, processes and policies in place to manage and monitor risks to the health safety and welfare of patients, staff and visitors to the practice.</p> <p>This was a breach of Regulation 17 (2) (b) of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014 Good Governance.</p>