HT Practice

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	**Requires improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive to people's needs?	**Good**
Are services well-led?	**Good**

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at HT Practice on 17 April 2015. Overall the practice is rated as good.

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

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 usually 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 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.

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

Summary of findings

Importantly the provider must:

- Ensure recruitment arrangements include all necessary employment checks for all staff.
- Ensure all identified risks, such as following fire risk assessments, are dealt with in a timely manner.
- Ensure all equipment used is safe and within its expiry date.

The provider also should:

- Consider amending appraisal process for nurses so that nurses are appraised by nurses who have managerial responsibility to do.
- Set up a process to record the serial numbers of prescriptions taken on home visits.
- Review policies to check they are dated and have been reviewed appropriately.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services as there are areas where it should make improvements. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. When things went wrong, reviews and investigations were thorough and lessons learned were communicated. We found that robust recruitment procedures did not take place. Staff had not been trained in fire safety and not all the risks identified during a fire risk assessment had been corrected. Some equipment was out of date and medicines were not always kept securely.

Are services effective?

Good

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 National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had usually received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. The patients we spoke with rated the practice highly for most 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 to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was

Summary of findings

well equipped to treat patients and meet their 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.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about their roles and 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 (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. 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 all patients over the age of 75 had a named GP. Regular multi-disciplinary team meetings were held for patients requiring end of life care. Home visits were offered to patients when these were required.

People with long term conditions

Good

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 medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Young people were treated in an age appropriate way. 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 and health visitors.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. Early morning appointments were available for patients who worked.

Summary of findings

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks for people with a learning disability and gave longer appointments where required.

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.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). People experiencing poor mental health received an annual physical health check. The clinicians took the opportunity to carry out any checks and provide vaccinations where required. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND. Counselling was offered to patients.

Summary of findings

What people who use the service say

During our inspection we spoke with six patients included a member of the patient participation group (PPG). We reviewed 29 CQC comments cards.

The patients we spoke with told us they could usually access emergency or routine appointments when they were requested. They also said it was usually not difficult to get through to the practice on the telephone. Patients told us staff at the practice were helpful, and they were able to choose the gender of the GP they saw. They told us the practice was open at times convenient to them, with one patient adding it was much easier since they started having early morning opening.

The CQC comments cards were also positive. Patients commented that they were treated in a respectful way by caring staff. They said appointments were easy to access and they were listened to by staff, feeling involved in their care or treatment.

We also looked at the results of the latest national GP survey. The survey results highlighted the areas the practice did best as:

83% of respondents found it easy to get through to the practice on the telephone (Clinical Commissioning Group (CCG) average 75%).

99% of respondents had confidence and trust in the last nurse they saw or spoke to (CCG average 97%).

91% of respondents said the last appointment they had was convenient (CCG average 92%).

The survey also highlighted areas the practice could improve as:

68% said the last GP they saw or spoke to was good at giving them enough time (CCG average 87%).

69% said the last GP they saw or spoke to was good at explaining tests or treatments (CCG average 85%).

59% of respondents said they would recommend the practice to someone new to the area (CCG average 75%).

Areas for improvement

Action the service MUST take to improve

- Ensure recruitment arrangements include all necessary employment checks for all staff.
- Ensure all identified risks, such as following fire risk assessments, are dealt with in a timely manner.
- Ensure all equipment used is safe and within its expiry date.

Action the service SHOULD take to improve

- Consider amending appraisal process for nurses so that nurses are appraised by nurses who have managerial responsibility to do so.
- Set up a process to record the serial numbers of prescriptions taken on home visits.
- Review policies to check they are dated and have been reviewed appropriately.

HT Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The team also included a GP specialist advisor, a practice nurse specialist advisor and an expert by experience. An expert by experience is someone who uses health and social care services.

Background to HT Practice

HT Practice has two surgeries. Trafalgar Square Surgery is based in a purpose built health centre in the centre of Ashton-Under-Lyne and Highlands Surgery is based in an older building less than a mile away. GPs, nurses and other staff work between the surgeries and patients were able to choose which surgery they attended. Both surgeries were accessible to patients with disabilities and Highlands Surgery had recently had a passenger lift installed.

Five GPs worked between the surgeries; two males and three females. Three GPs were partners and two were salaried. There were three practice nurses, a healthcare assistant, and reception and administration staff. One of the practice nurses also held the role of practice manager.

The surgeries were both open from 8am until 6pm on Mondays and Wednesdays, and from 7.30am until 6pm on Tuesdays, Thursdays and Fridays.

The practice delivers commissioned services under a General Medical Services (GMS) contract. At the time of our inspection 7940 patients were registered with the practice.

Patients requiring a GP outside of normal working hours are advised to contact an external out of hours service provider.

We found that one of the registered partners had retired and another partner had taken their place. The practice told us they would apply to change their registration appropriately.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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

Detailed findings

- 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 to both surgeries on 17 April 2015. During our visit we spoke with a range of staff, including GPs, nurses and reception staff. We also spoke with six patients, including a member of the patient participation group (PPG). We reviewed 29 CQC comments cards where patients had shared their views and experiences of the practice.

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. There were clear lines of leadership and accountability in respect of how significant incidents, including mistakes were investigated and managed. Before visiting the practice we reviewed a range of information we hold about the practice and asked other organisations such as NHS England and Tameside and Glossop Clinical Commissioning Group (CCG) to share what they knew. No concerns were raised about the safe track record of the practice.

Discussion with senior staff at the practice and written records of significant events revealed that they were escalated to the appropriate external authorities such as NHS England or the CCG. A range of information sources were used to identify potential safety issues and incidents. These included complaints, health and safety incidents, findings from clinical audits and feedback from patients and others.

The staff we spoke with confirmed that forms to report incidents were available on the practice's computers. They all had access to these and were encouraged to complete them when required. We saw that safety alerts was a standard agenda item for practice meetings and these were discussed by the team.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the previous year and we were able to review these. Significant events was a standing item on the clinical meeting agenda and they were discussed at other staff meetings if appropriate. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so. The required forms were available to all staff on their computers.

National patient safety alerts were received by a GP who disseminated them to staff via the practice manager. We saw evidence that these were discussed at the regular meetings held. All relevant staff were informed of safety alerts and subsequent discussions with other teams, such as the medicines management team, were documented.

The practice held an annual meeting to discuss all the significant events and complaints that had occurred in the previous 12 months.

Reliable safety systems and processes including safeguarding

The practice had safeguarding vulnerable adults and children policies in place which were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. In addition there were contact numbers displayed in the GP's surgeries and in the reception office. There was a GP lead for safeguarding. All staff had received training at a level suitable to their role, for example the GP lead had level three training.

Staff knew how to report concerns. Safeguarding was a standard agenda item at the regular clinical meetings held. The practice had made safeguarding referrals to the relevant teams when they had concerns. We saw examples of the practice working with other agencies to ensure the safety of patients. They liaised with services in other areas where necessary and we saw an example of the practice keeping a patient on their register until they were certain other agencies had acted appropriately.

The practice had a chaperone policy and procedures, but this did not include instructions on the actual procedure staff should follow when acting as a chaperone. The staff we spoke with told us they had received guidance on chaperone procedures and were aware of their role. The practice manager told us some staff had received training. They were given details about chaperoning during their induction, mentored by an experienced staff member, and no staff member chaperoned unless they were comfortable doing so. However, staff were not all following the same procedures in that some staff noted patients' records after they had acted as a chaperone and some thought the GP did this. A Disclosure and Barring Service (DBS) check had not been completed for all staff who carried out chaperone duties.

Are services safe?

The practice manager told us they would arrange training for staff in chaperoning.

Medicines management

The practice had fridges in each site for the storage of vaccines. The practice nurses took responsibility for the stock controls and fridge temperatures. We looked at a sample of

vaccinations and found them to be in date. The fridge temperatures were checked and recorded daily. Regular stock checks were carried out to ensure that medications were in date and there were

enough available for use.

Appropriate emergency medicines were available. At Trafalgar Square Surgery we saw that emergency medicines were in a locked cupboard. However the key was kept in this cupboard and the key was also seen to be in a medicine's fridge. The room they were kept in was away from the patient area but was kept unlocked. All medicines were stored securely at the Highlands Surgery. All the emergency medicine was in date.

The practice used paper prescriptions at times, for example when GPs took them on home visits. When this occurred the prescriptions were not signed for and a record was not kept of the prescription serial numbers carried by GPs. This means not all prescriptions could be accounted for.

The practice worked with pharmacy support from the local CCG and carried out medicine audits and reviews to ensure patients were receiving optimal care in line with best practice guidelines. For example they were working closely with the medicines management team and substance misuse nurse specialist as they were an outlier in hypnotic prescribing. Data showed that hypnotic prescribing was decreasing and the work was continuing. The medicines management team visited the practice regularly and kept them up to date with any changes to guidance.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and 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. A property management company had the responsibility for cleaning the Trafalgar Square Surgery, and they attended two to three times a day. The practice employed cleaners at the Highlands Surgery, who usually attended each morning before the surgery opened.

The practice manager, who was also a nurse at the practice, took the lead for infection control. They had undergone suitable training for this. All new staff received training in the prevention and control of infection. There was also annual infection control training for all staff that included hand washing procedures. There was an infection control policy in place that gave suitable guidance to staff, but this was not dated.

An infection control audit had been carried out in February 2015. Trafalgar Square Surgery had scored 100% and The Highlands Surgery had scored 96%. There was an action plan in place to deal with any required improvements. A programme of refurbishment was taking place at The Highlands Surgery as this was an older building. We saw that fabric privacy curtains were used in this building. They appeared clean but there was no policy in place to determine the frequency they were laundered. We also observed that some sharps disposal boxes were undated and further than the recommended three quarters full.

Treatment rooms at Trafalgar Square Surgery had the necessary hand washing facilities. The rooms at The Highlands Surgery, a converted house, were much older and although they were clean some rooms had original sinks with an overflow and original taps which could be infection control issues. Personal protective equipment, such as gloves and aprons, was readily available. Hand gels for patients were available throughout the building. Clinical waste disposal contracts were in place and spillage kits were available.

The practice had a system for checking Legionella at The Highlands Practice and records were kept of the weekly running of water in low-use outlets. The building management company had the responsibility for these checks at Trafalgar Square Surgery.

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 for both surgeries. All portable electrical equipment was

routinely tested. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer. We saw that instruments were single use. However, some of these were past their expiry date, including some forceps and disposable scalpels.

Staffing and recruitment

We saw the recruitment policy that was very short and undated. It did not give full information of the checks that must be completed prior to a new staff member starting work. The need for checking the identity of staff, carrying out a Disclosure and Barring Service (DBS) check where appropriate and checking the full work history of staff was not mentioned. The practice's safeguarding policy did mention the need for references to be checked.

We looked at a selection of personnel files. Most files included curriculum vitae, but we saw no evidence that gaps in employment had been questioned. There was no record why staff had left previous jobs. Evidence of identity was not always held and although a DBS check had been carried out for some staff, some files, including that of a practice nurse, did not have one. References were included in some files. The practice manager told us they always asked for references. This was often by email and the evidence had not been kept. Interviews were held as part of the staff recruitment process and we saw the interview ratings forms that were used to determine the suitability of staff.

When locum GPs were required the practice often booked regular locums that were known to the practice. They kept a file for locums which included evidence such as General Medical Council (GMC) registration and identification. If an agency was used relevant information was supplied by the agency prior to them working at the practice. The practice gave feedback to the locum agency following using one of their GPs and we saw evidence that when poor feedback was necessary they ensured they did not use the GP in question again. We saw the file of a salaried GP. This did not contain a work history, identification or references.

Staff worked between the two surgeries and the practice manager ensured there were enough staff at all times. They told us that patients often preferred to attend The Highlands Surgery due to there being more free parking available, and as the surgeries were so close together staff could move between the two whenever required.

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 annual and monthly 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.

We saw there was a risk assessment completed for each practice. Where hazards were identified these were discussed at practice meetings and plans put in place to reduce the hazards.

The building management company carried out fire risk assessments for Trafalgar Square Surgery. We saw the most recent fire risk assessment for The Highlands Surgery, carried out February 2014. This highlighted the need for fire training for staff, but the practice manager told us this had not yet been completed for all staff. It also stated that all fire extinguishers must be attached to a wall. We saw that some fire extinguishers were free standing on the floor. In addition, there was no evidence seen that safety checks had been carried out on all fire extinguishers, and some were recorded as last being checked during 2011. Monthly visual checks on fire extinguishers, emergency lights and emergency exits were taking place.

Arrangements to deal with emergencies and major incidents

There was an alarm system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. The practice premises also had panic buttons installed.

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support during March 2015. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency) at each surgery. When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. At The Highlands Surgery there was no warning sign to show where the oxygen was stored. There was also an old oxygen cylinder stored in a room and the practice manager told us they were arranging for this to be removed.

Requires improvement

Are services safe?

Emergency medicines were available at both surgeries. They were kept securely in The Highlands Surgery but at Trafalgar Square Surgery, although they were locked in a cupboard the keys were kept in the lock. 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. 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. The partners and the practice manager all held a copy of the plan at their homes to use in an emergency. The plan was dated August 2008, and it was stated that the practice manager would review it twice a year or at agreed intervals.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Once patients were registered with the practice they were invited to attend an appointment with the healthcare assistant. The healthcare assistant carried out routine health checks that included checking a patient's height weight, blood pressure and allergies. Lifestyle questions, such as around smoking status, alcohol consumption and diet were also asked. Individual advice was given and where appropriate patients were referred to other healthcare professionals or to a GP for an appointment. The practice nurses were also involved in performing new patient health checks.

When patients reached the age of 75 they were allocated a named GP. The practice had carried out health checks for patients over the age of 75 but these had stopped due to GP capacity. However, there were plans in place to reintroduce these checks in September 2015 when a new GP had started at the practice.

The practice had a system of registers for patients who had greater needs for example a learning disabilities register. This helped the practice identify patients who required specific appointments such as annual health checks or medication reviews. We saw the process that was in place for monitoring all patients with long term conditions. There was monthly monitoring to ensure patients had attended for a review of their condition at the appropriate time.

One of the GPs was responsible for receiving updates from the National Institute for Health and Care Excellence (NICE). We saw these were discussed as a standard agenda item in practice meetings, and urgent updates were disseminated to relevant staff as soon as they were received.

Read coding at the practice was used effectively. Read coding records the everyday care of a patient, including family history, relevant tests and investigations, past symptoms and diagnoses. They improve patient care by ensuring clinicians base their judgements on the best possible information available at a given time. We saw that clinicians completed patients' records so they could be easily followed by any appropriate person. Consultations, test results and letters were all stored on the computer system to ensure clinicians had all information available to them. When locums were employed the practice had a system in place to ensure the correct read codes had been input.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework system (QOF). This is a system for the performance management of GPs intended to improve the quality of general practice and reward good practice. The practice held meetings to regularly discuss practice performance and improvements in QOF and to ensure targets were met.

Clinical staff usually met weekly to discuss the management of individual cases and also met on an informal basis throughout the day. The practice also met with the local Clinical Commissioning Group (CCG) to discuss performance.

GPs carried out clinical audits. Examples of audits included looking at the prescribing of certain medicines to ensure safe practice was followed and the most appropriate medicines were prescribed for patients. The results showed compliance with guidelines and an improvement in outcomes. We saw that GPs carried out other audit cycles to use as evidence during their appraisal and revalidation process.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that most staff were up to date with attending mandatory courses such as annual basic life support. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by NHS England can the GP continue

to practise and remain on the performers list with the General Medical Council). One of the GPs took the lead for most clinical roles, although other GPs also had areas of responsibility. A practice nurse was the lead for diabetes.

The practice manager kept a record of the training completed for each staff member. We saw that in addition to mandatory training additional training appropriate to the role of the staff member had been arranged. We saw that the majority of staff were up to date with most of their mandatory training. Staff told us that they were able to request additional training if they had a particular interest, and other information was provided to them during the monthly sessions they had when the practice closed for half a day. Nurses told us they regularly attended training sessions to update their knowledge, and their continuing professional development (CPD) was monitored.

There was a system in place so that staff had an annual appraisal with their line manager. We saw that these were mostly up to date, and staff told us they felt well-supported at work. They said the practice manager and GPs were approachable. The practice manager carried out appraisals for the nurses, and one of the nurses carried out the practice manager's appraisal. The practice manager was a registered nurse who also had nursing sessions as part of their role. GPs were not involved in appraising nurses but on occasions sat in nurse clinics to observe.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage complex cases. It received blood test results, X ray results, and letters from the local hospital including discharge summaries and the out-of-hours GP services. The GPs told us they reviewed the results, took any appropriate action and ensured their patient records were up to date.

We saw that GPs and nurses attended regular meetings within the Clinical Commissioning Group (CCG) and met with other commissioned services. They also invited other services to their clinical and practice meetings, for example the CCG lead GP for diabetes was attending the next meeting. We saw an example of a GP liaising directly with the local hospital for updates on patients' conditions and expected discharge dates. This ensured care plans and relevant documentation, for example do not attempt cardio-pulmonary resuscitation (DNACPR), were in place. Liaison also took place between the practice and the ambulance service about DNACPR orders.

Health visitors were not based in the same building as the practice but the team held the mobile telephone numbers of health visitors so they could be contacted appropriately. Midwives attended the practice regularly. We saw that the lead GP for mental health had links with the local Child and Adolescent Mental Health Service (CAMHS). There was a drug and alcohol misuse team in the area. The drug misuse team held some sessions in the same building as the practice, and patients could be referred to attend there or in another building in the town centre.

The patients we spoke with, or received written comments from, said that if they needed to be referred to other health service providers this was discussed fully with them and they were provided with enough information to make an informed choice. They told us referrals were made in a timely manner.

Information sharing

The practice used several systems to communicate with other services. When patients were discharged from hospital the practice received a discharge letter electronically. When patients had attended the A&E department or the out of hours service, electronic notifications were received by the practice. A fax was sent to the practice by the walk in centre to inform GPs when a patient had attended. GPs reviewed the information and took action as required. If a patient was receiving palliative care GPs at the practice sent a handover fax to the out-of-hours provider to ensure they had the latest information about the patient. Electronic systems were also in place for making referrals.

All the electronic information needed to plan and deliver care and treatment was stored securely but was accessible to the relevant staff. This included care and risk assessments, care plans, case notes and test results. The system enabled staff to access up to date information quickly and enabled them to communicate this information when making an urgent referral to relevant services outside the practice.

Consent to care and treatment

Good

Are services effective?

(for example, treatment is effective)

Patients we spoke with told us that they were communicated with appropriately by staff and were involved in making decisions about their care and treatment. They also said that they were provided with enough information to make a choice and gave informed consent to treatment. The CQC comments cards we reviewed did not highlight any issues with consent.

The latest national GP patient survey reflected that 69% of respondents said the GP was good at explaining tests or treatments to them (CCG average 81%), and 87% said the same of the practice nurse (CCG average 79%). Also 66% of respondents said the GP was good at involving them in decisions about their care (CCG average 74%), with 82% saying the same of the practice nurse (CCG average 67%). Most of the patients we spoke with told us they were given options about their care and treatment, and the clinicians explained treatments or medicines to them.

Consent to care and treatment was obtained in line with legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004. The practice had an up to date consent policy that gave information about different types of consent. We saw that written consent was sought appropriately, for example prior to minor surgery.

There was no formal protocol for patients under the age of 16 attending the practice alone. However the clinical and administrative staff we spoke with demonstrated a clear understanding of Gillick competencies. These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment.

Although staff had not been trained in the Mental Capacity Act 2005 there were guidelines in place for the action to take if it was thought a patient did not have the capacity to consent. Patients with learning disabilities or mental health needs had a care plan in place and details of carers were recorded. Mental capacity assessments took place where necessary and we saw an example of a GP carrying out a mental capacity assessment for a patient in a nursing home.

Health promotion and prevention

We saw that new patients registering with the practice completed all the necessary forms then were offered a new patient appointment with a clinician. During this appointment information such as the patient's height, weight, smoking and alcohol consumption status and family history usually were discussed and relevant information recorded. Advice about lifestyle was given.

The patients with the highest risk of being admitted to hospital had a care plan in place. The practice manager monitored these and where necessary patients were contacted and offered extra support. The practice had stopped offering health checks for patients over the age of 75 due to GP capacity issues, but planned to reintroduce these in September 2015. They had carried out a survey with patients and all the patients over the age of 75 they asked said they found the health checks beneficial.

The practice had a system in place to ensure patients eligible for the flu vaccine received these. The healthcare assistant had also received training to deliver flu vaccinations. Clinics had been held for the flu vaccine and the practice have opportunistic vaccinations if patients attended for other matters. Also, when a patient attended for a flu vaccination staff carried out a health check if this was also due. The practice computer system alerted staff of patients who were due a flu or shingles vaccination, or other health check, when they attended the practice for any matter. For childhood flu vaccinations the practice invited patients for appointments outside nursery times. Reception staff telephoned patients who did not attend for vaccinations, and it was recorded if they declined an appointment.

The practice manager met the reception manager weekly to generate lists for health checks such as cervical smears. Reception staff had dedicated time to invite patients for smear tests and their first contact was usually by telephone. A letter was sent if this was not successful, and patients were asked to sign a declaration if they chose not to attend.

A range of health promotion information was available in the waiting area. This included services that could be accessed locally.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey. The patient survey showed that 74% of patients thought their GP was good treating them with care and concern (Clinical Commissioning Group (CCG) average 83%) and 72% thought their GP was good at listening to them (CCG average 85%). The figures when asked the same about the nurse were 84% (CCG average 89%) and 90% (CCG average 80%). The survey showed that 84% of patients found the receptionists helpful (CCG average 86%), 68% thought the GP gave them enough time (CCG average 85%), and 90% thought the same of the nurse (CCG average 81%).

The patients we spoke with gave us positive comments about the staff at the practice. They told us staff were friendly and always treated them in a dignified manner. The patients we spoke with told us they were given enough time during their appointments and the GPs and nurses listened to them. We reviewed 29 CQC patient comments cards. The majority of these gave positive comments about the practice. They commented they were treated with respect by staff who were friendly, helpful, listened to them and treated them with respect.

We saw that a satisfaction survey in July 2014 found patients using The Highlands Surgery thought there was not enough privacy in the reception area. Although it was difficult to change the lay-out of the reception desk and waiting room staff had identified an area at the side of reception where more privacy could be given when needed. It addition, there was usually a spare clinical room available for private conversations. The patients we spoke with and the comments cards we reviewed did not highlight this issue.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided around couches in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. The chaperone policy stated that patients must be given privacy when undressing. We noted that consultation room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

Patients could usually request to see a GP of a specific gender. On most days there were male and female GPs available, although this was not always at the same surgery. However, the surgeries were close together and patients were able to choose which to attend.

Care planning and involvement in decisions about care and treatment

The latest GP patient survey information showed 66% of patients felt the GP was involving them in decisions about their care (CCG average 74%), with 82% saying the same of the nurse (CCG average 67%). The survey showed that 69% of patients thought the GP was good at explaining tests and treatments (CCG average 81%) and 87% said the same of the nurse (CCG average 79%). The majority of the patients we spoke with told us the GPs and practice nurses explained tests and treatment to them and they felt they were listened to. Most said they were given options about their treatment where this was available. The CQC comments cards we reviewed also provided evidence of patients being listened to with no concerns being highlighted about people's involvement in their care planning.

The practice had access to an interpreter service when required. This was either face to face or by telephone. The staff we spoke with knew how to arrange interpreters. They said they were able to provide printed information about medical conditions in various languages. Staff told us that on occasions family members attended with patients to help with translating. They were aware of the circumstances where they could allow this and when a professional interpreter should be booked.

We saw that a range of information about various medical conditions was available in the reception area. Information about services that were available in the area was also displayed.

Patient/carer support to cope emotionally with care and treatment

Counselling services were available within the CCG area. GPs told us that although NHS services were available there was up to a nine month wait for these. Counsellors came to

Good

Are services caring?

the Trafalgar Square Surgery building as well as other locations in the area. When there was an urgent need for counselling GPs referred patients to charities in the area, for example MIND. They provided counselling and the waiting list was not as long. Patients could also self-refer to services, and there was a drop-in café patients could attend.

Most of the patients we spoke with told us they had not required emotional support. However, one patient told us that following bereavement they were given a lot of support by the practice and counselling had been offered. We saw that an information pack was available to give patients practical advice about what to do following bereavement, and also give them information about support groups.

Good

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 people's 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.

One GP took the clinical lead in most areas, but other GPs did have some areas of responsibility. A practice nurse took the lead for diabetes. There was a system in place to ensure patients with long term conditions had regular appointments to review and monitor their condition. Also medicine reviews were arranged at appropriate intervals for patients who required regular medicines. One of the GPs was a member of the Clinical Commissioning Group (CCG) medicines management team and was able to disseminate the latest information to their colleagues.

The practice kept registers for patients with specific conditions. These included patients with a learning disability, mental health needs, cancer and those receiving palliative care. Patients with a learning disability had an annual review of their needs. Patients with mental health needs also had an annual review with a GP, and the GP attended to their other health needs at this time if required. The practice computer system had a facility to alert the clinician when a patient attended and other needs were due to be considered at the same time.

Information about the prevalence of disease was kept and this was compared with other practices in the CCG locality every four months. The CCG then produced prevalence figures for key conditions such as atrial fibrillation.

All patients over the age of 75 were given a named GP. Care plans were in place for patients with a higher risk of an unplanned hospital admission, and self-management advice was appropriately provided. A GP had oversight of the care plans and ensured they were regularly updated. The practice provided examples of hospital admissions being prevented due to the care plans being followed.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The majority of patients spoke English as their first language, but translation services were available for others. Staff told us interpreters for patients who spoke Portuguese or Bengali were most often used. Face to face and telephone translation services were used. Staff confirmed they never allowed children to translate for their older relatives and if a patient brought a relative to translate they booked an interpreter if they had any concerns or thought it was more appropriate.

The practice provided equality and diversity training through e-learning. Most staff had completed this training earlier in 2015, and the GPs had been trained in 2013.

The Trafalgar Square Surgery was in purpose built premises. There was parking for patients with disabilities and the building was fully accessible. The Highlands Surgery was located in an older building. There was street parking immediately outside the premises. There was consulting rooms on the ground floor and a passenger lift had recently been installed so the first floor was accessible to all.

The practice manager told us there were very few homeless people in the area and they were not aware of any current homeless patients. They explained that it was possible for a homeless patient to register without an address and a social worker was usually involved in the process. The walk in centre was also in the same building as the Trafalgar Square Surgery so consultations were always available for people.

Housebound patients could be identified on the computer system. The practice nurse routinely visited housebound patients to carry out annual chronic disease management and give vaccinations.

Access to the service

We spoke with six patients during our inspection. Two of these had booked an emergency appointment that day and the others had pre-booked routine appointments. Patients told us it was easy to book a routine appointment and they were usually given a same day appointment in an emergency. We reviewed 29 CQC comments cards and only one commented that they sometimes had to wait for an appointment. Others commented that they were easy to access and the system had improved.

The results of the latest national GP patient survey showed that 83% of patients found it easy to get through to the practice on the telephone (CCG average 75%) and 91% said their last appointment was convenient. We checked the

Good

Are services responsive to people's needs?

(for example, to feedback?)

appointments available at 10.50am on the morning of our inspection. We saw the next available routine appointment was the next working day and emergency appointments were available for the day of our inspection.

The practice manager told us that emergency appointments were shared between the clinician on duty. Patients could choose which surgery they attended. Telephone appointments could be made and patients were told the approximate time they would receive a telephone call from a GP. GPs also triaged emergency appointments when all the usual slots were taken. They explained that they always fit patients in when they needed to be seen and children were always seen on the day they requested an appointment.

The Highlands Surgery and Trafalgar Square Surgery were both open from 8am until 6pm on Mondays and Wednesdays and from 7.30am until 6pm on Tuesdays, Thursday and Fridays.

Housebound patients were identifiable from the computer system so home visits were offered. Home visits were also provided to patients unable to leave their home due to their illness.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. There was a complaints policy in place, but this was a statement about what patients should expect and not a guide for staff to follow if a complaint was received. Information about how to complain was available at both surgeries and also on the practice website. Staff told us the practice manager was very supportive and willing to speak with any patient about any complaints or concerns they had.

We saw that a record of all complaints was kept, and there was an annual review of all complaints made. This was discussed by the patient participation group (PPG) as well as practice staff. We saw that a member of the PPG had offered to speak with any patient about complaints they had, and their telephone number could be given to patients. We looked at the complaints made in the previous year and they had all been appropriately recorded, investigated and responded to. Where learning needs had been identified these had been noted. We saw evidence of practice being changed as a result of a complaint that had been made.

Complaints was a standard agenda item in clinical meetings. The practice manager told us if the complaint related to an individual it would be discussed with the individual and support would be given to staff where appropriate.

Staff knew how to advise patients to make a complaint. They told us that complaints were discussed during meetings and if there were areas highlighted where learning was required this was communicated during meetings.

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 mission statement on their practice leaflet. Not all staff were aware of it but all described a culture of supporting patients and moving forward. The staff we spoke with told us they were kept up to date with issues within the practice and felt part of the wider team. GPs also told us that staff as a whole seemed to be well informed and supportive of their patients.

Comments we received from patients were very complimentary of the standard of care received at the practice. All staff were engaged in producing a high quality service and each member of staff had a clear role within the structure of the practice. For example, there were leads for safeguarding and infection control.

The practice was engaged with the local Clinical Commissioning Group (CCG) to ensure services met thelocal population needs. The two surgeries run by the practices were close together and able to meet the needs of the patients.

Governance arrangements

We saw systems in place for monitoring all aspects of the service such as complaints, incidents, safeguarding, risk management, clinical audit and infection control. All the staff we spoke with were aware of each other's responsibilities. The practice had a number of policies and procedures in place to govern activity and these were available to staff electronically. However, some of these policies were undated. Policy changes were discussed at the regular practice meetings to keep staff informed

We saw that the practice manager managed staffing issues. A new GP was in the process of being recruited and there were plans in place to increase some services when the GP started work in September 2015. The practice had become a training practice in August 2014 and feedback to date had been positive.

Leadership, openness and transparency

The service was transparent, collaborative and open about performance. Staff told us the lead GP was very approachable and they and the practice manager had an open door policy. Regular staff meetings were held for all staff, including separate clinical meetings. Minutes were kept of these meetings and these provided evidence of patient outcomes being monitored internally and by the CCG. We spoke with staff members and they were all clear about their own roles and responsibilities. They all told us that felt valued, well supported and knew who to go to in the practice with any concerns.

Seeking and acting on feedback from patients, public and staff

The practice had an active patient participation group (PPG) that met every 12 weeks. The group was advertised in the patient waiting areas and they were trying to increase the number of members from the younger age group or black and minority ethnic (BME) patients. The PPG meetings always had an agenda and minutes were taken. They carried out a patient survey twice a year and we saw their action plans that were put in place and actioned following their surveys. Two members of the PPG attended a CCG locality patient group and they fed back ideas to the practice group.

Other ad hoc surveys were carried out by the practice. During one survey they asked patients over the age of 75 their opinion of over 75s health checks. Their opinion was taken into account when deciding the future of the service. Although the health checks were not being carried out at the time of our inspection this was a temporary measure until a new GP started work in September 2015.

The practice had been using the friends and family test since it started in December 2014. We looked at the results from 1 December 2014 and these were positive, with no-one being unlikely to recommend the practice.

The staff we spoke with told us the practice manager had an open door policy and they were encouraged to make suggestions about how the service could be improved. There were opportunities to put forward their ideas during the regular informal meetings.

Management lead through learning and improvement

Staff told us they received the training necessary for them to carry out their duties and they were able to access additional training to enhance their roles. Their personnel files contained details of the training courses they had attended. Staff told us they were supported in their personal development.

Are services well-led?

Good

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

We saw evidence that the continuing professional development (CPD) of the practice nurse was monitored and recorded. They were able to obtain clinical advice from any of the GPs at the practice.

Most of the annual staff appraisals were up to date. However, the practice manager (who was also a practice nurse) and another practice nurse appraised each other. The GPs were not involved in the appraisals of the nurses but told us they would sit in their clinics if they felt there was a need.

GPs were supported to obtain the evidence and information required for their professional revalidation.

This was where doctors demonstrate to their regulatory body, The General Medical Council (GMC), that they were up to date and fit to practice. The GPs and practice nurses regularly attended meetings with the CCG so that support and good practice could be shared.

The practice had been a training practice since August 2014. Medical students from the local university and registrars regularly attended the practice.

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

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 Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed We found that the registered person did not operate robust recruitment procedures to ensure they only employed fit and proper staff. This was in breach of regulation 19(1)(a)(b)(2)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. **How the regulation was not being met** The provider's recruitment policy did not include a requirement for the check of identification, a full employment history, explanation of gaps in employment and a procedure to follow if a staff member had a criminal record. Appropriate checks had not been carried out prior to employing new staff members. Regulation 19(1)(a)(b)(2)(3)

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance We found the registered person had not protected people against the risk of inappropriate or unsafe care and treatment, by means of good governance. This was in breach of regulation 17(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. **How the regulation was not being met** Where risks had been identified following a fire risk assessment actions were not taken to remove those risks. This included fire training for staff and storage of fire extinguishers. Some single use instruments were past their expiry date. Actions required following a fire risk had not been completed.

This section is primarily information for the provider

Requirement notices

Regulation 17(2)(a)(b)