

Drs Nodder Morgan & Taubman

Quality Report

Sixpenny Handley and Chalke Valley Practice

The Surgery

Salisbury

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

Ratings

Overall rating for this service

Good



Are services safe?

Requires improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Good



Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Drs Nodder Morgan and Taubman on 17 September 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, caring and responsive. However, the practice requires improvement in providing safe services.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed, with the exception of those relating to recruitment checks.

- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- 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.

We saw an area of outstanding practice:

Summary of findings

- The practice was proactive in screening patients for dementia. The lead GP ran an in house memory clinic and used an accredited questionnaire to assess for symptoms of dementia and carry out investigations. If appropriate patients were commenced on medicines which delay some of the symptom of dementia. A GP with extra training dementia care reviewed the care and treatment of all patients living with dementia at least once a year.

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

Importantly the provider must:

- Ensure recruitment arrangements include all necessary employment checks for all staff.
- Ensure all policies and procedures for the running of the practice are maintained, accurate and up to date.

In addition the provider should:

- Review the legionella risk assessment to ensure all actions have been taken.
- Review the contents of the emergency medicine pack in line with best practice.
- Review the procedures for ordering controlled drugs.
- Follow guidance from the Royal College of Obstetricians and Gynaecologists on insertion of intrauterine contraceptive devices.
- Appropriately test, service and maintain all equipment to ensure it is fit for use.
- Formalise the appraisal and training system.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as requires improvement for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe. Improvements were needed in ensuring equipment was maintained and serviced regularly; ensuring all necessary recruitment checks were carried out; and infection control processes were safe.

Requires improvement



Are services effective?

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

Good



Are services caring?

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Good



Are services responsive to people's needs?

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 to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their

Good



Summary of findings

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

Are services well-led?

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was pro-active. Staff had not consistently received inductions or regular performance reviews. They were able to attend staff meetings and events.

Good



Summary of findings

The six population groups and what we found

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

Older people

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

Good



People with long term conditions

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medicine needs were being met. For those people with the most complex needs, the named GP worked with relevant health and social care professionals to deliver a multidisciplinary package of care.

Good



Families, children and young people

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency attendances. 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 good examples of joint working with midwives, health visitors and school nurses.

Good



Working age people (including those recently retired and students)

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

Good



Summary of findings

to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.

People whose circumstances may make them vulnerable

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It offered longer appointments for people with a learning disability.

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

Good



People experiencing poor mental health (including people with dementia)

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice proactively screened patients for signs or symptoms of dementia and if required commenced these patients on appropriate medicines. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health. Post-natal checks included a review of the mother's mental health. Staff had received training on how to care for patients with mental health needs and dementia.

Good



Summary of findings

What people who use the service say

The national GP patient survey results published on July 2015 showed the practice was performing in line with local and national averages. There were 123 responses and a response rate of 54.2%.

- 95.8% found it easy to get through to this practice by phone compared with a national average of 74.4%.
- 96.5% found the receptionists at this practice helpful compared with a national average of 86.9%.
- 82.7% said they usually got to see or speak to their preferred GP, which was above the national average of 60.55%.
- 91.3% found it easy to get appointments or speak to someone, compared with the national average of 85.4%.
- 100% said the last appointment they got was convenient compared with a national average of 91.8%.
- 91% described their experience of making an appointment as good compared with a national average of 73.8%.

- 63.5% usually waited 15 minutes or less after their appointment time to be seen compared with a national average of 65.2%.
- 55.2% felt they didn't normally have to wait too long to be seen compared with a national average of 57.8%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received seven comment cards which were all positive about the standard of care received. Patients said they were consulted about their treatment options and given sufficient time to decide what treatment to have done. Patients said staff were polite and caring and took the time to listen to their concerns and followed up treatments effectively.

We spoke with six patients during the inspection. All six patients said that they were happy with the care they received and thought that staff were approachable, committed and caring.

Drs Nodder Morgan & Taubman

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 advisor and a practice manager specialist advisor.

Background to Drs Nodder Morgan & Taubman

Drs Nodder Morgan and Taubman is a GP practice which is based in two locations collectively known as Sixpenny Handley and Chalke Valley Practice. The main location is based at Sixpenny Handley, which is situated in Dorset. The branch location Chalke Valley Practice is based in Wiltshire. The practice area covers parts of Wiltshire, Dorset and Hampshire and covers approximately 200 square miles. The practice is commissioned by Wiltshire clinical commissioning group (CCG) and there are arrangements in place for funding from Hampshire and Dorset CCG. The practice is part of the Wessex Local Medical Committee.

Drs Nodder Morgan and Taubman is a dispensing practice and they dispense to all patients within their practice area, due to its rural location. There are no care homes within the practice area. Approximately 4500 patients are registered with the practice.

There are three GP partners, one GP assistant, one GP registrar, four part time practice nurses and four healthcare assistants. In addition there is a practice manager and a team of four dispensers and seven receptionists. The practice employs its own cleaning team of two cleaners.

There are two female and one male GP partners.

The practice is a training practice for doctors who wish to become GPs and undergraduate and postgraduate medical students.

The practice is open at the following times from 8am until 1pm and 2pm until 6.15pm on Mondays to Fridays. Extended hours pre-bookable appointments are available on Monday evenings from 6.30pm until 8.30pm. The practice is closed on a Tuesday afternoon and patients are able to access the branch location if they need to see a GP. The practice operates a telephone triage duty system so patients can be seen on the same day if needed. Out of hours patients are advised to contact the relevant service provider, such as the South West Ambulance Trust via the NHS 111 service.

We inspected the main location at:

Sixpenny Handley Surgery

The Surgery, Dean Lane, Sixpenny Handley, Salisbury, SP5 5PA

The branch location is situated at:

Broad Chalke Surgery

The Surgery, Doves Meadow, Broadchalke, Salisbury, SP5 5EL

Why we carried out this inspection

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

Detailed findings

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 that we hold about the practice and asked other organisations to share what they knew. Including local NHS England, Healthwatch and the clinical commissioning group. We carried out an announced visit on 17 September 2015 at Drs Nodder Morgan and Taubman. During our visit we spoke with a range of staff which included GPs, nurses and reception staff. We spoke with patients who used the service.

We asked the practice to send us some information before the inspection took place to enable us to prioritise our areas for inspection. This information included practice policies and procedures and some audits. We also reviewed the practice website and looked at information posted on NHS Choices website.

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People 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.

Are services safe?

Our findings

Safe track record and learning

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

- Staff told us they would inform the practice manager of any incidents and there was also a recording form available on the practice's computer system.
- The practice carried out a thorough analysis of the significant events.

We reviewed safety records, incident reports national patient safety alerts and minutes of meetings where these were discussed. Lessons were shared to make sure action was taken to improve safety in the practice. For example, on one occasion blood specimens were not collected for testing by the local hospital due to specimens being kept in two different locations. A GP registrar took the bloods to the hospital for processing. The practice put processes in place to ensure all specimens were collected when needed. This situation had not reoccurred.

When there are unintended or unexpected safety incidents, patients received reasonable support, truthful information, a verbal and written apology and are told about any actions to improve processes to prevent the same thing happening again.

Overview of safety systems and processes

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

- Arrangements were in place to safeguard adults and children from harm and these usually reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training relevant to their role.
- We noted that the adult safeguarding policy required updating to reflect the new regulations of the Health

and Social Care Act 2012. The children's policy had a flowchart of actions staff were expected to take if they considered a child was at risk. This was in line with best practice.

- A notice was displayed in the waiting room, advising patients that nurses would act as chaperones, if required. A chaperone is a person who acts as a safeguard and witness for a patient and health care professionals during a medical examination or procedure.
- The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at did not contain sufficient evidence to show that appropriate recruitment checks had been undertaken prior to employment. We looked at four staff files, three of whom had been recruited since 2013. None of the files had all the required checks. For example, proof of identification, evidence in the form of references of satisfactory conduct in previous employment, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (DBS). These 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. The practice policy stated that if a potential member of staff was known to the practice then employment references would not be requested.
- The policy for DBS checks stated that clinicians would have a DBS check if appropriate, but did not refer to non-clinicians. When a member of staff did not have a DBS check, there was no risk assessment in place showing the reasons why this had not been carried out.

Medicines management

- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). The practice carried out regular medicines audits, with the support of the local Clinical Commissioning Group pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Prescription

Are services safe?

pads were securely stored and there were systems in place to monitor their use. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation.

- The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. There were arrangements in place for the destruction of controlled drugs. However, we noted that order forms for controlled drugs had been pre-signed by a GP. The forms were not accessible to members of the public or patients, but this is not permitted under the Misuse of Drugs Act 1971 and its associated regulations.
- The practice offered a full range of primary medical services and was able to provide pharmaceutical services to all patients on the practice list. The practice had appropriate written procedures in place for the production of prescriptions and dispensing of medicines that were regularly reviewed and accurately reflected current practice. The practice was signed up to the Dispensing Services Quality Scheme to help ensure processes were suitable and the quality of the service was maintained. Dispensing staff had all completed appropriate training and had their competency annually reviewed. The practice used an electronic scanner to monitor the transit of medicines through the practice to the patient. Since this system was introduced three years ago, there had been no reported incidents of the incorrect medicines being dispensed.
- We saw a positive culture in the practice for reporting and learning from medicines incidents and errors. Incidents were logged efficiently and then reviewed promptly. This helped make sure appropriate actions were taken to minimise the chance of similar errors occurring again.
- The practice had established a service for patients to pick up their dispensed prescriptions at two locations and had systems in place to monitor how these

medicines were collected. They also had arrangements in place to ensure that patients collecting medicines from these locations were given all the relevant information they required.

Monitoring risks to patients

Risks to patients were assessed, but not consistently well managed.

- The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.
- A GP inserted intrauterine contraceptive (coil) devices for patients. They said that they did not have an assistant present in the room when this was done. This did not align with best practice guidance as set out in the Royal College of Obstetricians and Gynaecologists clinical guidance. There were no risk assessments in place to determine why an assistant was not present.
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.
- The practice had undertaken a risk assessment for legionella (a bacterium which can contaminate water systems in buildings) and had decided that the risk was low.
- A fire risk assessment had been carried out in August 2014. We found that the practice had domestic smoke detectors. There were a total of four policies on fire safety and instructions differed in each policy. For example, instructions on display in staff and public areas differed from those in a policy, and read as though staff should attempt to extinguish a fire. Fire training had been given.

Are services safe?

- We found that most of the equipment was tested and maintained regularly, for example, a new hot water and heating boiler had been installed in May 2014, but an annual service was overdue. The last full test of portable electrical appliance had been carried out in 2012.
- Equipment used for measurements was usually calibrated to ensure that they were accurate.
- 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 that enough staff were on duty.

Arrangements to deal with emergencies and major incidents

- The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used in cardiac emergencies). When we asked members of staff, they all knew the

location of this equipment and records confirmed that it was checked regularly. We checked that the pads for the automated external defibrillator were within their expiry date.

- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use. The emergency medicine pack did not have benzylpenicillin for treatment of suspected meningitis but were able to access supplies quickly if needed.
- A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

- The practice had systems in place to 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.
- 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 participated in the Quality and Outcomes Framework (QOF). This is a system intended to improve the quality of general practice and reward good practice. The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The most recent published results were 100% of the total number of points available. This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014 showed:

- Performance for diabetes related indicators was better than the national average.
- The percentage of patients with hypertension having regular blood pressure tests was better than the national average
- Performance for mental health related QOF indicators was better than the national average.
- The practice showed us clinical audits that had been undertaken in the last three years. We looked at two completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, one audit was on Barrett's Oesophagus, which is a condition which could potentially develop into cancer. The first audit cycle in July 2013 showed that not all patients diagnosed with this condition were having appropriate tests carried out, such as an endoscopy. The repeat audit in December 2013 showed that appropriate actions had been taken and a surveillance programme had been established.

- Other examples included audits to confirm that the GPs who undertook minor surgical procedures and the insertion of intrauterine contraceptive (coil) devices were doing so in line with their registration and National Institute for Health and Care Excellence guidance which provides recommendations on treatments.
- Patients who were prescribed warfarin had their most recent blood clotting rate recorded on their repeat prescription sheet to ensure the correct dose of warfarin was prescribed. Warfarin is a medicine which thins the blood so clots do not form quickly and is used in patients with heart problems. All patients on warfarin were referred to the local hospital anticoagulant clinic to manage monitoring and enable them to obtain advice on how to manage their condition.
- The system for moving patients from warfarin to other new oral anticoagulant (NOAC) medicines, which removed the need for regular blood tests, was in line with current guidance. Patients on warfarin were identified and GPs identified whether they would benefit from NOAC medicines and discussed with the patient, prior to changing the medicine.
- The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. We spoke with the community matron who was part of the palliative care team. They told us that advanced care planning and do not resuscitate decisions were always discussed with patients and relevant professionals. They considered the practice liaised and communicated with the team at all times of the day or night when needed. GPs ensured end of life patients had their mobile telephone numbers to enable them to be contacted out of hours.

Effective staffing

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

- Staff had the skills, knowledge and experience to deliver effective care and treatment. Training had been provided in areas such as basic life support, infection control and safeguarding.
- Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example in compression bandaging.

Are services effective?

(for example, treatment is effective)

- As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. We received positive feedback from the trainees we spoke with.
- We found there was a comprehensive induction programme in place for GP registrars. The induction covered areas such as shadowing various staff at the practice for example, receptionists and dispensary staff. During the four week induction, time was allocated for half a day study each week. Along with observing appointments with all GPs in the practice.
- Staff were supportive of each other and considered that they knew who to go to in the practice with any concerns.
- Staff told us they had not yet received a formal appraisal as they had been working at the practice for less than a year. Their training needs were met and they would have conversations with the GPs and practice manager about performance on an informal basis.

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. Information such as NHS patient information leaflets were also available.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

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

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, where appropriate, recorded the outcome of the assessment.
- The process for seeking consent was monitored through records audits to ensure it met the practices responsibilities within legislation and followed relevant national guidance.

Health promotion and prevention

It was practice policy to offer a health check to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. The practice was proactive in screening patients for dementia. The lead GP ran an in house memory clinic and used an accredited questionnaire to assess for symptoms of dementia and carry out investigations. If appropriate patients were commenced on medicines which delay some of the symptoms of dementia.

The practice's performance for the cervical screening programme was 86.48%, which was above the national average of 81.88%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccines in line with current national guidance. Last year's performance was above average for the majority of immunisations where comparative data was available. For example:

Are services effective?

(for example, treatment is effective)

- Flu vaccination rates for the over 65s were 69.92%, and at risk groups 44.44%. These were similar to national averages.
- Childhood immunisation rates for the vaccinations given to under twos ranged from 93.1% to 100% and five year olds from 94% to 100%.

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

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed that 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 and that 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.

Patients completed CQC comment cards prior to our inspection to tell us what they thought about the practice. We received seven completed cards and all were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with six patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey in July 2015, and patient satisfaction questionnaires sent out to patients by each of the practice's partners.

The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'among the best' for patients who rated the practice as good or very good. The practice was also above average for its satisfaction scores on consultations with doctors and nurses. For example:

- 96.4% said the GP was good at listening to them compared to the national average of 88.6%.
- 94.9% said the GP gave them enough time compared to the national average of 86.8%.

- 99.3% said they had confidence and trust in the last GP they saw compared to the national average of 95.3%

Care planning and involvement in decisions about care and treatment

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 feedback on the comment cards we received was also positive and aligned with these views.

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

- 94.4% said the last GP they saw was good at explaining tests and treatments compared to the national average of 86.3%.
- 94.5% said the last GP they saw was good at involving them in decisions about their care compared to the national average of 81.5%.
- Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room and practice 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. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

The patient survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example:

Are services caring?

- 95.2% said the last GP they spoke to was good at treating them with care and concern compared to the national average of 85.1%.
- 95.4% said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 90.4%.

The patients we spoke with on the day of our inspection and the comment cards we received were also

consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

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

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

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

- The practice offered extended hours appointments on a Monday evening 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 or patients who would benefit from these.
- Urgent access appointments were available for children and those with serious medical conditions.
- Disabled facilities, hearing loop and translation services were available.

Staff told us that they did not have any patients who were of "no fixed abode" but would see someone if they came to the practice asking to be seen and would register the patient so they could access services. There was a system for flagging vulnerability in individual patient records.

Access to the service

The practice was open between 8am and 6.30pm on Mondays to Fridays; appointments were available during these times. Extended hours appointments were offered on Monday evenings from 6.30pm to 8.30pm. When either of the locations were closed, for example Sixpenny Handley was closed on Tuesday afternoons, patients could be seen at the other location. Telephone and on the day appointments were also available. Patients we spoke with were satisfied with the appointments system and said it was easy to use. They confirmed that they could see a doctor on the same day if they felt their need was urgent although this might not be their GP of choice.

On the day of our inspection, the practice was able to offer a routine appointment within two days. One patient said that they waited longer than that to see a preferred GP, but this suited them, as it provided continuity of care. The

practice had displayed the standard timetable at both locations, on its website and in the practice. This detailed which locations GPs, nurses and allied health professionals would be working in. Patients we spoke with were aware of this and said that they found it convenient, as they could be seen at their location of choice.

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

- 80.2% were satisfied with the practice's opening hours compared to the national average of 75.7%.
- 91% described their experience of making an appointment as good compared to the national average of 73.8%.
- 63.5% said they usually waited 15 minutes or less after their appointment time compared to the national average of 65.2%.
- 95.8% said they could get through easily to the surgery by phone compared to the national average of 74.4%.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system in the form of leaflets and posters. Patients we spoke with were aware of the process to follow if they wished to make a complaint. All of the patients we spoke with told us they had never needed to make a complaint about the practice.

We looked at two complaints received in the last 12 months and found these were satisfactorily handled, dealt with in a timely way, and there was openness and transparency with dealing with the complaint.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted

Are services responsive to people's needs?

(for example, to feedback?)

on and improvements made, for example determining the best method of contacting patients, whether by telephone or letter. There were no concerns raised about clinical matters.

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 charter 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.

Governance arrangements

The practice had systems in place to govern the running of the business. However, these were not consistently implemented to ensure that there was effective oversight of how the practice was operating:

- There was a clear leadership structure in place with staff members having designated lead roles, such as infection control and prevention and safeguarding. These roles were not clearly defined to ensure information and training were provided in a timely manner.
- Policies and procedures were in place to support the running of the practice, however, there was no systematic approach to ensure all policies and procedures were reviewed regularly and the information in them was current. For example, the disaster recovery plan and child protection plan had been reviewed in 2015, but the recruitment policy which formed part of the staff handbook was not dated.
- There was no overall training matrix to identify when training had been provided and when it was planned for.
- Staff told us they had not received a formal appraisal, but their training needs were met and they would have conversations about performance on an informal basis with the GPs or practice manager. We found that only one member of staff had a completed formal appraisal on their file.
- There was a programme of continuous clinical and internal audit which was used to monitor quality and to make improvements.

- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions, with the exception of legionella management and recruitment checks.

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

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

Leadership, openness and transparency

The partners in the practice were visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff. All staff were involved in discussions about how to run the practice and how to develop the practice. The partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and were confident in doing so and felt supported if they did. We also noted that team away days were held every year. Staff said they felt respected, valued and supported, particularly by the partners in the practice.

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

The practice encouraged and valued feedback from patients. Their patient participation group (PPG) was in the process of being reformed. We met with six members of this new group and all said they were looking forward to

Are services well-led?

Good 

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

working with the practice and being its critical friend. (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care).

We saw evidence that the practice had reviewed its' results from the national GP survey to see if there were any areas that needed addressing. We noted that the practice manager only responded to negative comments about the

practice. We discussed this with them and they said they would respond to all comments in the future. The practice was actively encouraging patients to be involved in shaping the service delivered at the practice.

The practice had also gathered feedback from staff through staff meetings and away days. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

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	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Required checks were not routinely carried out to ensure persons employed were of good character. Regulation 19 (1) (a) 2 (a) 3 (a) (b)
Family planning services	
Maternity and midwifery services	
Surgical procedures	
Treatment of disease, disorder or injury	