

# Hightown Surgery

## Quality Report

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

## Ratings

### Overall rating for this service

Good 

Are services safe?

Requires improvement 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Good 

# Summary of findings

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## Overall summary

### Letter from the Chief Inspector of General Practice

We carried out an announced follow-up inspection of Hightown Surgery on 22 October 2015. This inspection was a follow-up to our inspection of 6 November 2014 when the practice was rated as 'Inadequate'. The practice was placed into Special Measures in April 2015 and required to make significant improvements. The practice submitted an action plan detailing how they would make improvements and when they would be compliant with the regulations governing providers of health and social care.

At our follow-up inspection, we found the practice had made improvements across all five domains of safe, effective, caring, responsive and well led. Some improvement was still required in recruitment checks undertaken on locum GPs. Overall the practice is rated as Good

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

- The practice had made improvements that promoted the safe treatment of patients. We saw that arrangements were in place for an appointed GP to lead multi-disciplinary team meetings at the practice to manage the care of palliative patients. A named GP was appointed as the safeguarding lead for the practice.
- GPs delivering services were given sufficient time and support to familiarise themselves with systems in place at the practice, which resulted in the safer care and onward referral of patients to secondary care providers (hospitals and specialist clinics).
- Recruitment checks for staff were in place. However, all checks as required by Schedule 3 of the Health and Social Care Act (Regulated Activities) Regulations 2014 were not complete for locum GPs and several checks had not been carried out before the locum GPs started working for the provider.
- The practice had made improvements that increased the effectiveness of care for patients. The practice

# Summary of findings

had a core group of locum GPs delivering services, which contributed to the effectiveness of treatment of patients by the practice and provided a degree of continuity of care.

- The Patient Participation Group (PPG) for the practice told us things had improved since the CQC inspection of 2014. Patients reported that they had seen improvements in the continuity of care and that GPs were caring and inclusive towards them.
- The provider had responded to the concerns of patients, communicating positively with the PPG.
- The provider leadership team had responded positively to the feedback from Inspectors following

the inspection of November 2014. The retention of locum GPs to deliver services was more robust, and patients were familiar with these GPs. Strong clinical leadership was provided by a Clinical Director, appointed by the provider within the last 12 months.

There are areas where the provider MUST make improvements. The provider must:

- Ensure that all recruitment checks as required by Schedule 3 of the Health and Social Care Act 2008, are in place for all staff, including locum GPs.

**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. Some further work is needed to ensure all recruitment checks required on locum GPs are in place . We found:

- A core of locum GPs delivered services at the practice, which improved the continuity of care for patients.
- The instance of booked locum GPs failing to honour bookings at the practice had been reduced significantly.
- There was system in place for reporting and recording significant events and, locum GPs we spoke to could demonstrate how this was used. However, we were unable to confirm how learning was applied by locum GPs who provided more ad hoc cover.
- Lessons were shared to make sure action was taken to improve safety in the practice.
- The practice had defined systems, processes and practices in place to keep people safe and safeguarded from abuse.
- Some of the required recruitment checks were not in place for locum GPs.
- Systems for effective communication between GPs, whose other work commitments meant they would not see each other at the practice, were in place

**Requires improvement**



### Are services effective?

The practice is rated as good for providing effective services. Improvements made by the provider meant that:

- Patient outcomes were at or above average for the locality; Quality Outcome Framework (QOF) figures available at the time of the inspection showed performance in the management of long term conditions was good, as well as in several other areas of patient care.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits were used to bring about improvement, for example, in the levels of antibiotic prescribing.
- Sufficient staff were retained who had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for staff.

**Good**



# Summary of findings

- Staff had been working with multidisciplinary teams to understand and meet the range and complexity of people's needs.

## Are services caring?

The provider is rated as good for providing caring services. Improvements made by the provider since our last inspection showed:

- Complaints to the CQC about the lack of continuity of care and the provider response to this, had reduced significantly.
- Patients felt positive about the regular GPs providing services, saying they were treated with compassion, dignity and respect and that 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.
- Patients could access details easily on how to contact the Patient Participation Group (PPG).

Good



## Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

- Patients said they found it easier to make an appointment with a named GP and that there was more continuity of care, with urgent appointments available the same day. However, we saw that the number of locums used between July and September had increased, which would have impacted on continuity of care for patients. It was unclear as to whether this situation would continue or whether it had been caused by peaks in annual leave of locum GPs.
- Regular multi-disciplinary team meetings to support the Gold Standards Framework of palliative and end of life care were in place and led by a named GP for the practice.
- The provider had decorated the practice, giving it a fresher and more welcoming appearance.
- Information about how to complain was available and easy to understand. Learning from complaints was shared with staff and other stakeholders.
- We saw that the provider had responded to comments posted on the NHS Choices website about the practice.

Good



# Summary of findings

## Are services well-led?

The practice is rated as good for providing well-led services. We saw that significant improvements had been made since our inspection of November 2014.

- The provider had recently appointed a clinical director who offered a direct contact for GPs working at practices run by SSP Health Ltd.
- A GP who worked for two sessions each week at the practice had taken the lead on palliative care and was also a safeguarding lead.
- GPs we spoke with were familiar with the systems in place and were aware of how they were used.
- The practice had a number of policies and procedures to govern activity and held regular meetings for review of performance and to discuss practice level issues.
- There was an overarching governance framework which supported the delivery of the patient care. This included arrangements to monitor and improve quality and identify risk.

Clinical audits were conducted at a higher level, with action points cascaded to GPs working at the practice. This included audits in response to alerts on medicines as well as targeted work, for example, on reduction of inappropriate anti-biotic prescribing.

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. We saw that:

- The practice offered care to meet the needs of the older people in its population. Longer appointments were offered to people with multiple health conditions.
- It was responsive to the needs of older people, and offered home visits when required and urgent appointments for those with enhanced needs.
- Patients we spoke to from this population group said there was now some continuity of care offered by the core GPs working at the practice, and that this was important to them.

Good



### People with long term conditions

The practice is rated as good for the care of people with long term conditions. We found that:

- Nurses at the practice ran effective clinics for treatment of patients with multiple long term conditions.
- Patients at risk of hospital admission were identified as a priority, and received health care that reduced their risk of unplanned admission to hospital.
- Performance indicators for the treatment and management of patients with diabetes showed the practice was performing at or above the national average in this area of health care.
- Longer appointments and home visits were available when needed, for example, when delivering the flu vaccination to housebound patients.
- Patients had a structured annual review to check that their health and medicines needs were being met. For those people with the most complex needs, a GP liaised with relevant health and care professionals to deliver a multidisciplinary package of care.

Good



### Families, children and young people

The practice is rated as good for the care and treatment of families, children and younger people.

Good



# Summary of findings

- Data collected by NHS England between 1 April 2014 – 31 March 2015 showed the practice performed well in the delivery of childhood vaccinations, with the lowest score being 94.1% of children aged up to 12 months receiving all required vaccinations.
- Other than one score of 95.2%, for children aged 5 years receiving a pre-school booster vaccination, the practice achieved a 100% success rate in the delivery of childhood vaccinations for children aged 0 – 5 years.
- Cervical screening had been delivered to 80.86% of female patients at the practice, which is in line with national results.
- Appointments were available outside of school hours and the premises were suitable for children and babies.

We saw good examples of joint working with health visitors.

## **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 practice offered appointments with a male or female GP were required.
- The delivery of the extended hours clinic had been decided in consultation with patients and was on a Friday evening each week.
- Patients commented that they found it easy to book an appointment when they needed one.

Access to on-line prescription ordering and appointment booking was limited.

**Good**



## **People whose circumstances may make them vulnerable**

The practice is rated as good for the provision of care for people whose circumstances may make them vulnerable.

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability, and those patients who were also carers.
- It offered longer appointments for people with a learning disability and for carers who requested this.
- It had information for 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**





# Summary of findings

## 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).

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88% of patients diagnosed with a mental health condition had a comprehensive agreed care plan documented within their patient record.
- The practice 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 and their carers 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.

Good



# Summary of findings

## What people who use the service say

The national GP patient survey results published on 2 July 2015 showed the practice was performing above most local and national averages. 295 survey forms were distributed and 107 were returned. This gave a response rate to the survey of 36.3%. These views are representative of just over 5% of the practice population. Figures showed:

- 93.5% found it easy to get through to this surgery by phone (CCG average of 64.8%, national average of 73.3%).
- 91.2% found the receptionists at this surgery helpful (CCG average 83.3%, national average 86.8%).
- 90.9% were able to get an appointment to see or speak to someone the last time they tried (CCG average 81.1%, national average 85.2%).
- 93.4% said the last appointment they got was convenient (CCG average 92.2%, national average 91.8%).
- 84.7% described their experience of making an appointment as good (CCG average 66.9%, national average 73.3%).
- 71.1% usually waited 15 minutes or less after their appointment time to be seen (CCG average 62.8%, national average 64.8%).

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. The practice only received the comment cards to issue to patients, two days before our inspection. We received 12 comment cards; seven of these were positive about the standard of care received. Patients particularly commented on the care provided by a core group

of regular locum GPs providing services at the practice, saying this had provided stability and some continuity of care. Five comment cards contained negative comments about the service, mainly around continuity of service from GPs.

Patients we spoke with on the day of our inspection said standards had improved since the last CQC inspection. Patients were happy about the appearance of the practice, which had recently been decorated, and appeared clean, tidy and was more welcoming. Patients knew which GPs worked on which days, and this helped them when booking appointments to see a GP of their choice. However, patients remained nervous about the future of the practice, and noted that although some continuity of service had been provided by GPs, this was not a guarantee. For example - some GPs had reduced the number of sessions they worked, which left more cover required for the practice, usually by GPs patients were not familiar with.

## Areas for improvement

### Action the service MUST take to improve

- Ensure that all recruitment checks as required by Schedule 3 of the Health and Social Care Act 2008, are in place for all staff, including locum GPs.

# Hightown Surgery

## Detailed findings

### Our inspection team

#### Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP, a practice manager and a second CQC inspector.

## Background to Hightown Surgery

Hightown Surgery is located in a residential area of Merseyside and serves a patient list of 1,988 patients. The practice falls with NHS South Sefton Clinical Commissioning Group (CCG). The practice is managed by a large provider, SSP Health Ltd. All services are delivered under a Primary Medical Services (PMS) contract.

The provider retains a core group of locum GPs who deliver the services. The combined hours of the GPs equate to just over one full time working GP each week. There are two practice nurses whose combined part time hours provide 28 hours of nursing care each week. The practice also has a health care assistant who supports the work of the nurses.

Services are delivered from a former domestic property which has been developed over time to provide further consultation facilities. The practice has a consultation room on the ground floor, wheelchair and step-free access. A hearing loop is available for people with hearing difficulties. The practice does not provide its own out of hours care. In the out of hours period, patients are directed to the NHS 111 service who will triage calls and refer on to the locally appointed provider, Urgent Care 24 (UC24).

The practice is open between 8am and 6.30pm Monday to Friday. The practice appointments cover a two

and a half hour window in the mornings and afternoons. Due to different GPs, the start times of the surgeries can vary. For example, from 9.30am to 12.40pm and from 2.40pm to 5.40pm each week day, Extended hours surgeries are offered on Friday of each week, from 6pm – 7pm. Patients are made aware of the different start times of surgeries.

The practice was inspected in November 2014, rated as inadequate overall and placed into Special Measures. The provider was required to make significant improvements; specifically we found the domains of safety of care and leadership were inadequate. The practice was rated as requiring improvement in the domains of effective and responsive care and treatment, and for the domain of caring.

At this inspection we discussed the lack of a Registered Manager for the practice. The CQC had written to the practice in July of 2014, outlining the breach in conditions of registration this presented. The provider had given a commitment to address this. However, we understand from the Medical Director that further work is in place, between the provider and the CQC Registrations department, which will address this matter.

## 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 function. In November 2014 the practice had been rated as inadequate and was placed into Special Measures in April 2015. Being placed into Special Measures represents a decision by CQC that a

# Detailed findings

service has to improve within six months to avoid CQC taking steps to cancel the providers registration. Compliance actions were set for the provider following the inspection carried out in November 2014.

This inspection was carried out to consider whether sufficient improvements have been made and to identify if the provide is now meeting legal requirements and associated regulations.

## How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 22 October 2015. During our visit we spoke with a range of staff including two GPs working at the practice on the day of our inspection and with one GP by phone. We spoke with the Regional Manager, practice nurse and two practice receptionists. Members of the corporate management team at the practice including the Medical Director, Chief Operating Officer and Head of Human Resources. We observed how people were being cared for and talked with patients and carers. We reviewed comment cards where patients and members of the public shared their views and experiences of the service. We spoke with the practice PPG.

# Are services safe?

## Our findings

Following our inspection of November 2014, the practice was rated as Inadequate for the provision of safe care and treatment and was required to make improvements.

### Safe track record

In our follow up inspection of October 2015, we found:

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 a standard recording form available on the practice's computer system.
- The practice carried out analysis of the significant events.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. Lessons were shared to make sure action was taken to improve safety in the practice. For example, we saw an interruption to IT function at the practice, was reviewed as a significant event. Conclusions showed practice staff recognised that a print out of a patient list for morning and afternoon surgeries would have been useful in helping to manage the flow of patients.

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

There was no point in the week where there was a crossover of the locums working at the practice, to facilitate a meeting between clinicians. We saw that a structured calendar of meetings was in place, for example, multi-disciplinary team meetings, which each GP took an active lead role in. Minutes of these meetings were available to the other regular locum GPs working at the practice. The improved communications between GPs appeared embedded, promoting patient safety.

### Learning and improvement from safety incidents

Significant events was a standing item on the practice meeting agenda and a dedicated meeting was held annually to review actions from past significant events and complaints. There was evidence that the practice had

learned from these and that the findings were shared with relevant staff. The provider cascaded minutes of meetings which included discussion of significant events to locum GPs working for the provider, so they could review discussions and findings. We were unable to determine how successful this system was, for example, in the application of learning for GPs who provided more ad hoc cover at the practice.

Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and said they felt comfortable doing this.

We saw that requests for home visits to patients were recorded and triaged by the GPs on duty on that day. There had been no instances that we were aware of where home visits had been unreasonably declined.

### Reliable safety systems and processes including safeguarding

Practice GPs we spoke with described how alerts from the Medicines and Healthcare Regulatory Agency (MHRA) were received and cascaded to GPs and nursing staff at the practice. The clinical director had responsibility for this and we saw that GPs received this information without delay. We saw that a monthly newsletter produced at provider level, summarised these alerts.

A messaging system used by GPs working at the practice, meant GPs were aware of any follow-up to a patient's care that was required. A GP we spoke with on the day of our inspection showed how this was used effectively between GPs to ensure key tasks in relation to a patient's care were completed.

The practice staff and GPs could demonstrate their awareness and knowledge of safeguarding procedures. The provider has a corporate level safeguarding lead who any member of staff could approach to ask for advice or guidance. One of the locum GPs was the appointed safeguarding lead, with a further locum and the practice nurse acting as deputies. In the instance of any absence of these staff at the time of a safeguarding incident, staff said they felt confident in approaching the corporate lead for safeguarding. We saw GPs were trained to the required level (level three) in safeguarding.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients

# Are services safe?

attended appointments; for example children subject to child protection plans. Although GPs could tell us how patient records were annotated to indicate whether they were vulnerable and on any safeguarding register, both GPs at the practice could not say if there were patients on the practice safeguarding register.

The practice had a chaperone service available to patients who requested this service. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). We saw staff who undertook these duties had been trained on how to act as a chaperone and had enhanced background checks from the Disclosure and Barring Service (DBS) in place to ensure they were not unsuitable for these duties. (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).

## Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

All prescriptions were reviewed and signed by a GP before they were given to the patient or approved on the Electronic Prescribing System. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

We saw records that noted the actions taken in response to a review of prescribing data. For example, patterns of antibiotic, hypnotics, sedatives and anti-psychotic prescribing within the practice. Medicines audits and reviews were initiated centrally and action points sent to

GPs to apply. For example, we saw that regular searches were performed to ensure that antibiotic prescribing was carried out in line with NICE guidance and conformed with CCG prescribing protocol.

There was a system in place for the management of high risk medicines such as warfarin, methotrexate and other disease modifying drugs, which included regular monitoring in accordance with national guidance. Appropriate action was taken based on the results.

## Cleanliness and infection control

We observed the premises to be clean and tidy. We saw cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. The practice had recently been redecorated which gave the practice a fresh appearance.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

The practice had a lead for infection control and the practice nurse acted as a deputy. All staff received induction training about infection control specific to their role and received annual updates. Minutes of practice meetings showed that any issues in relation to infection control were discussed.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

## Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date which



# Are services safe?

was September 2015. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales and blood pressure measuring devices.

## Staffing and recruitment

We reviewed the retention of locum GPs for the practice. We saw that up until June of 2015, the service had been delivered consistently by three locums, which covered all hours at the practice. This altered in July, August and September when more locums were involved in delivery of the service through these summer months.

We saw that there were three occasions where locums had failed to honour bookings. In these instances, staff had contacted the head office of the provider and a plan to deal with this was implemented. This meant patients who needed to be consulted with on that day would be dealt with by phone, and those patients booked for routine appointments could be offered an alternative appointment. On occasions, the provider had arranged a further surgery in the afternoon, in order to meet the healthcare needs of the patients affected by such incidents.

We noted that although the number of locums used to deliver services on a monthly basis had increased, there was still a degree of regularity with which each locum was retained.

Recruitment checks for locum GPs were in place, but we found that they were incomplete. We saw that some checks had not been conducted before a GP had worked for the provider. We also noted that details of level of cover provided by each locums medical indemnity cover, was not checked and evidence of this retained. For example, for how many sessions a GP was insured to deliver, and how the practice had confirmed any work done elsewhere by the locum in each week.

In a file given to us by staff, we saw that all recruitment checks as required by Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, had not been undertaken by the provider or confirmed via any locum supply agency, in respect of locum GPs appointed. We reviewed a locum appointment protocol, issued by the provider and given to us by the Head of Human Resources for the provider. We could see the protocol had last been reviewed in February 2015. At Appendix A of the protocol is

a pre-engagement checklist, detailing confirmation of checks required. We noted that legislation referred to on page one of the locum appointment protocol, was incorrect (referring to the provisions of the Health and Social Care Act 2001 in relation to requirements imposed on GP practices to carry out recruitment checks on locums retained by the practice). The provider should review information to ensure that all regulation referred to is correct, and applied to recruitment checks on locum GPs.

## Monitoring safety and responding to risk

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

## Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that 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. The notes of the practice's significant event meetings showed that staff had discussed a medical emergency concerning a patient and that the practice had learned from this appropriately.

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.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Records showed that staff were up to date with fire training and that they practised regular fire drills.

# Are services effective?

(for example, treatment is effective)

## Our findings

Following our inspection of November 2014, the practice was rated as requires improvement for the provision of effective care and treatment.

At our follow-up inspection of October 2015 we found improvements had been made and the practice is now rated as good for the provision of effective services.

### Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of clinical meetings and communications to GPs from the Clinical Director which showed this was discussed and implications for the practice's performance and patients were identified and required actions agreed. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

Staff we spoke with described how they carried out comprehensive assessments which covered all health needs and was in line with these national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients with diabetes were having regular health checks and were being referred to other services when required.

### Management, monitoring and improving outcomes for people

Information about people's care and treatment was routinely collected and monitored at a central level by the pharmacist employed by the provider. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards

practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, we saw an audit on the prescribing of antibiotics which was repeated to ensure that current best practice was followed by all clinicians.

### Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. All staff undertook annual appraisals that identified learning needs, which were recorded and passed to the head office of the provider who would arrange training required.

We saw that sufficient numbers of locum GPs had been retained to provide services at the practice, and that a regular core of locums used had improved the effectiveness of the service at the practice.

Practice nurses and the health care assistant had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties. For example, on administration of vaccines, blood collection (phlebotomy) and cervical cytology.

### Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. All relevant staff understood their responsibilities for passing on, reading and acting on any issues arising from these communications.

Multi-disciplinary team meetings were in place and those patients who required shared care within the community were being supported by the practice.

Out-of hours reports, 111 reports and pathology results were all seen and actioned by a GP on the day they were received. Discharge summaries and letters from outpatients were usually seen and actioned on the day of receipt. We did not find any backlog in the processing of correspondence from secondary care providers. The GPs who saw these documents and results were responsible for



# Are services effective?

(for example, treatment is effective)

the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no further instances identified since our last inspection of any results or discharge summaries that were not followed up.

We saw that internally, locum GPs used the tasking system on practice computers as an effective means of communication in relation to ensuring that colleagues were aware of any further follow-up action that required initiating in their absence.

## Information sharing

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

The practice used several electronic systems to communicate with other providers. Practice staff updated the provider of out of hours services, on any patients newly added to the palliative care register, or those on with complex needs who may required a GP within the out of hours period.

## Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe

how they implemented it. Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually or more frequently if changes in clinical circumstances dictated it. All clinical staff demonstrated a clear understanding of the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions).

## Health promotion and prevention

The practice offered 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. The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. The practice's performance for the cervical screening programme was 80.86%, which was in line with 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. A practice nurse had responsibility for following up patients who did not attend. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening. The practice performed well in delivery of immunisation and vaccination programmes:

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Childhood immunisation rates for the vaccinations given to children twelve months and under reached 94.1% of eligible patients, and 100% of two year olds received all required immunisations, which was at or above the local average achievement.

# Are services caring?

## Our findings

Following our inspection of November 2014, the provider was rated as requires improvement for the domain of caring.

At our follow-up inspection of October 2015 we found improvements had been made and the practice is now rated as good for the provision of caring services.

### Respect, dignity, compassion and empathy

We observed that members of staff were courteous and very helpful to patients and treated people 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.

We received 12 patient CQC comment cards; seven were positive about the service experienced. Patients said they felt the practice offered an improved service and staff were helpful, caring and treated them with dignity and respect.

We also spoke with six members of the Patient Participation Group (PPG). They also told us the service had improved since our last inspection but some matters still needed to be addressed, for example communication updates regarding the future of the practice. As patients, they said the practice GPs respected their dignity and privacy. They also commented that the provider had engaged with them more constructively.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. Information from the NHS England GP Patient Survey, published in July 2015 shows:

- 80.6% said the GP was good at listening to them compared to the CCG average of 87.2% and national average of 88.6%.

- 80.6% said the GP gave them enough time (CCG average 84.7%, national average 86.6%).
- 90.9% said they had confidence and trust in the last GP they saw (CCG average 94.3%, national average 95.2%)
- 83.2% said the last GP they spoke to was good at treating them with care and concern (CCG average 83%, national average 85.1%).
- 94.4% said the last nurse they spoke to was good at treating them with care and concern (CCG average 90.7%, national average 90.4%).
- 91.2% said they found the receptionists at the practice helpful (CCG average 83.3%, national average 86.8%)

### Care planning and involvement in decisions about care and treatment

Patients told us that 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. 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 showed the majority of patients gave positive responses, but that there was room for further improvement. For example:

- 80.7% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 83.9% and national average of 86%.
- 70.8% said the last GP they saw was good at involving them in decisions about their care (CCG average 79.9%, national average 81.4%)

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/carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations. The

## Are services caring?

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.

Staff told us that if families had suffered a bereavement, one of the GPs would contact 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. Patients who were carers confirmed that the regular core of locum GPs who

had been at the practice recently made it easier for them to explain the issues they faced as carers, to a GP who they were familiar with, and that this was important to them. We saw evidence that the provider had engaged more fully with patients and with the practice PPG. Patients reported that the practice GPs and the provider had shown more empathy towards them and had taken steps to provide some degree of continuity of care through the use of a core group of locum GPs at the practice.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

Following our inspection of November 2014, the provider was rated as requires improvement for the responsiveness of the practice to the needs of patients.

At our follow-up inspection of October 2015 we found improvements had been made and the practice is now rated as good for the provision of responsive services.

### Responding to and meeting people's needs

We found that the practice was responding to patients needs, especially at times of the year when there was an increased demand for services. The provider demonstrated how they increased the availability of GP appointments on offer to patients in winter months to a ratio of 80 per 1,000 patients on the practice register, per week. This is above the normal ratio of 70 appointments per thousand patients on the register, per week.

We saw that all requests for home visits were logged and were triaged by the GPs on duty at the practice. We were not made aware of, nor did we find any evidence of locum GPs declining to do house calls to those patients that needed them.

### Tackling inequity and promoting equality

Administrative support staff who worked at the practice lived locally and knew patients who were registered at the practice. Staff used this local knowledge when offering appointments to patients, for example, whether a patients could drive and whether appointments at a certain time may prove difficult to attend with a carer. We saw that all care and treatment was delivered based on the needs of patients and that all patients had equal access to the service.

### Access to the service

The practice was open between 8am and 6.30pm Monday to Friday. Due to the differing start times of locum GPs, morning and afternoon surgery start and finish times varied but patients were given access to information on this in good time. Typically, surgery times in the morning and afternoon were for two and a half hours. For example, appointments were typically from 9.30am to 12.40pm every morning and from 2.40pm to 5.40pm each afternoon.. Extended hours surgeries were offered on Friday evenings from 6pm – 7pm. In addition to pre-bookable

appointments that could be booked up to six weeks in advance, urgent appointments were also available for people that needed them. The practice had introduced on-line access to book appointments but patients could still not order repeat prescriptions on-line.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was better than local and national averages. People told us on the day that they were able to get appointments when they needed them.

- 75.9% of patients were satisfied with the practice's opening hours (CCG average 70.4%, national average of 74.9%).
- 93.5% patients said they could get through easily to the surgery by phone (CCG average 64.8%, national average 73.3%).
- 84.7% patients described their experience of making an appointment as good (CCG average 66.9%, national average 73.3%).
- 71% patients said they usually waited 15 minutes or less after their appointment time (CCG average 62.8%, national average 64.8%).

### Listening and learning from concerns and complaints

One of the locum GPs working at the practice acted as the clinical contact with the PPG and did attend meetings when possible. We noted that patients had particularly appreciated this. In response to feedback from patients, the extended hours surgery which had originally been delivered on a Monday evening, was moved to a Friday evening. The staff at the practice reported that this worked well and that patients had welcomed this change.

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 for example in the practice information leaflet.

## Are services responsive to people's needs? (for example, to feedback?)

We were not aware of any rise in number of complaints since our inspection of November 2014. The practice continued to handle any complaints received in the usual manner and this was in line with the practice complaint policy.

Of the CQC comment cards submitted by patients, five cards detailed negative comments, saying the issues of continuity of care had not been sufficiently addressed. We did note in our inspection that the number of locums used

to deliver services had increased in number through July, August and September. We were unable to determine at the time of our inspection whether this was purely due to the summer months when staff would take annual leave, or whether the increase in different locums delivering services would continue. This was an aspect of service delivery that patients still had concerns about and felt had not been sufficiently addressed by the provider.

# Are services well-led?

Good 

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

## Our findings

Following our inspection of November 2014, the provider was rated as inadequate for the domain of well-led.

At our follow-up inspection of October 2015 we found improvements had been made and the practice is now rated as good for the provision of well-led services.

### Vision and strategy

The practice leadership team did not have a specific strategy in place for service delivery beyond the end of the performance year as other contractual arrangements had been made to deliver services in the performance year 2016-17. Patients at the practice were aware of this change and were awaiting further details on how services would be delivered locally.

### Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to all staff on the shared drive of computers within the practice. We looked at a number of these policies and procedures and most staff confirmed that they had read the policy and when. All policies and procedures we looked at had been reviewed annually and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, the practice manager was the lead for infection control named GPs were the lead for safeguarding. We spoke with staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The GPs and practice manager took a leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. The included using the Quality and Outcomes Framework to measure its performance. The QOF data for this practice showed it was performing in line with or above national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

Clinical audit was conducted in response to any safety alerts or changes in guidance on treatment for patients. These were carried out at a higher, corporate level and information on changes needed were cascaded to GPs in the practice.

The practice held monthly staff meetings where governance issues were discussed. We looked at minutes from these meetings and found that performance, quality and risks had been discussed.

### Leadership, openness and transparency

The GPs working at the practice were visible in the practice and staff told us that they were approachable and took the time to listen to all members of staff. The system of regular locum GPs providing services at the practice, gave staff GPs who they looked to as leaders and reported good working relationships amongst the practice staff.

Clinical leadership was provided by the recently appointed Clinical Director, who worked across the practices that the provider was responsible for. We saw that further leadership was available from the Medical Director. The Patient Participation Group (PPG) reported that the provider had engaged meaningfully with them since the last CQC inspection and they were aware that responsibility for providing services would move to a new provider soon. Patients felt that as information had been available, the provider had shared this with them.

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

The provider took part in the NHS England GP Patient Survey and results from this showed that, in areas we know to be particularly important to patients, the practice had performed well. For example, in being able to get through to the practice by phone – practice score 93.5% compared to the CCG average of 64.8% and national average of 73.3%. Meetings with the PPG had provided feedback to the practice and senior management team. We saw the provider had responded to this, for example, by the installing a notice board in the surgery which gave contact details of key members of the PPG and their photographs so they would be easily recognised. A suggestions box had also been located in the surgery for patients to feedback any concerns or issues they may have had. The PPG reported that the provider had facilitated meetings with the PPG and had engaged more constructively with them since the last CQC inspection.

# Are services well-led?

Good 

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

## Management lead through learning and improvement

The practice staff, including the GPs working at the time of our inspection told us the provider had supported them in bringing about improvements at the practice. We saw that staff had protected learning time and this was used to facilitate training for staff, offered by the local CCG. GPs told us they were supported with their evidence requirements for annual appraisal and we saw that the nurse was aware of the requirements for revalidation from January 2016.

The provider used QOF results as a driver of improvement; we noted from information provided at the time of our inspection that performance stands at 98% for 2014-15 with an exception reporting rate of 0.58% which is above the national and local average.

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 Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed  <b>The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</b>  Regulation 19 Fit and proper persons employed  The provider is failing to comply with Regulation 19(2) of the regulations. All information specified in Schedule 3 of the regulations was not available in respect of locum GPs used by the practice.