Hightown Surgery

Quality Report

1 St Georges Road
Hightown
Merseyside L38 3RY
Tel: 0151 929 3603
Website: www.hightownvillagesurgery.nhs.uk

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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	Inadequate
Are services safe?	Inadequate
Are services effective?	Requires improvement
Are services caring?	Requires improvement
Are services responsive to people's needs?	Requires improvement
Are services well-led?	Inadequate

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

This is the report of findings from our inspection of Hightown Surgery. Our inspection was a planned comprehensive inspection, which took place on 6 November 2014. The surgery is run by a large provider called SSP Health Ltd. Services are delivered under an Alternative Primary Medical Services (APMS) contract.

Our overall rating of the service is that it is inadequate. We found that at times, measures to reduce risk were not always followed, which exposed patients to the risk of unsafe practice. The locum GPs in place at the time of our inspection and the newly recruited practice nurse were caring in their interactions with patients, but the practice is rated as requiring improvement in the domain of caring. Patients were shown little consideration or empathy when they raised concerns about their treatment and the service provided by SSP Health Ltd. The practice was not responsive to patient concerns and did not involve patients in the planning of how services were delivered. The needs of particular patient groups were not fully met. The practice was not well-led; locum GPs were not fully supported by the provider, and worked largely in isolation.

Our key findings were as follows:

- Treatment of patients was not always safe. Systems in place to promote patient safety were not embedded at practice level, as locums were unfamiliar with them.
- Care and treatment delivered was not always effective. The locum GP was unable to provide any evidence of clinical audit in relation to updated guidance, for example, guidance issued on the review of treatment of patients with atrial fibrillation. The locum GP could not show or explain plans in place to conduct this audit. The locum GP could not show us any examples of review of patient referrals, peer review or benchmarking of patients treatment over time. The last audit conducted by the locum GP was in March

Summary of findings

2014, before working for SSP Health Ltd. The locum GP followed systems to ensure that further treatment recommended by secondary (hospital care) was delivered to patients.

- The practice was not caring towards patients. Patients were aware that both locums were leaving and that there were no meaningful plans or measures in place to recruit permanent GPs. The provider failed to acknowledge and address patients concerns about the lack of continuity of care. Telephone calls we received from patients in the days before our inspection, evidenced the level of distress this had caused to patients.
- The provider was not always responsive to the concerns of patients, and failed to have regard to the complaints, comments and views of patients. The practice did not give information to patients on how long locum GPs would be delivering services for, and whether permanent GPs would be recruited for the practice.
- The practice lacked strong supportive leadership. Arrangements were not in place to ensure that, at all times, there were sufficient GPs available to deliver services. Suitable arrangements were not in place to ensure that GPs were appropriately supported in relation to their responsibilities. The provider had no arrangements in place for a GP to take part in multi-disciplinary team meetings for shared care of palliative patients.

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

Importantly, the provider must:

- Ensure that governance processes are applied and embedded at practice level. Check and monitor that shared learning from incidents is applied and embedded at practice level, particularly for locum GPs.
- Have regard to the complaints and comments made and views expressed by patients and those acting on their behalf.
- Communicate with and involve patients in a transparent way, particularly around continuity of GP care for patients, especially those with a mental health condition such as dementia.
- Improve systems in place to ensure there are sufficient GPs available at all times to deliver services.
- Improve leadership and support for GPs who work as locums, offering peer review of their work and support in the making of clinical decisions which may require discussion with other specialist clinicians, for example, a dementia or mental health lead for the provider.
- Ensure arrangements are in place so that GP's take part in multi-disciplinary team meetings for the care of palliative patients.

In addition the provider should:

- Consider the needs of the working age population by allowing access to on-line appointments and repeat prescription ordering to increase service accessibility for patients.
- Check oxygen supply for use in emergency is still suitable for safe use.

On the basis of this inspection and the concerns identified, which have resulted in an inadequate rating for two key domains and a rating of requires improvement in the other three domains, I am placing the provider into special measures. This will be for a period of six months. We will inspect the practice again in six months to consider whether sufficient improvements have been made. If we find that the provider is still providing inadequate care we will take steps to cancel its registration with CQC.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

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?

Inadequate

Treatment of patients was not always safe. The provision of services by two locum GPs who had made a longer term commitment to the practice had brought about some improvement, but further work was needed in this area. The number of different locum GPs delivering services, meant there was limited continuity of care to patients. The provider did not have a contingency plan which dealt with circumstances when locum GPs failed to report for duty at the practice.

Are services effective?

Requires improvement

Services were not always effective. Patient treatment followed recognised best practice guidance. Clinical audit was conducted at a higher level and information on patients whose treatment should be reviewed was cascaded to GPs at the practice. Patients where then re-called and their treatments were reviewed. However, due to a series of locum GPs being used to deliver services, the review of all patients was not always timely.

Are services caring?

Requires improvement

Patients spoke of the improvement in care and services since locum GPs had made some commitment to staying with the practice. A patient who was also a carer for a family member with dementia told us how the locum GP had visited their family member at home, and provided a very caring service. We saw how administrative support staff treated people with kindness and respect. However the problems experienced by patients, caused by a lack of continuity of care were not addressed or fully acknowledged by the provider. The provider showed little empathy or understanding toward patients who expressed their concerns about this, especially in relation to the care and treatment of older patients who where supposed to have a named GP at the practice.

Are services responsive to people's needs?

Requires improvement

The practice was not always responsive to the needs of patients. Repeat prescriptions could not be ordered on-line or over the phone, but only by submitting a written request. The provider had no firm arrangements in place for a GP to regularly take part in multi-disciplinary team meetings particularly in respect of shared care of palliative patients in the community. This had been the case since November 2013.

Summary of findings

Are services well-led?

Inadequate

The practice was not well-led. Policies and procedures for staff to follow were not fully embedded at a local level. Steps to address this had not been put in place. Locum GPs were not fully conversant with some governance processes. Leadership was remote for clinical staff, particularly the locum GPs. The newly recruited nurse did have accessible leadership and mentoring from a nurse at a neighbouring practice. Communication with patients on how services would be delivered was not transparent. The provider had given assurances to patients that one of the GPs working at the practice at the time of our inspection was a permanent GP. Information available to us at the time of our inspection confirmed this was not the case. This had damaged patient confidence in the practice. The duties of the practice manager had not been delegated to other staff in her absence, which led to mistakes being made. The Patient Participant Group was not fully engaged with the practice and felt they were not listened to. Patients commented on the lack of leadership at the practice.

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

Inadequate

There were aspects of care and treatment that were inadequate, which related to all population groups. Some continuity of care had been provided by a locum GP who had made a short term commitment to the practice. Older patients told us they valued this. The practice had met its target for ensuring older and vulnerable patients had a care plan on their records and access to a named GP in charge of their care. However, this exercise had been completed by the temporary locum GP who was not familiar with the patients or the impact their conditions had on them. A number of patients who spoke with us expressed their concern and frustration at having to explain their conditions to different GPs whilst the practice has been staffed by short term locum GPs. Patients told us letters sent to them and other patients, giving the name of a director of the group as their named GP, did little to inspire patient or carer confidence in the care provided.

People with long term conditions

Inadequate

There were aspects of care and treatment that were inadequate which related to all population groups. Care and treatment for the majority of patients with long-term conditions was good. Nurses at the practice ran disease management clinics which were effective. Nurses said they were happy to visit patients in their home to deliver disease management care, if this was required, for example in cases of patients with chronic obstructive pulmonary disease (COPD). However, improvements were required, particularly in the area of care for palliative patients and those with long term complex conditions. GPs at the practice had not attended any multi-disciplinary team meetings in relation to the planned care of palliative patients for over 12 months.

Families, children and young people

Inadequate

There were aspects of care and treatment that were inadequate which related to all population groups. The practice had good performance outcomes, particularly in the delivery of childhood vaccinations and immunisations, where they had reached 100% of babies attending and receiving necessary vaccinations. The practice had reached 95% of pre-school children being up to date with their required vaccinations and immunisations. New patients received a full health check on registering with the practice, where their needs were assessed. Those patients requiring on-going support to manage long term conditions, for example asthma or diabetes, were added to disease registers, meaning they would receive regular

Summary of findings

health checks and medicine reviews. However, the lack of adequate contingency arrangements to provide GP cover at all times presented risks to those patients who needed to be seen quickly, for example very young babies and those children with pre-existing health conditions, whose health was deteriorating.

Working age people (including those recently retired and students)

Inadequate

There were aspects of care and treatment that were inadequate which related to all population groups. Patients within this population group are between 19 and 74 years of age. Patients reported on Care Quality Commission comment cards that it was easy to get an appointment to see a GP and that they appreciated the choice of being seen by a male or female GP. Patients did comment that the practice had a website but there was no facility for patients to order repeat prescriptions electronically. Services to this patient group were not fully advertised and promoted, for example blood collection clinics at the practice. We noted that information on display in patient waiting areas was incomplete, for example how to contact the patient participant group. The complaints policy was not displayed for patients to refer to.

People whose circumstances may make them vulnerable

Inadequate

There were aspects of care and treatment that were inadequate which related to all population groups. The longer term locum GP at the practice was aware of some patients who were on specific registers because they were vulnerable, for example, those with a learning disability. The GP was also the safeguarding lead at the practice and was aware of local safeguarding arrangements. However, as the GPs were locums, this patient group did not experience continuity of care, which can be particularly difficult for those patients with learning disabilities and their carers.

People experiencing poor mental health (including people with dementia)

Inadequate

There were aspects of care and treatment that were inadequate which related to all population groups. People who were carers of patients with dementia spoke of their frustration at having to explain their family member's condition on multiple occasions to different GPs. We could see that this situation had started to improve since September 2014, when a locum GP made a longer term commitment to the practice, however the other female locum GP was leaving the practice in November 2014. The lack of succession planning meant we were unable to judge how the provider was addressing this issue.

Summary of findings

What people who use the service say

Comments we received about the practice were mixed. Patients all said they were able to get a GP appointment reasonably quickly. Of the ten CQC comment cards received, five patients said they were happy with the care and treatment they had received. All patients commented on how much they liked the new locum GP and that they hoped this GP would stay with the practice. Patients we spoke to on the day of our inspection (five patients) told us they appreciated the reception and administrative staff, saying they were kind and helpful.

The other five CQC comment cards spoke of problems with continuity of care and that patients saw this as a significant issue. Patients we spoke with on the day of our inspection were aware that the locum GP had only made a short term commitment to the practice and were worried about the future of the service. In the days before our inspection we received a significant number of telephone calls from patients who had seen the posters announcing our inspection of the practice. Patients explained to us how frustrated they were about the lack of continuity of care. They described how on several occasions no GP had been at the practice to deliver services, how the provider SSP Health Ltd had failed to acknowledge their concerns or the distress this was causing those patients who relied on GP services.

The Patient Participation Group (PPG) told us the practice lacked direction and leadership. The PPG expressed their anxiety that they had received little meaningful engagement from the provider. The PPG told us the provider had recently sent out letters to those patients who should have a named GP responsible for their clinical care. The letter gave the name of a director of the provider as their named GP, as there was no long term GP at the practice to take on this responsibility. The PPG told us they and other patients saw this as a lack of open and transparent communication from the provider. The provider had declined to share succession plans with the patients, or any vision of how the practice would be run in the longer term.

A second letter was later sent out to patients giving the name of the locum GP who would be responsible for the care of older and more vulnerable patients. Patients questioned this as they had been made aware that this locum had not committed to the practice beyond the end of 2014.

We spoke to patients who were carers of older family members. Many of the carers were elderly themselves. We were told that the practice did little to offer emotional support to carers, and had little understanding of how frustrating it was for them to have to explain their family member's condition over and over again to different GPs.

Areas for improvement

Action the service MUST take to improve

- Ensure that corporate governance processes cascaded to practice level are applied and embedded at practice level. Check and monitor that shared learning from incidents is applied and embedded at practice level, particularly for locum GPs.
- Have regard to the complaints and comments made and views expressed by patients and those acting on their behalf.
- Communicate with patients in an honest and transparent way, particularly around continuity of GP care for patients at the surgery, especially those from vulnerable groups.
- Improve systems in place to ensure there are sufficient GPs available at all times to deliver services.
- Improve leadership and support for GPs who work as locums, offering peer review of their work and support in the making of clinical decisions which may require discussion with other specialist clinicians, for example, a dementia or mental health lead for the provider.
- Ensure arrangements are in place so that GP's take part in multi-disciplinary team meetings for the care of palliative patients.

Summary of findings

Action the service SHOULD take to improve

- Consider the needs of working age population by allowing access to on-line repeat prescription ordering services to increase service accessibility for patients.
- Check oxygen supply for use in emergency is still suitable for safe use.

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 specialist advisor GP, a specialist advisor practice manager and a second CQC inspector.

Background to Hightown Surgery

Hightown Village surgery serves just over 2,100 patients, in the Sefton area of Liverpool. The service is delivered by a large provider, SSP Health Ltd, who also provide services at several other practices in the Liverpool and Sefton area. Locum GPs deliver clinics throughout the week, with their combined hours creating the equivalent of just over one, full time GP. At the time of our inspection, there was one male and one female locum GP delivering services. The practice has two nurses, one working 15 hours per week, the other working six hours per week. The nurses provide disease management clinics, blood collection services and manage vaccination and immunisations for children and adults.

The practice delivers services under an alternative primary medical services contract (APMS).

Services are delivered from a former domestic property which has been extended to provide further consultation facilities. The practice has a consultation room on the ground floor, wheelchair and step-free access. A hearing loop is also available for people with hearing difficulties.

There are no branch surgeries attached to this practice. The practice does not provide its own out of hours care. This is provided by an external provider.

We had been made aware of patients' complaints about the service; these related to the lack of continuity of care and how frustrated patients were by this. We were given assurances by the provider during our inspection, and by NHS England before our inspection that this situation had improved recently, with the appointment of one permanent employed GP at the practice, supported by a long-term locum. In preparing for our inspection, we noted that the patient register at the practice had dropped from 2,237 when taken over by the current provider to 2,125 patients at the time of our inspection.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme. This provider had not been inspected before and that was why we included them in our 2014-15 inspection programme.

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.

Detailed findings

How we carried out this inspection

Before our inspection we reviewed data from a number of sources. We considered the results of the last NHS England patient survey, asked patients who use the service for their views, and left comment cards for patients to complete before we visited the practice on 6 November 2014.

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 6 November 2014. During our visit we spoke with a range of staff including the locum GP, the practice nurse, the Chief Operating Officer, a regional manager, HR manager, data manager and other practice staff including a relief practice manager and administrators. We spoke with patients who used the service. We observed how people were being cared for and talked with carers and family members. We reviewed some records in relation to patients. We reviewed comment cards where patients and members of the public shared their views and experiences of the service. We also spent time talking with the Patient Participant Group (PPG).

Inadequate

Are services safe?

Our findings

Safe track record

The GP we spent time with on the day of our inspection, felt the practice had a good record on safety. We were told there had been no major safety issues. We asked about the process in place to report, record and investigate any safety incidents. The GP described how incidents were recorded on paper forms and how the practice manager would co-ordinate a response. The GP described an intranet reporting system to record events but could not locate this on the system when talking to us.

From incidents we reviewed we saw that risk had been increased at times by the number of different locums delivering services, which affected continuity of care. We reviewed an incident concerning patient care. This showed a locum GP had a telephone consultation with a patient. As recorded on the significant event form, the locum GP 'had a light surgery on that day and could have visited the patient but did not do so'. The locum GP advised the patient to contact the out of hours service if their condition worsened. The patient rang the practice several days later and was visited at home and admitted to hospital. The patient had a long term health condition; the form completed to record the significant event stated 'from records, clearly unwell'. There was no evidence of learning from this event, or guidance from the provider with criteria for prioritising home visits to patients.

We had been made aware of incidents where follow up care to patients following hospital investigations, had been missed. On two occasions we were able to establish that this was due to locum GP's not following a specific procedure, for example by creating a task on the computer system to request a patient make an appointment to see them. When this error was identified it was not recorded as a significant event, so learning was not taken from the incidents and shared with all. Further, a system where reception staff would check against annotations made by a GP on correspondence sent by the hospital, was not in place, which meant this type of mistake could potentially occur again.

Learning and improvement from safety incidents

The provider had a system in place for reporting, recording and monitoring significant events. However, these were not embedded at practice level and evidence of 'closing the loop' and real learning was limited.

We looked at recorded incidents. We were able to see that these had been reviewed with a practice manager. We saw that there had been some learning from these but that opportunities for discussion with the other locums working at the practice were limited. We asked the locum GP about peer review of their work or other clinical back-up. We were told they could ring the provider pharmacist for advice, although the pharmacist worked remotely and getting an answer back may take some time.

We reviewed a recently completed patient safety incident. From this we could see that the patient's failure to attend a series of appointments at the practice had not been acted upon by the locum GPs delivering the service. We could not identify any evidence that the provider had considered the outcome of the analysis of the safety incident or had implemented improvements in the service as a result of this event. We noted again that opportunity for discussion of the incident with other GPs was limited.

We were aware of complaints from patients about occasions when no locum GP had been available to deliver planned appointments at the practice. We were told that on those occasions, a nurse practitioner had been made available, or a GP had delivered extra sessions at a later date to ensure that the contractual number of appointments required were delivered. The complaints from patients on this subject had been treated as complaints, rather than incidents, so were not analysed and treated as a potential safety risk. The practice could not demonstrate a sufficiently robust contingency arrangement was in place to deliver appointments for those patients whose conditions required that they be seen by a GP. For example, those patients with severe acute or chronic illness or with a diagnosis of terminal illness. We could find no evidence that the provider had issued an agreed contingency plan to the practice, addressing identifiable risks, which staff understood and was activated and followed in such circumstances.

Reliable safety systems and processes including safeguarding

The provider had a safeguarding policy which all staff we spoke with were familiar with. When we reviewed training, we could see that staff had received safeguarding training. The GP we spoke with on the day of our inspection had

been trained to the appropriate standard in safeguarding. The GP was able to refer to a flow chart on the wall of the consultation room, which gave contact details of local safeguarding teams.

The newly appointed nurse had received safeguarding training to the appropriate level. However, when the staff team gave us an overview of the practice, it was apparent that the nurse did not realise she was a named safeguarding lead for the practice. This was confirmed when we interviewed the nurse later in the day.

A chaperone policy was in place and advertised on the waiting room noticeboard and in consulting rooms. The new nurse would perform this duty, but had yet to receive training. Administrative support staff had been trained for chaperoning duties and had undergone background checks to ensure their suitability for this work.

Medicines management

There were processes in place for the safe management of medicines. All vaccines and immunisations were stored in a central fridge, which was temperature checked on a daily basis. Replenishment stock was ordered in a timely manner and we saw that all stock was rotated to ensure it was used in date order.

We saw that emergency medicines were available for use and were kept in a secure but accessible location at the practice. The practice also kept an anaphylaxis box which had a list of medicines that should be kept in the box for use. These included adrenaline, benzyl penicillin and ventolin. Arrangements were in place to check all medicines regularly to ensure suitability for use.

There were systems in place to manage repeat prescribing of medicines. All disease modifying drugs were issued by a doctor. Some prescriptions marked as 'repeat' by a GP could be issued by reception staff without a patient needing to see a GP, for example 1mg Warfarin, after staff had checked that patients' latest blood test results had been cleared by a GP as being normal.

The administrative support staff had a system in place to match up requests for repeat prescriptions, with those signed by the GP. This helped to ensure that patients requests for repeat medicines were not overlooked, meaning the patient was never without their medication.

Cleanliness and infection control

The practice had systems in place to monitor, manage and maintain infection control and hygiene standards. The practice manager was the lead at the practice for infection control. In the absence of the practice manager, who had been away from work for some time, the practice nurse was the lead on this responsibility.

We conducted a visual inspection of all rooms at the practice. The treatment room was clean and uncluttered. Chairs in the room and the treatment bed were clean and had wipeable surfaces. Sealed vinyl flooring was in place which was clean and free from any cracks or wear and tear. We saw that personal protective equipment (PPE), such as gloves, masks and aprons were readily available in the room, and hand wash gel dispensers were full and placed at sinks, close to paper towels. Checks of cleaning tasks completed each day were in place; we saw that privacy curtains were cleaned every six months or more frequently if required.

Sharps bins for the safe disposal of used syringe needles were available, placed on a surface were they would not be knocked over. These were correctly labelled with the date they were put into use. A separate clinical waste bin with the correct yellow bin liner was in the treatment room. Bins in the room were operated by foot pedal as required. Spillage kits were also available in the room for dealing with any spill of bodily fluids. Information was available on the safe use of these and also on how any needle stick injury should be dealt with.

We asked to see evidence of Legionella testing at the practice but staff could not provide this or any risk assessment on whether Legionella testing was appropriate for this site.

Equipment

The practice had the equipment required to deliver services safely. We asked the practice nurse and GP if there was a defibrillator at the practice and were told there was not, but we later found one when checking equipment in consultation and treatment rooms.

All rooms where patients were seen had a blood pressure monitoring machine. We saw that these had been recently tested and checked for accuracy. Oxygen was available for use but this had not been checked recently for safety in

use, i.e to see that the cylinder was full. All portable appliances had been safety tested and there were stickers on these appliances giving the date they must be re-tested by.

Staffing and recruitment

At the time of our inspection, the practice manager had been on long term absence and another staff member had been on leave. The practice relied on the support of a practice manager from another site for one day each week. If required, a regional manager would visit for one morning each week to provide further support. Staff told us the current staffing arrangement meant they were 'stretched' in trying to complete all administrative duties. A new practice nurse had been recruited and had started working at the practice recently. The new practice nurse told us she felt well supported, had the benefit of a mentor and had undergone an induction period.

We checked the recruitment files of two staff members. In these we found appropriate referencing and background security checks had been conducted. Each file held copies of current professional registrations with the appropriate organisation and evidence of up to date medical insurance.

The provider had not recruited permanent GPs to deliver services at the practice. A number of locum GPs had been used to deliver services to patients in the past 12 months. There had been five occasions in the past 12 months when no GP was at the practice to deliver scheduled clinics for patients. Patient appointments had to be cancelled. This compromised patients health and well-being.

The provider could not demonstrate a clear succession plan for the practice.

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, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see in communal areas.

The practice had an up to date register of people who were carers of patients who used the practice. The practice had met its responsibility to provide a care plan for patients that were deemed to be at risk of unplanned admission to hospital, for example older patients with dementia or severe chronic illnesses.

The provider did not have a system in place to assess the risks presented by running the practice with locums. Measures to deal with non-attendance at the practice of a locum to deliver services, were inadequate. Although the provider pointed to extra sessions delivered to compensate for this, these were often on a different date which would not be convenient for some people.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing staff had received training in basic life support. Emergency equipment was available including access to oxygen and a defibrillator. However, not all staff we asked knew the practice had a defibrillator or the location of this equipment, and we found the oxygen had not been checked for safety of use.

A business continuity plan was in place, which gave information on how to address any incident and how the head office of the provider would support the practice. We asked the management representatives, present on the day of our inspection, how contingency plans had worked in practice when locums had failed to honour a booking. Managers confirmed that only telephone support had been offered by the provider and that a replacement locum GP had not been available to attend to appointments made by patients.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice had arrangements in place to offer newly registered patients a full health check and clinical needs assessment. The new nurse at the practice was able to show us how they contributed to ensuring those patients who registered with a long-term condition were added to appropriate registers so their health needs were met.

Management, monitoring and improving outcomes for people

Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and the latest prescribing guidance was being used. We were shown evidence to confirm that following the receipt of any medicine alert the GPs had reviewed the use of the medicine in question and where they continued to prescribe it, outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

We saw that the GP working at the practice was following best practice guidance in the treatment of patients. We looked for evidence of audit of patient treatment. The Chief Operating Officer of the provider told us that clinical audit was conducted at a higher governance level, and results were provided to GPs at practice level, along with any actions required; for example, re-call of patients for review of medication. We saw from intelligent monitoring information available to us before our inspection, that the practice was within acceptable prescribing ranges for medicines such as antibiotics, and that the types of antibiotics prescribed fell within expected ranges. We could see from data taken from the Quality Outcomes Framework information, that those patients who required regular testing and review of blood results were seen in a timely manner. This was supported by data supplied by the Data Quality Manager for the provider. From this we could see that audits had been carried out on monitoring of patients receiving anti-coagulation treatments (Warfarin), in September 2014. There was also evidence of audit of medicines for patients who had not collected their prescriptions when they should. These patients were recalled if required (October 2014).

Effective staffing

The provider did not have adequate staffing numbers, clinical or clerical, to deliver services at the practice. Contingency arrangements to cover any locum that failed to honour a booking, needed further work and development. Reception staff we spoke with told us they had sufficient skills and experience to deliver tasks required of them. Staff told us that whilst the permanent practice manager had been on extended leave, they had received support from a practice manager from a neighbouring surgery, but this was only on one day each week, which had left them 'stretched'. The regional manager would also give support one morning each week.

The practice had recently recruited a new practice nurse. When we asked, this nurse told us they had been given a full induction and had the support of a mentor if needed. We spoke with a longer serving member of staff. They told us they had received regular appraisals and review of their performance. We were shown records that confirmed this. We could see from a staff training matrix that the skills set of administrative and support staff was sufficient to meet the needs of the practice.

Working with colleagues and other services

The provider had systems in place to provide locum GPs with access to information required on referral pathways for patients, for example, for a hospital scan or other investigations. The GP we spoke with on the day of our inspection confirmed he had access to this information.

The nurse at the practice was able to show us how referrals were made to other clinicians or teams in the community, for example, the community diabetic team. Referral pathways were also in place for podiatry services and a dietician. The nurse told us she could email or telephone community teams for advice on referrals if required.

Practice staff told us they had effective arrangements were in place to update patient records following any visit by out of hours care services.

The regional manager for this practice had entered into correspondence with other community clinicians to try and overcome the difficulties of having a GP from the practice to attend multi-disciplinary team meetings, where care of patients in the community with complex needs, would be reviewed and discussed. When we spoke to the regional

Requires improvement

Are services effective?

(for example, treatment is effective)

manager, we were told that now a longer term GP was in place, these meetings would be attended. However, at the time of this inspection no GP from the practice had attended these meetings for over 12 months.

Information sharing

We saw that there was good sharing of information between the practice and out of hours services.

We looked at how information and correspondence came into the practice from other sources, for example, blood test results, results of scans and x-rays or other specialist investigations. The locum GP working at the time of our inspection told us he dealt with all correspondence and was clear on systems in place to update patient records. We did find that other locum GPs had previously not followed up requests for further interventions requested on hospital discharge information. The GP we spoke to told us this may have been due to locums not being familiar with the process to be followed, but confirmed he was clear on the process required to ensure these interventions took place.

Patients registered with the practice, who were receiving treatment at the local hospice were visited at the hospice by a separate GP, who was a specialist in palliative care. We were told that information in relation to treatment of those patients was sent through to the practice so that records were updated. In cases where patients returned home, the specialist palliative care GP would continue to treat and support those patients in their own home.

Consent to care and treatment

Both the GP and the nurse at the practice demonstrated a good understanding around the need for patient consent, and how people should be supported to make decisions about their care and treatment. The practice nurse showed us how consent was recorded when performing cytology (smear tests). When questioned the nurse was clear on matters such as Gillick competency, which is a method of assessing a child or young person's understanding of their care and their ability to reach decisions on this. The GP was able to confirm that he had undergone training in the Mental Capacity Act 2005 and that this was recently refreshed with e-learning.

Health promotion and prevention

It was practice policy to offer all new patients registering with the practice a health check with the practice nurse. The GP was informed of all health concerns detected and these were followed-up in a timely manner.

The practice followed up those patients who did not attend any appointments for health promotion and protection appointments, for example, for cervical smears. The practice audited patients who did not attend annually. There was a named nurse responsible for following-up patients who did not attend screening. The practice kept a register of those patients that were also carers for a person with a long term health condition and we were able to see that all those patients had been offered a flu vaccination. The nurse at the practice correctly identified which groups of people additional vaccines should be offered to, for example, those over 65 years of age and considered to be 'at risk', and those over 75 years of age. Additional vaccines may include those for flu and shingles.

Requires improvement

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients spoke of the improvement in services since locum GPs had made some commitment to staying with the practice, at least in the short term. One patient who was also a carer for a family member with dementia told us how the locum GP had visited their family member at home, and provided a very caring service.

The provider retained the services of a specialist palliative care locum GP for patients who spent time in the local hospice. Patients who were registered at the practice, were seen by this GP, both when in the hospice and when discharged to go home. This provided continuity of care for patients and helped support their carers emotionally.

Nurses said they were happy to visit patients in their home to deliver disease management care, if this was required, for example in cases of patients with chronic obstructive pulmonary disease (COPD). When we reviewed data for the practice, the results of the last National Patient Survey, (2013) carried out by NHS England, showed that responses to questions about the caring nature of the service were all positive. CQC comment cards, completed by patients, indicated that when they had been seen by one of the nurses, they had always been treated with dignity and respect. Comments about the locum GPs at the practice at the time of our inspection were also favourable, indicating that patients were listened to by the GP and were treated respectfully. However, the comment cards we received were not representative of the majority of feedback from patients. In the days before our inspection we received a significant number of telephone calls from patients who had seen posters announcing our inspection visit. Those patients told us the standard of service they had received since the provider, SSP Health Ltd, had taken over the the practice had been very poor. We asked patients to describe their experiences. We were told that locum GPs failed to attend the surgery. Patients told us some of the locums would not do home visits to those patients who couldn't attend the surgery. We saw a letter from a patient who had rang the practice for an appointment to see a GP due to their worsening health condition. The patient had been told there was no GP at the practice on that day and that they should make their way to a walk in centre, which was not easy to get to via public transport. From the letter, we saw the patient had been distressed by this incident.

However, there was no response letter from the provider to the patient to acknowledge that this was unacceptable or to apologise or to acknowledge the anxiety and distress experienced by the patient. Patients told us that their complaints to SSP Health Ltd about the lack of continuity of care were not addressed. We reviewed a number of complaints made directly to NHS England by patients. All complaints were of a similar nature; that there was no continuity of care and that SSP Health Ltd had failed to address patients concerns when this affected their treatment. At the time of our inspection, a patient (who had given their name on a CQC comment card), recorded their experience of the practice. Sentiments were negative and comments were made about the lack of empathy the practice and SSP Health Ltd had shown to patients who felt let down when no GP had been available to see patients.

Care planning and involvement in decisions about care and treatment

From information available from the last National Patient Survey, we could see that the percentage of patients on the practice register that had a comprehensive care plan documented, which was agreed between patient and GP, was 87.5%, which is in line with the England average. One figure in particular from the National Patient Survey, was almost 10% higher than the England average. This was in respect of patients who said they were involved or very involved in decisions about their care. The England average was 85%, but the practice had scored 94.4% for this response. This data was 12 months old, and didn't fully reflect the changes at the practice since SSP Health Ltd took over Hightown Surgery. SSP Health Ltd had not conducted a patient survey to gather views on the service they had provided over the previous 12 months. The practice had met its target in producing care plans for each patient that was deemed to be vulnerable, or who could be at risk of unplanned hospital admissions. However, the provision of a named GP for those patients had proved problematic due to the service being delivered by locum GPs who would not be staying with the practice.

Patient/carer support to cope emotionally with care and treatment

The practice nurse confirmed that she was aware that people with long term conditions may need extra emotional support to cope with their illnesses. Those patients who were elderly or housebound and had a chronic condition, could be visited at home by the nurse for check-up appointments.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was not always responsive to the needs of patients and improvements are required.

Several patients with longer term conditions required regular blood tests. We were told by more than one patient that they had been referred to other clinics, for example in Crosby, to have bloods taken for a period of at least 12 months. Patients said this was inconvenient and they had been able to have blood collection done by the health care assistant in the past. When a patient complained about this in September 2014, they were told that they could actually have blood taken by the nurse at the practice and the information they had been given was incorrect. This example was given to us by patients, to demonstrate the practice did not address patient feedback. When we looked into the complaint resolution and any learning from the complaint, we noted the patient was sent correct information about blood collection services. However, no signage was displayed in the reception or waiting area confirming that phlebotomy (blood collection) services were available at the practice. This meant other patients who had been given incorrect information where not made aware of the error.

The practice had an active Patient Participation Group (PPG). Members of the PPG told us they felt the group was not fully supported by the practice. We asked for examples of why they thought this. We were told that information notices about what the PPG does, with the names, contact details and pictures of its key members was not available to patients. The group told us patients were not aware that issues could be put to the PPG. One member of the group had bought a display board suitable for displaying information, photographs and contact details of people who made up the PPG and requested that it was placed in the reception area for patients to refer to. The provider had failed to meet this request.

We spoke to one patient who ran a carer support group in the village. We also spoke to patients who were carers of older family members. Many of the carers were elderly themselves. We were told that the practice did little to offer emotional support to carers and had little understanding of how frustrating it was for them to have to explain their family member's condition over and over again to different GPs. Patients said they were aware the newer locum GP had only committed to the practice until the end of 2014, and the other female locum GP was leaving at the end of November 2014. Patients told us the lack of information on how services would be delivered in the longer term and the lack of continuity of care increased anxiety about the care of their family member.

Tackling inequity and promoting equality

The practice had implemented the Gold Standards Framework (GSF) for end of life care. They had a palliative care register. We found the practice had not been able to contribute to multi-disciplinary team meetings for the care of patients receiving end of life care in the community. This was due to locum GPs being unable to commit to attending these meetings. A regional manager had entered into correspondence with the multi-disciplinary team to try to resolve this.

Staff who worked at the practice and lived locally, knew patients well. As a result, they were able to judge if a patient would require a double appointment with the GP, for example, those attending with carers. Double appointments were not exclusively for any one population group and where staff found that this would be needed to address a patient's health problems, a double appointment with the GP would be offered.

Access to the service

Repeat prescriptions could not be ordered on-line or over the phone, but only by submitting a written request. Patients from the working age population we spoke with told us this would be a useful service and one that they would use regularly. The practice could not show any plans in place to bring the practice in line with many others who do offer some on-line access to appointments and repeat prescription ordering services.

The practice was offering some extended hours appointments on a Monday, when GPs ran a surgery until 7.30pm. The practice also opened at 8.00am every morning between Monday and Friday. People we spoke with on the day of our inspection told us they did not experience problems trying to get a GP appointment.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. The complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there is a designated responsible person who handles all complaints in the practice.

We reviewed the complaints received by the practice to see if they were discussed and if learning was taken from the outcome and shared amongst staff. One complaint we reviewed related to a patient with hearing difficulties. The GP seeing the patient was not aware that a hearing loop facility was available at the practice. The expected learning from this would be that signage advertising the availability of a hearing loop in the surgery would be put into place, and information in the practice leaflet updated. We checked for signage indicating a hearing loop system was in place, and found there was none. We were given a copy of the updated practice leaflet; this did not advertise that a hearing loop was available. We further noted that the new, extended hours on a Monday were not included in the updated practice leaflet.

We reviewed a complaint that had been made to NHS England in March 2014 about the practice. The complaint focussed on issues around appointments for patients that could not be met due to locums failing to honour a booking. Other matters such as patients being kept waiting for two hours, only to be sent home as no GP was available, were also raised. From the complaint log, we could see the practice had sight of the complaint. Analysis of the complaint by the practice was limited to comments regarding the onus on response to the complaint being with NHS England. The practice complaint log commented that all relevant details had been passed to NHS England. There was no attempt made by the practice to make direct contact with the patient, in order to consider the points made directly, or assure the patient that their feedback would be acted upon. At the time of our inspection, the same patient (who had given their name on a CQC comment card), recorded their experience again of the practice. Sentiments were negative and comments were made about the lack of empathy the practice and provider had showed to patients who felt let down when no GP had been available to see patients.

Are services well-led?

Inadequate

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

Our findings

Vision and strategy

The practice was not well-led at a local level. Although there were policies and procedures for staff to follow, these were not embedded at a local level. Leadership was remote and not accessible to clinical staff, particularly the locum GPs. The newly recruited nurse did have accessible leadership and mentoring through a nurse at a neighbouring practice.

The locum GP we spoke with could not say what the vision for the organisation was, or tell us of any particular short or medium term goals of the organisation.

Patients commented on the lack of leadership at the practice.

Governance arrangements

We reviewed policies and procedures, which we were informed were standardised for the SSP Health Ltd group of GP practices. However, the ones we looked at did not support Hightown practice particularly well. For instance, the new practice nurse did not realise she was a safeguarding lead at the practice. Similarly, both the GP and the practice nurse did not know there was a defibrillator available for use at the practice. There was no system in place to ensure the responsibilities of the absent practice manager were undertaken to an appropriate standard. There was no clear line of accountability for checks made on essential daily tasks. For example, checks that GPs had created tasks on the computer system in response to incoming test results. We saw how, on two occasions, patients test results required a follow up GP appointment. These appointments were not offered to the patients. Evidence that these omissions had been discussed with the GP or actions and learning to prevent reoccurrence was not available.

When we spent time talking to the GP, we found he was unaware of Quality Outcomes Framework (QOF) results for the practice. He had not attended any meetings with the local clinical commissioning group, for example, to discuss particular initiatives specific to the Sefton area. There was no local level engagement with other surgeries in the area, even those run by the same provider. We could see that audits had been conducted, but these were carried out at a group level rather than practice level. The Data Quality Manager showed us information on recent audits conducted. These included one in relation to patients on anti-coagulation treatments, a review of patients who had not collected prescriptions for their medicines, and an audit on the monitoring of fridge temperatures and staff adherence to cold chain policy.

Leadership, openness and transparency

The newer locum GP at the practice discussed with us how he had tried to support staff and provide leadership to them in the short time he had been there. The patients were appreciative of the GPs efforts and told us they liked him and hoped he would stay with the practice. Staff told us they appreciated the new locum GP and also hoped he would stay with the practice.

The two locum GPs at Hightown practice worked largely in isolation with minimal support from leaders. There were no arrangements in place for meetings with peers at other practices close by. The practice received some support from a Regional Manager, but this was largely focussing on practice management issues for example, to cover staff absences, and headline QOF results. The locum GP we spoke with could not give us any examples of areas of focus, based on QOF results.

Some patients had written to NHS England about the lack of continuity of the health care services from GPs at the practice. The response from NHS England, indicated they had been told that the two locum GPs who were with the practice at the time of our inspection, were permanent SSP Health Ltd employees. This conflicted with information given to us at our inspection, and the information given to patients by the locum GPs at the practice. One GP confirmed they were a locum and were leaving within the month of our inspection (November 2014). The newer locum confirmed to us on the date of our inspection that they were working as a locum and had not committed to the practice beyond the end of December 2014. Patients we spoke with were aware of this and told us this lack of transparency had damaged their trust in the provider.

We saw that regular practice meetings took place which all staff attended. A separate meeting was held for the locum GP and the regional manager. When we spoke to staff about leadership and management, they told us they 'self-managed' on a daily basis. All staff said they appreciated the presence of the regular locum GPs as this

Are services well-led?

Inadequate

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

familiarity supported working relationships. Staff did comment that trying to cover all administrative tasks whilst the practice manager and one other staff member had been away, had left them 'stretched'.

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

The 2013 National Patient Survey data and patient complaints helped to gather patient feedback. The PPG had meetings with the practice bi-monthly. Suggestions by the PPG about placing a noticeboard with contact details of members of the PPG had not been acted upon, which may have encouraged more patient feedback. Members of the provider management team, present on the day of our inspection, acknowledged that the practice had been subject to negative press and that patients felt they were not being listened to. The Chief Operating Officer, who was present on the day of our inspection, suggested the national shortage of GPs contributed to the problems experienced at the practice, particularly those GPs who were prepared to work at a practice with small patient numbers. However, the provider was unable to show us any active steps taken to try to address the issues raised. We saw a generic advert was placed permanently on the provider website for locum GPs, but no targeted work had been done to address patient concerns about a permanent GP for Hightown practice.

Management lead through learning and improvement

There was some communication in place between other surgeries nearby who were also part of SSP Health Ltd, but no meetings were arranged for GPs to discuss areas for improvement in response to QOF data or other key performance indicators. The newer locum GP told us he had not seen the latest QOF figures for the practice. There was no input from GPs to higher management about the specific problems the practice faced, how these could be addressed and how GPs could be supported to deliver those improvements, for example, a clear succession plan, or effective plans to address problems caused when a locum did not honour a booking.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers The provider is failing to comply with regulation 10(1)(b) and 10(2)(b)(i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 There were inadequate systems in place to identify, assess and manage risks relating to the health welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity. The provider failed to identify that further interventions recommended by hospital clinicians, were missed by locum GPs due to them being unfamiliar with the process for requesting those interventions. No check system had been put in place to prevent this mistake from re-occurring. The provider failed to have regard to the complaints and comments made, and views expressed by patients and those acting on their behalf. The provider had not taken any meaningful steps to address complaints on the lack of continuity of care for patients. The provider had not conducted any risk assessment as to whether services delivered by locums, increased the risk of error over time. The continuity plan in place to deliver services when locums failed to honour bookings was insufficiently robust.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services

This section is primarily information for the provider

Compliance actions

The provider is failing to comply with regulation 17(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 9(3)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Patients were not provided with appropriate information and support in relation to their care or treatment. The provider did not give information to service users on how long locum GPs would be delivering services for, and whether permanent GPs would be recruited for the practice. Review of complaints showed that if service users had this information they could have made an informed decision about who they would register with for GP services.

Regulated activity

Diagnostic and screening procedures

Surgical procedures

Treatment of disease, disorder or injury

Regulation

Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing

The provider is failing to comply with regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not have systems in place to ensure that, at all times, there were sufficient numbers of suitably qualified skilled and experienced persons employed for the purposes of carrying on the regulated activity. There were five occasions within a 12 month period where no GP was available to deliver sessions at the practice, which patients had appointments for.

Regulated activity

Regulation

Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff

The provider is failing to comply with regulation 23(1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Compliance actions

Suitable arrangements were not in place to ensure that persons employed for the purposes of carrying on the regulated activity were appropriately supported in relation to their responsibilities. Locum GPs worked with little support from the provider. There was no system in place to provide peer review of GPs work. The locum GP we spoke with on the day of our inspection described an on-line system for logging serious incidents but had not used this and could not show us where it was on the computer system. No training or instruction in the use of this system had been given to the GP.

Regulated activity

Diagnostic and screening procedures

Surgical procedures

Treatment of disease, disorder or injury

Regulation

Regulation 24 HSCA 2008 (Regulated Activities) Regulations 2010 Cooperating with other providers

The provider is failing to comply with regulation 24(1)(a) and (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 12(2)(i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The practice had not taken part in multi-disciplinary team meetings for shared care of palliative patients since November 2013.

SPECIAL MEASURES

On the basis of this inspection and the ratings given to this practice, this provider has been placed into special measures.

This will be for a period of six months when we will inspect the provider again.

Special measures is designed to ensure a timely and coordinated response to practices found to be providing inadequate care.