

# The Highlands 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?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Good 

# Summary of findings

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## Overall summary

### Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Highlands Practice on 16 August 2016. Overall the practice is rated as good.

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

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- Risks to patients were assessed and well managed apart from those associated with vaccine management.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints

and concerns. The practice had gathered feedback from patients through the Patient Participation Group (PPG) who were shown complaints and asked for their opinion on how they might respond.

- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice 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.
- The provider was aware of and complied with the requirements of the duty of candour.

The areas where the provider should make improvement are:

- Review the identification of carers by the practice and implement a support mechanism for this patient group.
- Improve governance arrangements in the practice for the administration of vaccines under patient group

# Summary of findings

directions (PGD) to ensure staff are competently trained and that the PGD is completed in a timely manner to ensure that nurses do not practice outside of the legal framework.

- Review the system for access to same day appointments to ensure equal access for all patient groups.

**Professor Steve Field (CBE FRCP FFPH FRCGP)**

Chief Inspector of General Practice

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

### Are services safe?

The practice is rated as good for providing safe services.

- There was an effective system in place for reporting and recording significant events
- Lessons were shared to make sure action was taken to improve safety in the practice.
- When things went wrong patients received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, apart from those related to vaccines.
- Risks to patients were assessed and well managed.

Good



### Are services effective?

The practice is rated as good for providing effective services.

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

Good



### Are services caring?

The practice is rated as good for providing caring services.

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

Good



# Summary of findings

- However, the practice had identified less than 1% of the patient population who were also carers.

## Are services responsive to people's needs?

Good



- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified. For example, they have recruited a pharmacist for the practice, as part of the NHS England pilot programme.
- The practice has implemented an e-consult web based consultation system to meet the needs of working age people.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice offered a range of access options including, daily bookable telephone appointments, weekly early morning and late night clinics, alternate Saturday GP and nurse clinics and an e-consult service.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

## Are services well-led?

Good



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

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings.
- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.

# Summary of findings

- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken
- The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active.
- There was a focus on continuous learning and improvement at all levels.

# Summary of findings

## The six population groups and what we found

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

### Older people

The practice is rated as good for the care of older people.

Good



- The practice offered proactive, personalised care to meet the needs of the older patients in its population.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- Patients in one nursing home for dementia received a weekly ward round from a nominated GP in the practice. A nominated GP carried out a weekly ward round in a nursing home for patients with dementia.
- The practice ensured older people were discussed at least every three months at the multi-disciplinary meeting.

### People with long term conditions

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

Good



- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- The percentage of patients with diabetes, on the register, in whom the last average blood sugar result was within acceptable limits in the preceding 12 months, was 72% which was comparable to the local CCG average of 78% and a national average of 78%.
- Patients diagnosed with diabetes in the last five years were reviewed in a “virtual clinic” with a Community Diabetic Nurse regularly.
- There the practice ran a dedicated monthly Saturday clinic for patients with Chronic Obstructive Pulmonary Disease, a chronic lung condition, to improve quality of diagnosis. The practice nurse wrote supporting information to help patients understand their condition.
- Longer appointments and home visits were available when needed.
- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

# Summary of findings

## Families, children and young people

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

Good



- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- The practice's uptake for the cervical screening programme was 77%, which was comparable to the CCG average of 77% and the national average of 82%.
- Appointments were available outside of school hours and the premises were suitable for children and babies.

## Working age people (including those recently retired and students)

The practice is rated as good for the care of working-age people (including those recently retired and students).

Good



- 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.
- The practice offered a range of access options including, daily bookable telephone appointments, weekly early morning and late night clinics, Saturday GP and Nurse clinics and a new e-consult service.

## People whose circumstances may make them vulnerable

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

Good



- The practice used alerts on patient records to enable staff to manage individual patient needs based on their behavioural symptoms.
- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- The practice offered longer appointments for patients with a learning disability.



# Summary of findings

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

## People experiencing poor mental health (including people with dementia)

The practice is rated as good for the care of people experiencing poor mental health (including people living with dementia).

- 83% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months, which is comparable to the national average of 84%.
- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption had been recorded in the preceding 12 months was 91%, which was comparable to a local CCG average of 93% and a national average of 89%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia.
- The practice carried out advance care planning for patients living with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and those living with dementia. For example, there was a weekly prescription process for patients who need help with understanding and taking medication. Alerts were placed on patients' records to highlight particular behaviours and how to manage them.

Good



# Summary of findings

## What people who use the service say

The national GP patient survey results were published on January 2016.

The results showed the practice was performing in line with or above local and national averages.

242 survey forms were distributed and 114 were returned. This represented less than 1% of the practice's patient list.

- 69% of patients found it easy to get through to this practice by phone compared to the national average of 73%.
- 81% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the national average of 76%.
- 87% of patients described the overall experience of this GP practice as good compared to the national average of 85%.

- 87% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the national average of 79%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 22 comment cards which were all positive about the standard of care received.

We spoke with six patients during the inspection. All six patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. The patient interviews were mainly positive and used words like understanding, compassionate and friendly. Several patients commented on the waiting system for same day appointments and the difficulty getting an appointment if you were unable to come and queue up early. This was under review by the practice.

# The Highlands Practice

## Detailed findings

### Our inspection team

#### Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist adviser, an assistant CQC inspector and a practice manager specialist adviser.

## Background to The Highlands Practice

The Highlands Practice, 102 Highlands Road, Fareham, Hampshire, PO15 6JF is on the edge of Fareham town.

The Highlands Practice is situated in a purpose built health centre with seven rooms off of one large corridor. There is a bell to ring for assistance with disabled access because there are no automatic doors. There are two waiting areas, both equipped with suitable chairs for patients with limited mobility.

There are seven noticeboards displaying information for patients, including the practice cleaning schedule, action to take in the event of a fire and how to make a complaint.

The Highlands Practice provides medical services to around 16,000 patients in Fareham in one of the least deprived areas in the country. 10% of the practice population is over 75 years of age. Less than 3% mixed of the patient population are from Asian ethnicities, with the majority of the practice population identifying themselves as White British.

There are eight GP partners with three salaried GPs who together provide 7.3 whole time equivalent GPs. This is a mix of two male and seven female GPs.

There are currently four practice nurses and two health care assistants. At the time of our inspection, the practice had just appointed a clinical pharmacist to assist with complex medicine issues.

The clinical staff are supported by a practice manager and an operational manager who manage the 26 part-time clerical, reception and administrative staff. The Highlands Practice trains medical students and trainee GPs.

The practice is open between 8.05am and 6.30pm Monday to Friday. Appointments are from 8.30am to 6.30pm daily. Extended hours appointments are offered from 7.00-8.00am on Thursday mornings and from 5.30pm to 8.00pm on Tuesday evenings. There are additional clinics on alternate Saturdays between 8.30am to 12pm, with a mix of GP and nurse clinics.

When the practice is closed, the public are encouraged to use the NHS 111 service.

There has been no previous CQC inspection for this provider.

## Why we carried out this inspection

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

# Detailed findings

## How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 16 August 2016. During our visit we:

- Spoke with three GPs, a practice manager, an operational manager, five administration and reception staff and three practice nurses and spoke with patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.'

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

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

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

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

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

# Are services safe?

## Our findings

### Safe track record and learning

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

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice carried out a thorough analysis of the significant events.
- The practice received updates from the local clinical commissioning group (CCG) system for reporting significant events. This was discussed and allowed analysis of themes and learning from neighbouring practices. For example, the vaccine schedule for children was reviewed and changed following a significant event report regarding the whooping cough vaccine.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed, most recently on 20 May 2016. We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, the minutes showed a case discussion regarding the complexity of care needs for a patient at home. This showed how the practice team were experiencing difficulty managing the social issues for one patient. An open discussion regarding options for referrals and involving other professionals showed how the whole team took responsibility to help solve the issues. This led to an agreement that all clinical staff could bring discussions about patients with complex needs to the practice meeting to allow for multi-disciplinary discussion to help find alternative options for care.

### Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, apart from those related to patient group directions (PGDs) related to safe management of vaccines.

Patient group directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. However, we found evidence that this system did not consistently keep patients safe. Specifically, there were several significant gaps in dates between the signed authorisation of the PGD by a GP and the signature of the nurse who administered the vaccine. This meant that the competency of the nurse to administer this vaccine could not be guaranteed.

For example, there were 17 PGDs in place and there were significant concerns with four examples:

- 1: Influenza had a gap of 11 months between the nurse signature (1.09.15) to GP signature (10.08.16) This affected 664 patients in this time frame.
- 2: Revaxis (diphtheria tetanus and polio): had a gap of nine months between nurse signature (1.11.15) to GP signature (10.08.16). This affected 203 patients.
- 3: Meningitis B: three nurse signatures (1.09.15) with no GP signature. This affected 193 patients.
- 4: Rotavirus infection vaccine: gap of 14 months between nurse signature (30.06.15) and GP signature (10.08.16) this affected 203 patients.

In addition, one PGD was illegible, one PGD had nurse's signatures all in one space with no printing to clearly identify the signatory, and one PGD had an illegible GP signature with no date.

The concerns were raised with the practice manager and senior GP who immediately audited the number of patients affected. Following an open discussion the practice team demonstrated a full review of PGDs by 5pm. A new protocol was written. An action plan was received within 48 hours which included five learning and training steps for practice nurses, managers and lead GP to attain. There was a completion timeframe with a review date and nominated date for discussion at the partners meeting in September, as a significant event.

## Are services safe?

- Health care assistants were trained to administer vaccines and medicines against a patient specific prescription or direction from a prescriber. There was a training schedule, competency assessment and appraisal system in place.
- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child protection or child safeguarding level 3. Practice nurses and health care assistants were trained to child safeguarding level 3. The practice had a system to ensure that children who missed appointments were followed up. This aimed to increase access for vulnerable families.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones was trained for the role and had received a Disclosure and Barring Service (DBS) check. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training.
- The infection control lead nurse disseminated information to all staff by newsletter and the practice's intranet. Annual infection control audits were undertaken, most recently on 3 August 2016 and we saw evidence that action was taken to address any improvements identified as a result. For example, this led to a discussion with the cleaning service contractor to improve the standard of the daily cleaning schedule.
- The arrangements for managing medicines, including emergency medicines in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal), apart from those associated with vaccines. Processes were in place for handling repeat prescriptions which included the review of high risk medicines.
- The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing.
- The practice implemented Electronic Prescribing and had achieved 25% of patients registered for this service.
- Blank prescription forms and pads were securely stored and there were systems in place to monitor their use.
- We reviewed four personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employment in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

### Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office which identified local health and safety representatives. The practice had up to date fire risk assessments and carried out regular fire drills. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and Legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff was on duty managed by the recently appointed operations manager and practice manager.

## Are services safe?

### **Arrangements to deal with emergencies and major incidents**

The practice had adequate arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book was available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.



# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

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

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs. For example, following a local incident the practice shared NICE guidelines for children with fever to increase awareness for all clinical staff.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

### Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 94% of the total number of points available. This was comparable to the national average of 95% and a local average of 97%.

Data from 2014/15 showed the practice was an outlier for the percentage of patients with COPD, a chronic lung condition, who had a review. For example, the data suggested The Highlands Practice had exception reported about 20% of patients with COPD, compared to a local average of 14% and a national average of 11%. On further enquiry, the practice presented non-validated data for 2015 to 2016 which showed an improvement to less than 10%. The practice stated the previous high exception rate was a coding error, now resolved.

The overall exception reporting rate for The Highlands practice was 9%, which was lower than the CCG average of 11% and comparable to the national average of 9%.

(Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

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

- Performance for diabetes related indicators was better than the national average. For example, the percentage of patients in whom the last blood pressure reading was within acceptable limits was 84%, which was higher than a local CCG average of 78% and a national average of 78%
- Performance for mental health related indicators was higher than the national average For example; the percentage of patients with schizophrenia or similar psychoses who had a comprehensive care plan was 96%, which is higher than the local CCG average of 90% and a national average of 88%.

There was evidence of quality improvement including clinical audit.

- There had been six clinical audits completed in the last two years, six of these were completed audits where the improvements made were implemented and monitored.
- The practice participated in local audits, national benchmarking, accreditation, peer review and research.
- Findings were used by the practice to improve services. For example, recent action taken as a result included a local discussion to ensure locum GPs were following local prescribing guides for certain antibiotic medicines.
- Information about patients' outcomes was used to make improvements such as: an audit to monitor the use of the British Thoracic Guidelines in asthma care. Specifically, the number of inhalers was reviewed alongside the number of annual reviews undertaken. The practice found that 16 patients received more than 12 inhalers in one year and only seven had an annual review. The findings were shared across the practice using education of GPs and asthma nurses. A new recall system was instigated. The audit was repeated in 2016 and this found that the number of patients receiving more than 12 inhalers per year had reduced to 13. However, they found that the number of patients attending the asthma review had dropped to three. Further work was planned to try and embed changes to enable patients to gain more knowledge and control of their condition. For example, the lead GP recommended including reception and prescribing clerks in a further education session.

### Effective staffing



# Are services effective?

## (for example, treatment is effective)

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

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions attended regular updates and had protected time for training and link meetings.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. All staff had received an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire safety awareness, and basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.
- This practice took part in TARGET training sessions which were supported by the local clinical commissioning group. The practice closed for half a day, once per quarter for 'Protected Learning Time'. TARGET provided: Time for Audit, Research, Governance, Education and Training. During this time, patients were directed to the NHS 111 service. Practice closures were advertised to patients well in advance.

### Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

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

### Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored through patient records audits.

### Supporting patients to live healthier lives

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

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation and local voluntary services like shopping. Patients were signposted to the relevant service.
- A dietician was available on referral and smoking cessation advice was available from a local support group on the premises every Friday.

# Are services effective?

(for example, treatment is effective)

The practice's uptake for the cervical screening programme was 77%, which was comparable to the CCG average of 77% and the national average of 82%.

There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. For example, patients screened for bowel cancer in the last 30 months was 65% which was comparable to the local CCG average of 66% and a national average of 58%.

Females, aged 50-70 years, screened for breast cancer in the last 36 months was 68% which was comparable to a local CCG average of 72% and national average of 72%.

Childhood immunisation rates for the vaccines given were comparable to CCG and national averages. For example, childhood immunisation rates for the vaccines given to under two year olds ranged from 81% to 99% , compared to a local CCG average of 82% to 99% and five year olds from 91% to 98%, compared to a local CCG average of 94% to 99%.

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

# Are services caring?

## Our findings

### Kindness, dignity, respect and compassion

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

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

All of the 22 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. Six comments were mixed with reference to the difficulty in getting through on the telephone. This was in line with what patients told us on the day.

We spoke with one member of the patient participation group (PPG). They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey published in January 2016 showed patients felt they were treated with compassion, dignity and respect. The practice was mostly above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 95% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 86% and the national average of 89%.
- 91% of patients said the GP gave them enough time compared to the CCG average of 83% and the national average of 87%.
- 94% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 94% and the national average of 95%.

- 88% of patients said the last GP they spoke to was good at treating them with care and concern compared to the national average of 85%.
- 83% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 91%.
- 90% of patients said they found the receptionists at the practice helpful compared to the CCG average of 86% and the national average of 87%.

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

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

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

- 86% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 83% and the national average of 86%.
- 91% of patients said the last GP they saw was good at involving them in decisions about their care compared to the national average of 82%.
- 79% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the national average of 85%.

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

- Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.
- Information leaflets were available in easy read format.
- There was a dedicated information board for dementia care.

### Patient and carer support to cope emotionally with care and treatment

## Are services caring?

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations, for example, Community Action Fareham, Age Concern, Stroke group, Combat Stress. Information about support groups was also available on the practice website.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 123 patients as

carers (less than 1% of the practice list). Written information was available to direct carers to the various avenues of support available to them on a noticeboard in reception.

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

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. For example, the practice has implemented an e-consult online consultation system in June 2016 to meet the needs of working age people. It features self-help, administrative help and online GP consultation for adults. Responses to patient queries are received by the end of the next working day. There has been an average of 7-8 users per day.

- The practice offered extended hours on a Tuesday evening and Thursday morning for patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccines available on the NHS as well as those only available privately.
- There were disabled facilities, a hearing loop and translation services available.
- Other reasonable adjustments were made and action was taken to remove barriers when patients find it hard to use or access services. For example, a nurse-led clinic was available on a Saturday from 8.30am – 11.30am with 45 minute appointments to enable newly diagnosed patients with chronic respiratory diseases to attend for diagnosis and treatment.

### Access to the service

The practice was open between 8.05am and 6.30pm Monday to Friday. Appointments were from 8.30am to 6.30pm daily. Extended hours appointments were offered from 7.00-8.00am on Thursdays and 5.30pm to 8.00pm on Tuesday evening and alternate Saturdays 8.30-12.00, with a mix of GP and nurse clinics.

In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for patients that needed them.

The practice doors open at 8.05am and appointments start at 8.30am. We observed a line of patients waiting outside the practice before the doors open. Patients were then given a numbered ticket and added to the triage list for the appointments which are made available that day. Patients told us this means that people who cannot get through on the phone sometimes find that same day slots are taken by people who are able to attend early and queue. The practice was aware of this and had tried numerous systems over the years. The practice told us that once a new partner is recruited, this system was to be re-evaluated.

- Monday and Friday appointments are run using a “pool system” using half hour open access clinics which all GPs manage the on the day need.

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

- 82% of patients were satisfied with the practice's opening hours compared to the national average of 78%.
- 69% of patients said they could get through easily to the practice by phone compared to the national average of 73%.

Patients told us on the day of the inspection that they were not always able to get appointments when they needed them. Several patients found the same day appointment system difficult if they were unable to attend the surgery to queue.

The practice had a system in place to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

Patients were asked to call for a home visit early in the day, and these are then distributed among GPs who triage their own workloads, according to clinical need. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

### Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns.

# Are services responsive to people's needs?

(for example, to feedback?)

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system on a noticeboard in the waiting room, on the practice website, in the newsletter and in the practice leaflet.
- The practice had gathered feedback from patients through the Patient Participation Group who were shown anonymised complaints and asked for their opinion on how they might respond.
- Since May 2016 the practice had gathered feedback from patients through their website. The website was automated to allow patients to email the practice manager directly to offer comments and receive a response.

There were 34 complaints received, of which, we looked at 9 in the last 12 months and found these were satisfactorily handled, dealt with in a timely way, openness and transparency with dealing with the complaint. Lessons were learnt from individual concerns and complaints and also from analysis of trends and action was taken to as a result to improve the quality of care. For example, a patient complained about the communication style of a GP. This was raised in the management meeting and the GPs reflected on the case. They acknowledged that they needed to spend additional time talking to carers of patients with terminal illness or serious health conditions. This was implemented by the practice.

# Are services well-led?

Good 

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

## Our findings

### Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients.

- The practice had a mission statement which was displayed in the waiting areas and staff knew and understood the values.
- The practice had a robust strategy and supporting business plans which reflected the vision and values and were regularly monitored.

The practice held two strategy planning meeting for partners and managers in the last six months. This enabled sharing of plans related to CCG changes and the national plan from NHS England called the Five Year Forward View.

### Governance arrangements

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

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- There was a nominated GP lead for safety who had undertaken additional safety training. The impact of this was that they were able to drive a new approach of a no-blame culture and increased reporting and recording of safety incidents.
- Practice specific policies were implemented and were available to all staff.
- A comprehensive understanding of the performance of the practice was maintained.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. However, we found evidence that the governance system for managing vaccines using Patient Group Directions (PGDs) had not kept patients consistently safe.

### Leadership and culture

On the day of inspection the partners in the practice demonstrated they had the experience, capacity and

capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable and always took the time to listen to all members of staff.

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

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

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

- Staff told us the practice held regular team meetings. These were divided into monthly business meetings, quarterly safety meetings and individual team meetings. There were weekly management team meetings with staff representatives from nursing, administration and reception.
- The teams held their own monthly team meetings to receive disseminated information, such as admin, nursing and reception.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. We noted team away days were usually held every 12 months, with the next one planned for September 2016.
- There had been two strategy planning meetings held in the last six months to allow partners who had started within the last year to develop leadership skills.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.



# Are services well-led?

Good 

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

- Staff told us they all had an opportunity to talk informally over “afternoon tea”, a session where GPs were free to catch up with all staff and with one another.

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

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

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. The PPG met regularly, carried out patient surveys and submitted proposals for improvements to the practice management team. For example, the PPG raised their concerns about changes to local bus routes which do not reach the practice. The practice manager then wrote to the local council to ask for new considerations. Although this was rejected by the council, the PPG felt this was important to be raised and felt the practice had valued their concerns.
- The practice had gathered feedback from patients through the PPG who were shown complaints and asked for their opinion on how they might respond.

They received feedback through staff away days and generally through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.

## Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. The practice described the future growth of the local population related to building plans and the aging population likely to double. This influenced the succession planning and business plans for the practice.

The Highlands Practice worked with the local NHS Vanguard (Better Local Care) initiatives in Fareham with working groups looking to support the frailty pathway. This included an audit for the Vanguard to identify how home visits could be prioritised to improve responsiveness by working in different ways in the future.