Dr Hobbs, Dr Bashforth, Dr Sylvester and Dr Ford

Quality Report

Liphook Village Surgery
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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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr. Hobbs, Dr. Bashforth, Dr. Sylvester and Dr. Ford, otherwise known as Liphook Village Surgery on 8 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 required improvement for providing safe 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).

Our key findings were as follows:

- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- Patients had their needs assessed in line with current guidance. The practice promoted health education to encourage patients to live healthier lives.
- Feedback from patients and observations throughout our inspection highlighted the staff were kind, caring and helpful.
- The staff worked well together as a team.
- Administration staff provided individual support to patients when needed.
- Information collected for the quality performance against national screening programmes showed that this practice achieved 93.9% of the total target in 2014, which was slightly below the national average of 94.2%.

Summary of findings

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

Importantly, the provider must:

- Ensure that patient group directions are in date and signed by an authorised person and meet the legal and national guidance.

In addition the provider should:

- Ensure that the induction process for new members of staff includes fire safety procedures and those policies and procedures in relation to fire safety are reviewed and updated as necessary and discussed with staff.
- Ensure there is a policy around remotely accessing patient records away from the practice building.
- Ensure that all staff receive training or refresher training in safeguarding children and vulnerable adults at a level appropriate to their role and that all staff are aware of the GPs who provide the lead for adult and child safeguarding.

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?

Requires improvement

The practice is rated as requires improvement for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Although staff were clear about their responsibilities in relation to safeguarding children and vulnerable adults there was a lack of training for staff at all levels. The practice informed us that this was due to problems accessing appropriate training.

Medicines kept at the practice were stored securely and were in date. However the patient group directions that were in place to administer a range of vaccines had not been signed by a person legally allowed to do so.

Are services effective?

Good

The practice is rated as good for providing effective services. Staff referred to guidance from National Institute for Health and Care Excellence (NICE) and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. Data showed patient outcomes were at or above average compared with national figures.

There was evidence of regular appraisals for all staff where specific learning needs were identified. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. There was plenty of supporting information to help patients understand and access the local services available. We saw that staff treated patients with kindness and respect.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The practice was working towards improving outcomes for patients with diabetes and also to offer 8am to 8pm opening.

The practice provided extended hours appointments up to three evenings each week.

Summary of findings

Are services well-led?

Good

The practice is rated as good for being well-led. Staff were clear about the values of the practice. There were governance systems in place to monitor, review and drive improvement within the practice. There were formal clinical meetings, governance meetings and full team meetings to share best practice or lessons learnt. The practice proactively sought feedback from patients, which it acted on. The patient participation group was active. Staff received inductions and attended training and events appropriate to their roles.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. 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 GPs visited local care homes each week and worked with home staff to produce care plans. Older patients had a designated named GP.

The patient participation group had established a carers group which had developed into a village organisation for the benefit of all carers. GPs sign-posted patients to this group or with the patient's consent arranged for the carers group to make contact.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. The practice was aware of those patients with long term conditions and had processes in place to make urgent referrals to hospital should it be necessary and to arrange longer appointments or home visits where needed. All these patients had structured annual reviews to check their health and medication needs were being met. For those patients with the most complex needs the patient's GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children who were at risk. Staff knew how to recognise signs of abuse in children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours.

Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. We saw examples of children prioritised for urgent same day appointments.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of this group had been identified and the practice had adjusted the

Summary of findings

services it offered to ensure these were accessible, flexible and offered continuity of care. For example the practice offered evening appointments with the GP and telephone consultations were available instead of patients attending the practice. The practice offered online prescription ordering and patients could also book appointments on line.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice had a register of vulnerable patients. There were a group of travellers registered at the practice who were encouraged to stay registered for continuity of care. All staff were aware of the families and their social, cultural and health needs. The practice did not have an enhanced service for the provision of care to patients with a learning disability; however they actively encouraged these patients to attend for annual health checks.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Data showed the percentage of patients diagnosed with dementia that had a face to face review in the preceding 12 months was higher than the national average. The practice was also higher than the national average for the number of patients, experiencing poor mental health, who had an agreed documented care plan in the record.

A psychiatrist held a clinic at the practice once a month which improved access to patients experiencing poor mental health. Practice staff were aware of this patient group through alerts on their records and were flexible with their appointment system to ensure they were seen as quickly as possible.

Summary of findings

What people who use the service say

We spoke with six patients on the day of our inspection and spoke with three members of the Patient Participation Group (PPG).

Patients were complimentary about the practice staff who they said were friendly, polite and respectful. All the patients we spoke with praised the caring and professional GPs and nurses and their ability to respond to both young and older patients' needs. Patients commented positively on the way GPs and nurses listened to them and the way they explained their diagnosis or medicines, they told us that they did not feel rushed.

Our findings were in line with results received from the National GP Patient Survey. For example, the national GP patient survey results published in January 2015 showed that:

- 90.8% of patients described their overall experience of the practice as good.
- 83.9% of patients found it easy to get through to the practice by telephone.
- 90% of patients who responded said the last time they saw or spoke to a GP, the GP was good at giving them enough time.

These results were higher than the national average.

Areas for improvement

Action the service MUST take to improve

- Ensure that patient group directions are in date and signed by an authorised person and meet the legal and national guidance.

Action the service SHOULD take to improve

- Ensure that the induction process for new members of staff includes fire safety procedures and those policies and procedures in relation to fire safety are reviewed and updated as necessary and discussed with staff.
- Ensure there is a policy around remotely accessing patient records away from the practice building.
- Ensure that all staff receive training or refresher training in safeguarding children and vulnerable adults at a level appropriate to their role and that all staff are aware of the GPs who provide the lead for adult and child safeguarding.

Dr Hobbs, Dr Bashforth, Dr Sylvester and Dr Ford

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP and a specialist advisor in practice management.

Background to Dr Hobbs, Dr Bashforth, Dr Sylvester and Dr Ford

The GP partnership of Dr. Hobbs, Dr. Bashforth, Dr. Sylvester and Dr. Ford is situated in The Square in the village of Liphook. It is known as the Liphook Village Surgery. This is in the top 10% of the least deprived areas of the country. The practice is part of the South Eastern Hampshire Clinical Commissioning Group and is located in a purpose built property. There are approximately 5569 patients on the practice list.

The practice has one male and two female GP partners and a female salaried GP. The GPs are supported by a nurse practitioner, two practice nurses and two health care assistants. Further support is provided by a practice manager and assistant practice manager and administrative and reception staff. The practice is open 8.00am to 6.30pm Monday to Friday with evening GP appointments available three evenings until 7.30pm. Patients requiring a GP outside of normal working hours are advised to contact the 111 service to be directed to an external out of hour's service. The number of this service is clearly displayed in the reception area and on the practice website. The practice has a GMS (General Medical Services) contract.

Why we carried out this inspection

We carried out a comprehensive inspection of the services under section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We carried out a planned inspection to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to provide a rating for the services under the Care Act 2014.

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions

Detailed findings

- 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 8 July 2015.

On the day of our inspection we spoke with a range of staff including three GPs, two practice nurses, the assistant practice manager, reception staff and administration staff. We sought views from representatives of the patient participation group and patients attending for appointments that day. We left comments cards for patients to complete in the week leading up to our inspection. No comment cards had been completed by patients commenting on their care or treatment.

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. Significant events had been documented clearly and there was evidence these had been shared with the practice staff to support improvement. In one case the GP had reflected on their practice and had discussed the incident as part of their appraisal. As a result the practice had reviewed the information given to patients as part of the consent process.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of seven significant events that had occurred during the last six months and saw this system was followed appropriately. Significant events were discussed at partners' meetings and staff meetings and a dedicated meeting was held annually to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff.

We tracked a number of incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result and that the learning had been shared. For example when some out of date vaccines were found in a medicines refrigerator clinical staff implemented formal stock rotation and monthly medicines checks. Although all significant event records documented learning points and actions, these sometimes lacked detail. For example one event recorded that staff needed to understand how results were coded, the record did not show haw this would be achieved.

Where patients had been affected by something that had gone wrong they were given an apology and informed of the actions taken to prevent the same thing happening again.

National patient safety alerts were received into the practice by fax or email. These were disseminated to practice staff, who initialled that they had seen and read the alert. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for.

Reliable safety systems and processes including safeguarding

The practice had safeguarding vulnerable adults and children policies in place which were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. In addition there were contact numbers, of local safeguarding teams, displayed within the reception area and consulting rooms. However staff were not consistent in confirming which GP in the practice took the lead for safeguarding vulnerable adults. The practice manager explained that the lead GP responsible for adult safeguarding had recently been changed. This information had not been disseminated to all staff.

Clinicians did not all have recent training in child safeguarding at a level suitable to their role. The Intercollegiate Guideline recommends that all GPs have level three in safeguarding children and young people and nurses and health care assistants should have level two. Two GPs had evidence of level three training in child safeguarding and another confirmed their training was a number of years ago. We saw evidence that the practice had been actively trying to source suitable training for all GPs, nurses and other staff. Staff understood their role in reporting any safeguarding incidents and safeguarding was a standing item at all partners' meetings.

The practice had a computer system for patients' notes and there were alerts on a patient's record if they were at risk or subject to protection.

A chaperone policy was available on the practice's computer system. The practice nurses acted as chaperones if required and a notice was in the waiting room and consulting rooms to advise patients the service was available should they need it. The practice had also

produced a leaflet explaining the policy to patients. Staff had received training to carry out this role and all staff at the practice whatever their role had received a Disclosure and Barring Service (DBS) check.

Medicines management

Regular medicines audits were carried out with the support of the clinical commissioning group (CCG) pharmacy team to ensure the practice was prescribing in line with best practice guidelines. The practice monitored their prescribing habits to ensure patients received optimisation of their medicines. Each week the practice supplied the CCG medicines management team with prescribing data.

The practice had two fridges for the storage of medicines and vaccines. The practice nurses took responsibility for the stock controls and fridge temperatures. We looked at a sample of vaccines and found them to be in date. There was a cold chain policy in place and fridge temperatures were checked daily, this gave staff guidance about the temperature required for the safe storage of medicines and the action to take if the optimum temperature was not maintained.

The nurses used patient group directions (PGDs) to administer vaccines and other medicines that had not been produced in line with national guidance as they were not signed by an authorised person and were therefore not valid. (PGDs are written instructions for the supply or administration of medicines)..

Cleanliness and infection control

All areas within the practice were found to be clean and tidy, treatment rooms were uncluttered.

Treatment rooms had the necessary hand washing facilities and personal protective equipment (such as gloves) was available. Cleansing hand gels for patients were available throughout the building. Clinical waste disposal contracts were in place and waste was stored securely. There were cleaning schedules in place for the contracted cleaners.

The practice nurse was the designated clinical lead for infection control. There was an infection control policy in place. The infection control lead had carried out an infection control audit of the practice shortly before our inspection. An action plan had been produced to address any shortfalls identified. The infection control lead told us there was a plan to meet with the GP partners to prioritise the actions.

Equipment

Staff we spoke with did not raise any concerns about the safety, suitability or availability of equipment. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. We saw that medical equipment had been calibrated and was functioning correctly and accurately. (Calibration is a means of testing that measuring equipment is accurate). Electrical items had been portable appliance tested and were deemed safe to use.

The practice nurse carried out monthly checks on emergency equipment such as the defibrillator and the practice maintained an electronic record of these checks.

Staffing and recruitment

Staff told us there were enough staff to meet the needs of patients and they covered each other in the event of unplanned absences. One of the GP partners had recently left the practice; the partners had appointed a salaried GP to meet patient demand but acknowledged this had caused some temporary disruption to the availability of appointments. The practice made patients aware by adding a message for incoming telephone callers to hear. We did not find any examples where patients had not been able to access a same day GP appointment if their need was urgent.

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. We found that appropriate checks were made before any offer of employment. All GPs and nurses working at the practice had received a Disclosure and Barring Service (DBS) check to ensure they were suitable to carry out their role. There were risk assessments in place for the non-clinical roles showing the decision process when DBS checks had been deemed unnecessary.

The practice used locum GPs very rarely, they ensured they had the results of DBS checks, immunisation status and registration details of their defence organisation before they started work. There was a newly introduced procedure in place whereby the practice carried out DBS checks for GPs and nurses every three years. They were able to monitor the person's continued suitability for their role.

Requires improvement

Are services safe?

Monitoring safety and responding to risk

The practice manager was responsible for the compliance with fire, Legionella and other health and safety regulations for the premises.

There were procedures in place for monitoring and managing risks to patient safety. All new employees working in the building were given induction information for the building which covered health and safety. There was a health and safety policy available for all staff.

The practice had a fire risk assessment and carried out annual fire evacuations. We found that staff had not received specialist training in fire safety since 2012, although this was discussed in the practice at annual evacuations. The fire risk assessment had not assessed the risk to staff in upstairs rooms. We raised this with the practice who immediately completed this aspect of the assessment.

Arrangements to deal with emergencies and major incidents

There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. All GPs and nurses received annual basic life support training and all other staff received this training every three years. All staff were aware of the location of emergency medicines and equipment. The practice had a defibrillator available on the premises and oxygen. All staff were aware of their role and what to do should there be a medical emergency.

Emergency medicines such as adrenalin for anaphylaxis and medicines for acute breathing difficulties were available. These were stored securely and available in the treatment room. The practice nurse had overall responsibility for ensuring emergency medicines were in date and carried out monthly checks. All the emergency medicines were in date.

The practice had a business continuity plan in place for major incidents such as power failure or building damage. This had been tested during recent flooding of the practice. The practice had on that occasion been able to provide care for their patients while dealing with the incident. The business continuity plan referred to a neighbouring practice providing support but it was not documented if this had been formally agreed. The plan contained details of what the practice would do in an emergency which caused a disruption to the service.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners.

The GPs and nurses we spoke with explained how NICE guidance was discussed at meetings and templates created for their electronic record system to ensure that NICE guidance was incorporated into their patient assessment.

All new patients who registered with the practice were offered a full health check which included information about the patient's individual lifestyle as well as their medical conditions. Patients were booked for a longer appointment to discuss their needs and to also be introduced to what services were available in order for them to make best use of the practice. The practice nurse referred the patient to the GP when necessary.

The practice carried out assessments and treatment in line with best practice guidelines and had systems in place to ensure all clinical staff were kept up to date.

The practice used a system of coding and alerts within the clinical record system to ensure that patients with specific needs were highlighted to staff on opening the clinical record. For example, patients on the social services at risk register, learning disabilities and palliative care register.

The practice took part in the avoiding unplanned admissions scheme. The GPs reviewed their individual patients and discussed patient needs at informal meetings to ensure care plans were in place and regularly reviewed.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework system (QOF). This is a system for the performance management of GPs intended to improve the quality of general practice and reward good practice. Data showed that the percentage of patients with diabetes whose last blood pressure reading was 140/80 or less was lower than the national average. The GPs were aware and had discussed this; they were working to improving the outcome for patients. The diabetes lead nurse had been included in all meetings in relation to this.

Information collected for the QOF to review performance against national screening programmes showed that this practice achieved 93.9% of the total QOF target in 2014, which was comparable to the national average of 94.2%.

GPs were involved in clinical audits. Examples of audits included an audit of patients with diabetes to ensure the most up to date method of measurement of glycated haemoglobin was used consistently for patients at the practice and matched the measurement used across the Clinical Commissioning Group (CCG). The first cycle indicated that 32 patients were found to be coded using a former measurement. The audit was discussed in the practice and the second cycle showed that action had been taken to ensure consistency and the practice used the more recent international coding for diabetes control. This helped the practice to achieve good results in QOF in relation to diabetes.

The practice also undertook an audit of the correct coding of those children noted to have child protection issues. The first cycle showed that the coding was no longer accurate. Following the first cycle of this audit the practice delegated a member of staff with the sole charge of recording child protection issues and all partners referred any child safeguarding issues to the lead GP. The second cycle of the audit showed that those children coded as a child in need, on a protection plan or as looked after children were considerably more accurate, with only one wrongly coded record found. There was also a plan to re audit every six months to raise the awareness of staff to those children at risk and to ensure all children with safeguarding issues were correctly coded.

The practice had carried out further audits throughout 2014 and early 2015. For example; the long term use of Temazepam, a medicine used for a variety of reason such as for anxiety and insomnia. Also the identification of patients taking anticoagulation medicines and the review of their dosage. The second cycles for each of these audits had yet to be completed. There was also a second cycle of a review of patients with a potential of osteoporosis diagnosis and the possible prescribing of osteoporosis

Good

Are services effective?

(for example, treatment is effective)

medicines. Although the practice was able to show us that the outcomes for patients had improved by the second cycle there was no analysis of findings or conclusions recorded.

The practice also met with the local CCG to discuss performance and discussed prescribing habits with the CCG pharmacist and sent prescribing data to the CCG medicines management team each week.

The practice held a General Medical Services contract (this is a contract between NHS England and general practices for delivering general medical services and is the commonest form of GP contract) and also provided some CCG led enhanced services such as remote care and minor surgery and for immunisation.

Effective staffing

The practice had an induction programme for newly appointed members of staff that covered such topics as, health and safety and confidentiality. Although the induction policy covered evacuation procedures, fire safety did not form part of a new person's induction into the practice.

Staff received training that included: basic life support, equality and diversity, dementia and health and safety. There was a training schedule in place to demonstrate what training staff had previously received or were due to receive. The practice manager had identified there were gaps in the training of staff in safeguarding children and adults and had not to date secured the required training. Staff were able to demonstrate their knowledge of other subjects such as fire safety and the Mental Capacity Act 2005 however there had either been no recorded training in these subjects or it was a number of years ago. We were told that these subjects were discussed informally at staff meetings.

The practice closed for half a day every three months to accommodate training that was organised by the local CCG.

The practice nurses had attended a variety of external training events. They told us the practice fully supported them in their role and encouraged further training. The nurses were supported to attend meetings and events.

All GPs were up to date with their yearly continuing professional development requirements and they had been or were in the process of being revalidated. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England). There was an annual appraisal system and all members of staff received a formal appraisal.

Working with colleagues and other services

Incoming letters requiring action were immediately passed to the GPs prior to scanning the information onto the patient's notes. Scanning of letters onto patient notes was done the day letters were received into the practice.

The practice held multidisciplinary team meetings every six weeks to discuss patients with complex needs. For example, those with end of life needs or those with multiple long term conditions. These meetings were attended by district nurses and palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate.

Information sharing

Systems were in place to ensure information regarding patients was shared with the appropriate members of staff. Individual clinical cases were analysed at informal meetings between clinicians. The practice operated a system of alerts on patients' records to ensure staff were aware of any issues for example alerts were in place if a patient was a carer.

The practice used the Hampshire Health Record. This is a joint project across Hampshire clinical

commissioning groups for the access to a patients electronic records by registered clinicians only, who

work for the out of hours service, ambulance and emergency services as well as other GPs and hospital consultants. The Hampshire Health Record provides faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours. Patients could choose to opt out of their information being shared in this way.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software

Good

Are services effective?

(for example, treatment is effective)

enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence that audits had been carried out to assess the completeness and accuracy of data entry to these records.

Consent to care and treatment

The practice had a Mental Capacity Act policy in place to help GPs with determining the mental capacity of patients. We spoke with the GPs about their understanding of the Mental Capacity Act 2005 guidelines; they demonstrated a clear understanding of their roles and responsibilities. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision.

The GPs were aware of Gillick competence guidelines for children. Gillick competence is used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

There was a practice policy for documenting consent for specific interventions. A patient's verbal consent was documented in the electronic patient notes with a record of the discussion if it had been necessary to clarify any relevant risks, benefits or possible complications of any care or treatment.

Health promotion and prevention

The practice had a variety of patient information available to help patients manage and improve their health. There were health promotion and prevention advice leaflets available in the waiting rooms for the practice including information on dementia.

The practice also offered NHS Health Checks to all new patients. This allowed practice nurses to sign post patients to additional services such as lifestyle management and smoking cessation clinics or to provide health screening.

The practice's performance for the cervical screening programme was 82.77%, which was above the national average of 81.88%. The practice's immunisation rates were good and in most cases higher than the CCG average. The percentage of eligible patients who received a flu vaccination was higher than the national average.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey carried out between January – March 2014 and July – September 2014 and published in January 2015.

The evidence from all this survey was similar to the responses we received from patients and the Patient Participation Group. The practice satisfaction scores on consultations with doctors and nurses was lower compared with CCG and national averages. For example:

- 87.7% said the GP was good at listening to them compared to the CCG average of 90.1% and national average of 88.6%.
- 95.1% said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and national average of 95.3%
- And was higher where 90% said the GP gave them enough time compared to the CCG average of 89.3% and national average of 86.8%.

Curtains were provided in consulting 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. There was a sliding window at reception to avoid telephone conversations being overheard in the waiting room.

The practice had a confidentiality policy in place and all staff were required to sign to say they would abide to the protocols as part of their employment contract.

Care planning and involvement in decisions about care and treatment

Results from the national GP patient survey showed a lower result where 85% of patients surveyed 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%. The result for the last GP they saw was good at involving them in decisions about their care was 84.3% compared to the CCG average of 85% and national average of 81.5%.

Patients we spoke with on the day of our inspection 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 they wished to receive.

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed that patients were positive about the emotional support provided by the practice but this was slightly below the national and CCG averages. For example:

- 85.9% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 88.9% and national average of 85.1%.
- 87.6% 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%.

The patients we spoke with on the day of our highlighted that staff responded compassionately when they needed help and provided support when required. For example we were told that administration staff had helped a patient to complete forms to claim for a missed holiday owing to illness.

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

The practice had an active patient participation group (PPG) who had started and developed a carers group. This group now operated independently of the PPG but maintained strong links with the group and the practice. GPs had leaflets for the carers group and can signpost patients to them for help and support.

Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by a visit and/or by giving the family advice on how to find a support service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had an established patient participation group (PPG). Adverts encouraging patients to join the PPG were available on the practice's website and in the practice newsletter. The PPG met every six weeks and patient surveys were sent out annually. We spoke with three members of the group who told us the practice had been responsive to all their suggestions or concerns. For example, the PPG had raised concerns about the possibility of overhearing private conversations from reception. The practice had installed sliding windows which could be closed when reception staff were taking telephone calls. The PPG had also responded to the practice's concerns about patients reluctant to using the electronic check in system. Individuals from the group had given their time to come in to the practice to support patients to understand the system.

The practice engaged regularly with the NHS England Area Team and Clinical Commissioning Group (CCG) also with other practices to discuss local needs and service improvements that needed to be prioritised.

Tackling inequity and promoting equality

The practice had very few patients for whom English was not their first language, the practice created alerts for anybody who had communication difficulties. The practice had access to translation services, access for disabled people and a portable hearing loop for the benefit of patients who were hard of hearing.

The practice had an equal opportunities and anti-discrimination policy which was available to all staff on the practice's computer system. There was an equality and diversity leaflet readily available for patients.

Access to the service

The practice was open between 8:00am and 6:30pm Monday to Friday. The practice offered a number of same day urgent appointments with a duty doctor or in the triage clinic led by the nursing team. There were pre- bookable face to face or telephone appointments available each day with the GPs. The practice offered extended hours opening time, with the last appointment at 7.10pm three evenings each week. Comprehensive information about the appointment system was documented in the practice newsletter and opening times were publicised on the practice website.

Members of the PPG told us that this access system worked well and the practice made every effort to provide a high standard of care.

The service offered home visits to those patients who were housebound or too ill to attend the practice. They also provided care in a number of local care homes, nursing homes and a retirement village. This included weekly ward rounds, a weekly surgery for half a day each week and an outreach clinic.

The patient survey information we reviewed showed patients responses to questions about access to appointments. For example:

- 91.8% were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 89.2% and national average of 85.4%
- 71.7% were satisfied with the practice's opening hours compared to the CCG average of 77.1% and national average of 75.7%.
- 82.2% described their experience of making an appointment as good compared to the CCG average of 79.8% and national average of 73.8%.
- 59.7% 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%.
- 83.9% said they could get through easily to the surgery by phone compared to the CCG average of 84.3% and national average of 74.4%.

Listening and learning from concerns and complaints

The practice has a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England.

Information about how to make a complaint was available on the practice's website, in the waiting area and in a leaflet produced by the practice. The complaints policy outlined who the patient should contact if they were unhappy with the outcome of their complaint.

The practice maintained a spreadsheet to monitor and track any concerns or complaints. Lessons learned from

Good

Are services responsive to people's needs?

(for example, to feedback?)

individual complaints had been acted on and improvements made to the quality of care as a result. For example a patient's request for repeat pain relief added to their request for their usual medicines had been overlooked by the GP and not issued. This had caused distress to the patient over a weekend. The complaint was dealt with quickly and a system for future requests put in place for the patient. This was discussed amongst the GPs and lessons learnt to ensure the risk of a similar situation happening again were minimised.

The practice held a complaints and significant events meeting annually to check for trends and to review the learning points identified.

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

Dr. Hobbs, Dr. Bashforth, Dr. Sylvester and Dr. Ford, otherwise known as Liphook Village Surgery aimed to provide high quality, patient centred care and to provide services safely and efficiently to their patients.

Staff we spoke with were aware of the culture and values of the practice and told us patients were at the centre of everything they did.

The practice was engaged with the local clinical commissioning group to ensure services met the local population needs. The practice was appointed as a vanguard site. Each vanguard site will take a lead on the development new care models which will act as the blue prints for the NHS moving forward and the inspiration to the rest of the health and care system.

Governance arrangements

The practice had policies and procedures to support governance arrangements which were available to all staff on the practice's computer system. GPs could access patient records remotely, which enabled them to write records in real time when at outreach clinics or during ward rounds in care homes and have immediate access to full patient records. However there was no policy around the accessing of these records away from the practice building.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing slightly below national standards. For example performance against national screening programmes showed that this practice achieved 93.9% of the total QOF target in 2014, which was comparable to the national average of 94.2%.

The practice held meetings every two to three months to discuss progress with QOF. This ensured the GPs and nurses were aware of any areas of shortfall or where improvements were needed. The practice had identified that that the percentage of patients with diabetes who had a blood pressure reading of 140/80 or less was lower than the national average. We saw from practice meeting minutes that this had been discussed and all GPs were working to improve in this area.

Leadership, openness and transparency

Staff had specific lead roles within the practice for example safeguarding, infection control and women's health. There was a practice manager and deputy practice manager who oversaw the administration and support staff.

The practice had a protocol for whistleblowing and staff we spoke with were aware of what to do if they had to raise any concerns.

The practice had a system of regular clinical, multi-disciplinary, nurse and non-clinical staff meetings. All the staff we spoke with felt very supported by the managers and the GPs they felt they could raise any concern or make suggestions for change.

Practice seeks and acts on feedback from its patients, the public and staff

There was a patient participation group (PPG) in place and minutes from meetings and results of surveys demonstrated actions were taken when necessary. We spoke with three members of the PPG who told us they felt that the practice was responsive to any issues raised by the group. They were very positive about the role they played and told us they felt engaged with the practice. They told us that the practice was very patient centred and had involved them in any proposed changes to the service. For example they met with the practice and a member of the Alzheimer's Society to discuss the most appropriate flooring to use in the building to help patients with Alzheimer's disease.

The practice had also gathered feedback from staff generally through staff meetings, appraisals and discussions. Some staff had participated in 360 degree feedback and had been able to make comments about the GPs they worked with. They told us that GPs had been happy to take their feedback and suggestions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

Feedback from staff after their induction had led to changes in the way new staff received initial training and mentoring. Staff were able to discuss their induction with managers and GPs and were able to reflect on the process at appraisal. This feedback had led to more training and an acknowledgement that new employees required more on going support.

Are services well-led?

Good

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

Management lead through learning and improvement

The practice staff told us they worked well together as a team and there was evidence that staff were supported to attend training appropriate to their roles.

The GPs were all involved in revalidation, appraisal schemes and continuing professional development. There was evidence that GPs had learnt from incidents and complaints and that these had been discussed with the whole staff team.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients.

We saw there was a programme of scheduled meetings with a set agenda to support service improvement and safety.

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	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The practice had not ensured that patient group directions (PGD) were signed by a person legally able to prescribe the medicines for which the PGD was in place. How the regulation was not being met: The provider had not ensured the proper and safe management of medicines. Policies and procedures were not in line with current legislation in relation to the recording and administration of medicines. Regulation: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 12 (2) (g)