Lilliput 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?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Lilliput Surgery on Wednesday 19 October 2016. Overall the practice is rated as good.

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

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- Risks to patients were assessed and well managed.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- Patients said they found it easy to make an appointment with a GP and said there were urgent appointments available the same day but added that they sometimes had to wait to see a GP of their choice.
- The practice had developed three teams to meet specific needs of patients at the practice. These included the routine and long term condition team, the same day care team and the vulnerable and domiciliary team.
- 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. Improvements were made to the quality of care as a result of complaints and concerns.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice employed a clinical pharmacist to identify and act upon high risk medicines, oversee prescribing patterns, review patients who were taking 10 or more medicines, review post discharge medicines and support long term condition management.

Summary of findings

- Flu clinics were used to offer patients additional screening and reviews. This included a pulse check for all patients over the over the age of 65 years old to exclude abnormal heart patterns, blood pressure checks, asthma checks and chronic obstructive pulmonary disease reviews.
- Text reminders were used to remind patients of their appointment but could be used to cancel appointments and had resulted in a reduction of 'did not attend-DNA'.
- The practice had engaged with the IRIS project (Identification and Referral to Improve Safety) IRIS is a general practice-based domestic violence and abuse training support and referral programme to raise the profile of potential hidden domestic violence. The training for all staff explored ways of asking patients about domestic violence either as perpetrators or victims.

- The practice had good facilities and was well equipped to treat patients and meet their needs.
  - The practice had developed clinical templates for medicines management and contraception and had shared this learning with other neighbouring practices.
  - Recruitment procedures and checks were completed as required to ensure that staff were suitable and competent.
- 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.
- The provider was aware of and complied with the requirements of the duty of candour
  - Governance, administration and performance management arrangements were non-hierarchical, organised, detailed, structured and kept under review by the whole team. The management and leadership had an inspiring shared purpose and motivated staff to succeed and develop services.
- The practice worked with and actively shared learning with other organisations and the local community to improve how services were planned and delivered to ensure that services meet patient need.

We saw one areas of outstanding practice:

The practice had been creative in offering alternative ways to offer patients additional services. For example, using flu clinics to offer additional screening and the use of additional teams to meet specific needs of patients. For example, the practice were offering screening for atrial fibrillation (AF) which is an abnormal heart rhythm. Data showed a rise in AF diagnoses during the autumn flu campaign and a sustained diagnosis rate. Since May 15 the number of patients on the AF register had risen from 365 to 404. The practice had been identified as having higher AF diagnosis rates in the clinical commissioning group (CCG) and had performed 25 long term conditions reviews during the last flu sessions.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

- There was an effective system in place for reporting and recording significant events
- Lessons were shared to make sure action was taken to improve safety in the practice.
- When things went wrong patients received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- Risks to patients were assessed and well managed.
- Recruitment procedures and checks were completed as required to ensure that staff were suitable and competent.
- There were appropriate arrangements for the efficient management of medicines.
- Health and safety risk assessments, for example, a fire risk assessment had been performed and were up to date.
- The practice was clean, tidy and hygienic. We found that suitable arrangements were in place that ensured the cleanliness of the practice was maintained to a high standard.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to the national average.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

Are services caring?

Good

The practice is rated as good for providing caring services.

Summary of findings

- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified.
- Patients said they found it easy to make an appointment with a GP and said there were urgent appointments available the same day but added that they sometimes had to wait to see a GP of their choice.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.
- The practice had developed three teams to meet specific needs of patients at the practice. These included the routine and long term condition team, the same day care team and the vulnerable and domiciliary team.

Are services well-led?

Good

The practice is rated as good for being well-led.

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- 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.

Summary of findings

- The practice had an overarching governance framework which supported the delivery of the strategy and good quality care and was kept under review. This framework was structured, clearly documented and familiar to all staff.
- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken
- The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active.
- There was a strong focus on continuous learning and improvement at all levels.

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.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- Monthly multidisciplinary meetings were held and were coordinated by the community health and social care coordinator. GPs and nurse practitioners attended along with community nurses, community matron, mental health worker, social worker, and the clinical pharmacist.
- The practice had introduced longer 15 minute appointments as a routine for older patients with long term conditions.
- The practice administrator contacted patients to identify issues, and engage the support of the GP, community pharmacist or nursing teams dependent on need. Patients were also signposted to voluntary sector support services.
- All patients on their 75th birthday were invited to complete a questionnaire to support better care.
- The practice employed a clinical pharmacist to oversee prescribing patterns, review patients who were taking 10 or more medicines, review post discharge medicines and support long term condition management.
- Flu clinics were used to offer patients additional services. This included a pulse check for all over 65's to exclude abnormal heart patterns, blood pressure checks, asthma checks and chronic obstructive pulmonary disease reviews.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions.

- The Practice had a significant elderly demographic in a low area of deprivation.
- There was a high prevalence of long term conditions including heart disease, diabetes and cancer.
- Three nursing staff had lead management roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- There was an effective recall system which had enabled the practice to maximise their quality of care.

Summary of findings

- This quality of care was enhanced following the recent appointment of a Clinical Pharmacist.
- Patients with high blood pressure could borrow ambulatory monitoring and home monitoring equipment, and could check their BP in the reception area self-check machine.
- Patients with chronic obstructive pulmonary disease (COPD) received self-management plans, rescue medicines if appropriate and referral to local pulmonary rehabilitation services.
- The local hospital diabetic nurse specialists supported practice nurses with challenging management issues.
- The practice used flu clinics to offer BP and asthma reviews as well as identifying undiagnosed atrial fibrillation from pulse checks.
- There was a recall system for patients under surveillance for prostate cancer, ensuring blood screening was monitored and followed up appropriately.
- Longer appointments and home visits were available when needed.
- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named 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 living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. 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, and we saw evidence to confirm this.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw positive examples of joint working with midwives, health visitors and school nurses.
- The practice safeguarding lead was supported by a deputy who was also a clinical commissioning group (CCG) Safeguarding Lead. In addition there was an on-site health visiting team for direct liaison.

Summary of findings

- The practice had engaged with the IRIS project. (This project aimed to educate health care staff and raise the profile of potential hidden domestic violence). The training for all staff explored ways of asking patients about domestic violence either as perpetrators or victims.
- Children could be booked directly into same day appointments or through the triage service if advice was needed.
- Two GPs at the practice offered contraceptive implants and one was certified for inter uterine device insertions (coils) to complement the contraceptive services provided.

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 the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- Access was enhanced by offering appointments from 8.30am, and ensuring early and later appointments were offered for on-line booking. Evening access was available every Monday.
- If patients requested same day services they were assessed by the "same day team" which consisted of a GP and nurse practitioner. These appointments were accessed either by GP-led telephone triage or direct appointment.
- Text reminders were used to reduce DNA (did not attend) rates which also had the facility for patients to cancel appointments if appropriate.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.
- Patients had access to additional services on site such as physiotherapy, minor surgery, joint injections and cryotherapy. (Cryotherapy is the use of extreme cold in surgery, for example skin lesions, or other medical treatment.)
- The practice offered a "query system" for patients not requesting a direct conversation. Issues were dealt with in a timely manner and supported by the GPs personal assistant system.
- The practice had a high proportion of patients registered for on-line services, including prescription requests, queries and appointment booking.

Summary of findings

- There was equipment to support patients readily measuring height, weight and blood pressure in the reception area.
- The practice had systems in place to identify military veterans and ensured their priority access to secondary care in line with the national Armed Forces Covenant.

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 system to identify these patients and held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice informed 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.
- The practice offered a social prescription scheme which was a voluntary signposting service for engaging isolated patients in activities and groups. The volunteers befriended the patients and took them to meetings by way of introduction.
- Practice staff had been trained as part of the IRIS project seeking to identify and enquire about potential domestic violence issues.
- The practice held a daily query and triage list which provided effective and timely communication outside the practice. For example, with paramedic teams requesting assessment to prevent unscheduled admissions, or with hospital teams to discuss medical history.
- The practice had addressed high 'did not attend-DNA' rates and in doing so had identified patients who had been highlighted as frequently not attending for appointments and who were identified as vulnerable or presenting with other problems.

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).

Summary of findings

- 84% of patients diagnosed with dementia who had their care reviewed in a face to face meeting in the last 12 months, which is comparable to the national average of 84%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice carried out advance care planning for patients with dementia.
- The practice had actively engaged in work to improve dementia prevalence in the last few years. This had included direct assessment of patients thought to be at risk of dementia, and identifying patients with memory related issues but not diagnosed with dementia. Once diagnosed these patients were offered a medicine review and support provided by the local Memory Assessment Service, as well as carer identification and support.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia.
- Patients could self-refer to a talking therapies service at the practice.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2016 showed the practice was performing in line or slightly higher than local and national averages, 220 survey forms were distributed and 123 were returned. This represented about 1.3% of the practice's patient list. Results from the survey showed;

- 90% of patients found it easy to get through to this practice by phone compared to the national average of 73%.
- 83% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the national average of 76%.
- 83% of patients described the overall experience of this GP practice as good compared to the national average of 85%).
- 77% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the national average of 78%).

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 22 comment cards which were all positive about the standard of care received. Comment cards referred to the caring, respectful and friendly staff. However, one card gave negative feedback about staff attitude. Comment cards spoke of the responsive and high quality care. Three comment cards referred to difficulty obtaining an appointment with a GP of the patient's choice.

We spoke with 15 patients during the inspection. All 15 patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. Three patients also said they sometimes had to wait to see the GP of their choice, although one patient said they had come to the practice and saw their chosen GP who had identified the patient and had requested to see them.

We looked at the friends and family patient feedback between April and September 2016. These showed that of the 31 patients, 25 would be extremely likely or likely to recommend the practice to others. Two respondents did not know, two voted neither and two unlikely to recommend the practice.

Outstanding practice

The practice had been creative in offering alternative ways to offer patients additional services. For example, using flu clinics to offer additional screening and the use of additional teams to meet specific needs of patients. For example, the practice were offering screening for atrial fibrillation (AF) which is an abnormal heart rhythm. Data showed a rise in AF diagnoses during the autumn flu campaign and a sustained diagnosis rate. Since May 15 the number of patients on the AF register had risen from 365 to 404. The practice had been identified as having higher AF diagnosis rates in the clinical commissioning group (CCG) and had performed 25 long term conditions reviews during the last flu sessions.

Lilliput 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 specialist adviser, a CQC assistant inspector and an expert by experience.

Background to Lilliput Surgery

Lilliput surgery is located in Poole Dorset and has an NHS England general medical services (GMS) contract to provide health services to approximately 9,800 patients. The practice is open between 8am and 6.30pm Monday to Friday. Extended hours appointments are offered on Monday evenings until 7.45pm. In addition, pre-bookable appointments can be booked up to four weeks in advance. Telephone appointments are also available. Urgent appointments are also available for patients that needed them.

The practice has opted out of providing out-of-hours services to their own patients and refers them to an out of hours provider via the NHS 111 service. This information is displayed on the outside of the practice and on their website.

Data from public health England showed that the mix of patient's gender (male/female) is almost 50% each. 15.8% of patients were above the age of 75 which is higher than the England average of 7.8%. 5.8% of the patients are aged over 85 years old which is higher than the England average of 2.3%. The majority of practice patients are white British 1.3% have mixed ethnicity and 2.0% were Asian. The deprivation score was recorded as 10, on a scale of 1to10. One being more deprived and 10 being less deprived.

The practice is a teaching and training practice with good written feedback from trainees, including paramedics, and the local NHS health education team. Three partners are currently trainers and there are usually two or three trainees based at the practice. Four of the GPs working at the practice had been trainees at Lilliput Surgery. In addition the practice provide a learning environment to paramedics and student nurses.

The practice has an established team of seven GPs working as 5.5 whole time equivalent. There were three male and four female GPs. Four of these GPs are partners who hold managerial and financial responsibility for running the business. The GPs are supported by a strategic business manager, operations manager, administration manager, three nurse practitioners, a clinical pharmacist, three practice nurses, a treatment room nurse, health care assistants and additional administration and reception staff.

This report relates to the regulatory activities being carried out at:

Elms Avenue

Parkstone

Poole

Dorset

BH14 8EE

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. The 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.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on Wednesday 19 October 2016. During our visit we:

- Spoke with a range of staff and spoke with patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed 22 comment cards where patients and members of the public shared their views and experiences of the service.'

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

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

We also looked at how well services were provided for specific groups of people and what good care looked 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 whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia).

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.

Good

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events.

- The practice carried out a thorough analysis of the significant events. For example, the summary of events showed that the practice, during the period from October 2015 to September 2016 had reported a total of 30 significant events. These were then divided into categories which included clinical, prescribing, administration, security, communication, infection control, health and safety and information governance. Action was taken based on the findings of the investigations.
- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice had recognised that the significant event process needed to be formally embedded into the practice meetings and ethos and as a result had been a standing agenda item at weekly practice meetings from March to ensure that any actions and learning were addressed and followed through in a timely manner. A new improved significant event reporting form had been introduced in July which incorporated risk analysis and prompted further considerations of pertinent issues such as whether there were safeguarding concerns or whether the incident ought to be reported externally.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, an urgent referral was faxed to an incorrect number, all relevant staff were reminded of the correct protocol via email with assurances these had been read and a notice was displayed by the fax machine as a reminder. A conversation also took place with the individual member of staff to ensure they understood the procedure.

We looked at patient safety alerts and saw systems were in place to communicate these to staff. The GPs kept a spreadsheet to show what action, if any, had been taken in response to national medical safety alerts. For example, action plans showed that following a national alert, batch numbers on medicines used for low blood sugar had been checked at the practice and showed that no further action had been required.

Overview of safety systems and processes

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

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff and were kept under review. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs and the practice manager were trained to child protection or child safeguarding level three. Nurses were trained to level two and administration staff to level one.
- A notice in the waiting room advised patients that chaperones were available if required. All nursing staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). Selected administration staff had received training in chaperoning duties but were rarely used for this purpose. A risk assessment was in place indicating that

should these staff be used to chaperone, they would not be left unaccompanied. These staff were in the process of applying for a DBS check and were not being used as chaperones until these were completed.

- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. Clinical and environmental cleaning schedules were kept and monitored and regular meetings between the cleaning company and practice staff were held to discuss any issues. One of the practice nurses 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 the infection control lead nurse had invited the clinical commissioning group (CCG) infection control nurse to visit the practice in July 2016 for advice and to undertake an audit. Some minor actions were identified and had been addressed. For example, pillow cases had been replaced with wipeable covers. The most recent infection control audit had prompted staff to perform refresher training in infection control.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat prescriptions which included the review of high risk medicines. Records were maintained of these searches and any action taken by the GPs and clinical pharmacist. The practice carried out regular medicines audits, with the support of the clinical pharmacist and local CCG pharmacy teams, to ensure prescribing was in line with local and national best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. Nurses at the practice had qualified as Independent Prescribers or were working towards this qualification. They received mentorship and support from the medical staff for this extended role. Patient Group Directions (PGD) had been adopted by the practice to allow nurses to administer medicines in line with legislation. Health care assistants were trained to administer vaccines and medicines against a patient specific prescription or direction from a prescriber. The lead nurse had written an overview of the PGDs to demonstrate they were current, kept under review, and had been seen by and signed by staff.
- Patients told us they used the electronic prescribing service to request their repeat medicines. The lead GP told us the practice had been identified as the fourth highest electronic prescribing users in Dorset.
- The practice did not hold stocks of controlled drugs (medicines that require extra checks and special storage because of their potential misuse) but had procedures in place to store them safely.
- The practice used liquid nitrogen for certain treatments. Appropriate policies and storage facilities and protective equipment were in place.
- We reviewed three personnel files and found 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 Service.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was an overview of risk assessments to ensure monitoring of the assessments were kept under review. The practice had up to date fire risk assessments which had been conducted in August 2016. All electrical equipment had been checked in July 2016 to ensure the equipment was safe to use and clinical equipment had been checked earlier in October 2016 to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). The last legionella risk assessment had been performed in August 2015 and was next due in August 2017. Weekly water and shower flushes were performed by cleaning staff with records kept to ensure systems were in place to maintain staff and patient safety.
- 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 all the different staffing groups to ensure enough staff were on duty.

Good

Are services safe?

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to 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 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. A first aid kit and accident book were 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 stored securely.
- 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.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines, prescribing formularies and national travel websites.

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs. Guidelines were incorporated into templates used on the computer system and had been shared with other practices in the clinical commissioning group (CCG).
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). Data from Public Health England 2014/15 showed the practice had achieved 100% of the total number of points available which was higher than the CCG average of 98% and national average of 95%.

Exception reporting rates at the practice were generally higher than national and CCG averages. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). Overall clinical exception reporting rates were 14.9% compared to the CCG average of 12.1% and national average of 9.2%. The practice were aware of these figures and were addressing exception rates for different clinical indicators. For example, in 2014/15 the excepted percentage of patients with diabetes, on the register, whose last cholesterol was within normal limits was 26% compared to the CCG average 17% of and national average of 17%. The GPs had been able to explain the reasons for these exceptions but had introduced systems to reduce exceptions in 2014/15 to 21%. Following further actions the rates for 2015/16 had reduced again to 9.5%. The GPs told us they were now looking at further interventions for other diseases including respiratory conditions.

This practice was not an outlier for any QOF (or other national) clinical targets. Data from Public Health England 2014/15 showed:

- Performance for diabetes related indicators was better than the national average. For example, the percentage of patients with diabetes, on the register, whose last cholesterol measured within the preceding 12 months) was within normal limits was 87% compared to the CCG average 82% of and national average of 81%. In addition, the percentage of patients on the diabetes register, with a record of a foot examination and risk classification within the preceding 12 months was 97% compared to the CCG average 91% of and national average of 88%.
- Performance for mental health related indicators were better than CCG and national averages. For example, the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in the record, in the preceding 12 months was 94% compared to CCG averages 92% of and national averages of 88%.
- There was evidence of quality improvement including clinical audit. The practice had written a report on the audits performed at the practice. These were generally divided into four categories; prescribing, health and safety, access and demand management and service provision.
- We looked at 13 clinical audits completed in the last two years and two of the completed audits where the improvements made were implemented and monitored.
- The practice participated in local audits, national benchmarking, accreditation, peer review and research.
- Findings were used by the practice to improve services. For example, an audit in 2014 looked at the prescribing of specific anti-inflammatory medicines. The audit checked to see if patients had been given alternatives first, had contraindications recorded and follow up screening. The results showed that only 77% of patients had the reasons recorded compared to the target of

Good

Are services effective?

(for example, treatment is effective)

90% and only 67% of the patients had received screening for renal function compared to a target of 75%. A repeated audit in showed these targets had been achieved. For example, 95% and 84% respectively.

Effective staffing

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

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. Staff said that although there were timescales for induction these were flexible and could be extended until they felt confident in their role.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions. Staff told us they also worked with clinical specialists who helped to keep their knowledge up to date.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- 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 their learning needs and to cover the scope of their work and said they could access the training they needed. Staff could access ongoing support, one-to-one meetings, and facilitation and support for revalidating nurses and GPs. All staff had received an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. 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 investigation and test results.

The practice shared relevant information with other services in a timely way, for example when referring patients to other services. For example, the administrative team had been proactive in increasing the number of patients consenting to their Summary Care Record upload. This enabled providers outside the practice to make more informed care decisions. The practice was ranked as one of the highest with the most number of patients accepting the scheme in Dorset.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

Consent to care and treatment

Staff sought patients' consent to care and treatment 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, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was performed using computer templates, written consent forms and monitored through patient records audits.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example:

Good

Are services effective?

(for example, treatment is effective)

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their lifestyles. Patients were signposted to the relevant service.

The practice had been creative in offering alternative ways to offer patients additional services. For example, using flu clinics to offer additional screening and the use of additional teams to meet specific needs of patients. For example, the practice were offering screening for atrial fibrillation (AF) which is an abnormal heart rhythm. Data showed a rise in AF diagnoses during the autumn flu campaign and a sustained diagnosis rate. Since May 15 the number of patients on the AF register had risen from 365 to 404. The practice had been identified as having higher AF diagnosis rates in the clinical commissioning group (CCG) and had performed 25 long term conditions reviews during the last flu sessions.

The practice's uptake for the cervical screening programme in 2014/15 was 81% which was lower than the CCG average of 84%% and national average of 82%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in easy read and pictorial formats for those with a learning disability and whose first language was not English. For patients with a learning disability they ensured a female sample taker was available. The practice also performed audits on the screening which identified a very low inadequate specimen rate. For example, in the survey of the 47 samples taken only one was required to be repeated because of poor sample. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results. For example, breast screening rates in 2014/15 for women aged 50-70 was 78% which was better than the CCG average of 76% and national average of 72%.

The practice also encouraged its patients to attend national screening programmes for bowel cancer and there was a recall system for patients under surveillance for prostate cancer, ensuring blood screening was monitored and followed up appropriately.

Childhood immunisation rates for the vaccines given were better than CCG averages. For example, childhood immunisation rates for the vaccines given to under two year olds ranged from 73%% to 98% compared to the CCG average of 71% and 97%. Vaccination rates for five year olds ranged from 81%% to 95% compared to CCG averages of 75% to 97%.

Patients had access to appropriate health assessments and checks. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

All of the 22 patient Care Quality Commission comment cards we received 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.

We spoke with two members of the patient participation group (PPG). 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 felt they were treated with compassion, dignity and respect. The practice was either comparable average for its satisfaction scores on consultations with GPs and nurses. For example:

- 88% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 91% and the national average of 89%.
- 87% of patients said the GP gave them enough time compared to the CCG average of 90% and the national average of 87%).
- 98% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and the national average of 95%)
- 89% of patients said the last GP they spoke to was good at treating them with care and concern compared to the national average of 85%).
- 89% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 91%).
- 87% of patients said they found the receptionists at the practice helpful compared to the CCG average of 91% and the national average of 87%)

Care planning and involvement in decisions about care and treatment

Patients told us 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 from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised and given to the patients to retain and refer to. The practice were in the process of retaining a copy of these plans on the patients electronic record.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were slightly below local and national averages. For example:

- 87% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 89% and the national average of 86%.
- 79% of patients said the last GP they saw was good at involving them in decisions about their care compared to the national average of 82%.
- 80% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the national average of 85%)

The practice provided facilities to help patients be involved in decisions about their care:

- 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.
- Information leaflets were available in easy read format.

Patient and carer support to cope emotionally with care and treatment

Good

Are services caring?

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website.

The practice offered a social prescription scheme which was a voluntary signposting service for engaging isolated patients in activities and groups. The volunteers befriended the patients and took them to meetings by way of introduction.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 334 patients as carers (3.3% of the practice list). Written information was available to direct carers to the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP or the one they were most familiar with contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs or by giving them advice on how to find a support service including the social prescribing service.

The practice had systems in place to identify military veterans and ensured their priority access to secondary care in line with the national Armed Forces Covenant 2014.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice 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 offered extended hours on a Monday evening until 7.45pm for working patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- The practice had a system in place to assess whether a home visit was clinically necessary. These were carried out by the GPs and the frailty nurse practitioner and were arranged so patients could be seen at home throughout the day which meant they could access early intervention where needed.
- In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccines available on the NHS as well as those only available privately/ were referred to other clinics for vaccines available privately.
- There were disabled facilities, a hearing loop and translation services available.

The practice had responded to the needs of the local population and had developed three teams to meet the specific care needs for specific groups of patients. This included:

- A 'routine and long term condition team' which was composed of the non-duty GPs, three nurses providing long term condition follow-up, a treatment room nurse, a health care assistant (HCA) and support from the clinical pharmacist and attached on-site health visitor.
- A 'same day care team' of duty GP (two on a Monday) a nurse practitioner and support from the medical reception team.
- A 'vulnerable and domiciliary team' with a visiting nurse practitioner supported by a GP and care planning HCA with support from the clinical pharmacist and the on-site community nursing team.

These teams provided continuity of treatment and care, a prompt response to patients and improved access for patients needing to see a GP or nurse the same day.

The practice also shared information and learning with the wider community to improve health and social care in the community. For example:

- The social prescription scheme which identified vulnerable and isolated patients to befriending services, activities and groups had been successful at the practice. As a result the Social Prescription Team arranged a meeting with the practice to better understand how practice staff identified patients with an aim to disseminate this to other practices within the CCG.
- The practice had shared the practice developed medicines formulary for SystmOne with a local practice who had changed clinical system, and also shared a contraceptive template with another neighbouring practice.
- The practice had addressed high 'did not attend-DNA' rates and in doing so had identified vulnerable patients who had been highlighted as frequently not attending for appointments but who were identified as vulnerable or presenting with other problems. Learning from this process was then used by the CCG Safeguarding GPs as an example of best practice with other GP surgeries.

The practice had identified an opportunity to use flu clinics to offer patients additional services. This included a pulse check for all over 65's to exclude abnormal heart patterns, blood pressure checks, asthma checks and chronic obstructive pulmonary disease reviews.

Patients with long term conditions were empowered to be involved in their care and the practice had responded to provide equipment and facilities for patients to do this. For example, patients with high blood pressure could borrow ambulatory monitoring and home monitoring equipment, and could check their BP in the reception area self-check

machine. Patients with chronic obstructive pulmonary disease (COPD) received self-management plans, rescue medicines if appropriate and were encouraged to attend local pulmonary rehabilitation services.

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday. Extended hours appointments were offered on Monday evenings until 7.45pm. In addition to pre-bookable appointments could be booked up to four weeks in advance, urgent appointments were also available for people that needed them.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was mixed compared to local and national averages.

- 70% of patients were satisfied with the practice's opening hours compared to the national average of 78%.
- 90% of patients said they could get through easily to the practice by phone compared to the national average of 73%).

People told us on the day of the inspection that they were able to get appointments when they needed them but sometimes had to wait to see the GP of their choice.

The practice had identified that patients had not been satisfied with access to the practice and had looked at ways to free up more appointment times. For example:

- The practice had employed an additional nurse practitioner role.
- The practice also told us they had a relatively elderly demographic, with many patients presenting for routine care with multiple long term conditions. This had led to a challenge in dealing with all the patients' issues within a standard length consultation and had resulted in negative feedback. As a result the practice had changed the routine appointments to 15 minutes to improve care. By reorganization of the appointment schedule and adopting a team approach practice staff had been able to increase the routine appointment availability to support better continuity of care for older patients.
- The practice had looked at GP time and as a consequence had employed a clinical pharmacist to oversee medicines management to reduce GP time spent on routine issues.
- Text reminders were already being used but had been adapted to have the facility for patients to cancel appointments if appropriate in an attempt to reduce DNA (did not attend) rates. This had resulted in a reduction from 129 DNA hours between April and June 2015 to 68 DNA hours between April and June 2016.

Listening and learning from concerns and complaints

The practice had an effective 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.

During the period from October 2015 to September 2016 Lilliput Surgery had received a total of 28 written complaints. A total of 14 of these were upheld by the surgery. We looked at these complaints and found they were satisfactorily handled, dealt with in a timely way, with openness and transparency when with dealing with the complaint. Lessons were learnt from individual concerns and complaints and also from an in-depth review. An analysis of trends and action was taken to as a result to improve the quality of care. For example, the most recent analysis of trends, complaints and additional suggestions had resulted in the following:

- A water cooler was installed in the upstairs waiting area (in addition to the cooler in the downstairs waiting area).
- Signage had been introduced to inform patients of the availability of a separate room to talk to staff in confidence.
- The wording and tone of the standard letter templates used when patients did not attend for their appointment (DNA) was reviewed and amended in order to soften the context.
- Information had been added to the website informing patients of the need to book travel immunisation appointments at least six to eight weeks ahead of travel to avoid disappointment.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice also kept a record of compliments from the direct contact with patients, friends and family test results and a comments box situated in reception.

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 had a mission statement which was displayed in the waiting areas and staff knew and understood the values.
- The practice had a robust strategy and supporting business plans which reflected the vision and values and were regularly monitored. The partners had written the vision and values with staff input and were also in the process of discussing whether the practice strategy resonated with patients and to see if there was anything patients felt was missing.

Governance arrangements

The practice had a detailed, structured, organised, clearly documented 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, kept under review and were available to all staff on any computer station in the practice.
- A comprehensive understanding of the performance of the practice was maintained
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.
- Staff were only recruited following a thorough, systematic recruitment process which was documented in detail.
- Practice specific policies, guidance, systems and protocols were detailed, well maintained, and easily located by all staff.
- Processes were in place to monitor processes within the practice. For example, there were spreadsheets to monitor patient group directives, action taken on safety alerts, risk assessments, medicine expiry dates and action taken as a result of patient suggestions.
- A comprehensive understanding of the performance of the practice was maintained and used to influence business plans and recruitment. For example, patient feedback and performance of national patient survey had resulted in additional recruitment of staff and organisation of appointments.

Leadership and culture

On the day of inspection the partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment::

- The practice gave affected people reasonable support, truthful information and a verbal and written apology
- The practice kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure in place and staff felt supported by management.

- There was a stable, cohesive staffing structure with clearly identified roles and responsibilities within a non-hierarchical organisation.
- Staff told us the practice held regular team meetings and received weekly updates.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- Staff said they felt respected, valued and supported, particularly by the partners in 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.

Are services well-led?

Good

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

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

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. The PPG met regularly, carried out patient surveys and submitted proposals for improvements to the practice management team. For example, the action plan from the survey also stated that the practice intended to share survey results with all PPG (including virtual) members ahead of meeting for discussion and obtain ideas.
- The practice had gathered feedback from staff through staff meetings, appraisals and discussion. An annual staff survey had been performed in February 2016 which had identified gaps in communication. The practice manager and GPs had introduced weekly communication bulletins, additional staff meetings and further discussions about repeating the survey. Staff we spoke with told us they felt supported and that Lilliput Surgery was a good place to work. Staff said there had been unsettling times with changes of staff but added work was more settled now. Staff also told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management and added that they felt involved and engaged to improve how the practice was run. For example, staff had been consulted and assisted in developing and writing the practice vision and values.

Continuous improvement

There was a 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.

The practice shared learning with other practices and stakeholders to improve health care in the area. For example;

- A partner was the Safeguarding Lead for the CCG and had shared learning from the 'did not attend' (DNA) audit which had also identified vulnerable and isolated patients.
- The practice shared examples of templates and medicines formulary with other local practices in the CCG.