Highlands Health Centre

Quality Report

Highlands Health Centre
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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 undertook a comprehensive inspection of Highlands Health centre in Ivybridge on 23 October 2014. Highlands Health Centre is located at Fore Street, Ivybridge, Devon PL21 9AE and provides primary medical services to people living in the Ivybridge area and surrounding villages. The practice provides services to a diverse population and age group.

Our key findings were as follows:

The Highlands Health Centre operated a weekday service for over 3,770 patients in the Ivybridge area. The practice was responsible for providing primary care, which included access to GPs, minor surgery, family planning, ante and post natal care as well as other clinical services.

Patients who use the practice had access to community staff including district nurses, community psychiatric nurses, health visitors, physiotherapists, counsellors, and midwives. The practice had arranged for other clinics, such as bone density measuring, to be held at the practice.

Patients we spoke to and the comment cards we looked at confirmed that people were happy with the service and the professionalism of the GPs and nurses. The practice was visibly clean and there were effective infection control procedures in place.

We found that staff were well supported and the practice was well led with a clear vision and objectives. Staff had a sound knowledge of safeguarding procedures for children and vulnerable adults.

Care and treatment was being delivered in line with current published best practice. Patients' needs were consistently met in a timely manner.

All the patients we spoke to during our inspection were very complimentary about the service and the manner in which they were cared for. Recruitment, pre-employment checks, induction and appraisal processes were in place. Staff had received training appropriate to their roles and further training needs had been identified and planned.

There was an open culture within the organisation and a clear complaints policy.

We saw several areas of outstanding practice including:

Summary of findings

The practice has arranged for screening services such as ultra sound and testing for bone density to come to the practice so patients do not have to travel to the hospital.

Patients that have been bereaved receive a telephone call from the GP after six weeks and subsequently a card reminding them of the support available, on the first anniversary of the death of a loved one.

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?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were safeguards in place to identify children and adults in vulnerable circumstances. There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services. The practice delivered care and treatment in line with recognised best practice and worked with other support services to provide a service to patients. Staff received the necessary training and development for their role. There was a proactive approach to using data to analyse and improve outcomes for patients. There had been a range of clinical audits, which had resulted in improvements to patient care and treatment. There were robust recruitment procedures in place.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained. The practice organised for outside providers to deliver care at the practice.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice reviewed and understood the needs of their local population. The practice identified and took action to make improvements. Patients reported that they could access the practice when they needed. There were named GPs for patients over 75, and the patients reported that their care was good. The practice was well equipped to treat patients and meet their needs.

Summary of findings

There was an accessible complaints system with evidence demonstrating that the practice responded appropriately and in a timely way to issues raised. There was evidence that learning from complaints was shared with staff.

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 quality care and treatment. Staff reported an open culture and said they could communicate with senior staff. They felt supported by management. The practice had a number of policies and procedures to govern activity and regular governance meetings took place. There were systems in place to monitor and improve quality and identify risks. There were systems to manage the safety and maintenance of the premises and to review the quality of patient care. The practice proactively sought feedback from staff and patients and this had been acted upon. The practice had an active patient representative group (PRG) which was involved in the core decision making processes of the practice. Patient engagement was central to the operation of 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

Good

The practice is rated as good for providing care to older people. Health checks and promotion were offered to this group of patients. There were safeguards in place to identify older patients in vulnerable circumstances. The practice worked well with external professionals in delivering care to older patients, including end of life care. Pneumococcal vaccination and shingles vaccinations were provided at the practice for older patients during routine appointments. Vaccines for older patients who had problems getting to the practice or those in local care homes were administered in the community by the GPs. The practice had arranged for other clinics, such as bone density measuring to be held at the practice. The practice had implemented care plans for patients at risk of being admitted to hospital as part of an optional enhanced services scheme. This included older patients. Patients over 75 years old had a named GP to provide continuity in care.

People with long term conditions

Good

The practice is rated as good for providing care to people with long term conditions. The practice managed the care and treatment for patients with long term conditions in line with best practice and national guidance. Health promotion and health checks were offered in line with national guidelines for specific conditions such as diabetes and asthma. Although the practice did not provide named GPs for patients with chronic medical conditions, patients felt well cared for and said they could access appointments easily at the practice. The practice had implemented care plans for patients at risk of being admitted to hospital as part of an optional enhanced services scheme. This included patients with long term conditions. Longer appointments were available for patients if required.

Families, children and young people

Good

The practice is rated as good for families, children and young people. Staff worked well with the midwife to provide antenatal and postnatal care. Six week postnatal health checks were provided by a GP. The practice provided baby and child immunisation programmes to ensure babies and children could access a full range of vaccinations and health screening. Information relevant to young patients was displayed and health checks and advice on sexual health for men, women and young people included a full range of contraception services and sexual health screening including

Summary of findings

chlamydia testing and cervical screening. Patients could also be referred to the specialist sexual health clinic if needed. The GPs training in safeguarding children from abuse was at the required level three.

Working age people (including those recently retired and students)

Good

The practice is rated as good for providing care to working age people. The practice provided appointments on the same day. If these appointments were not available then a telephone consultation with a GP would be booked and extended surgery hours would accommodate the patient if needed to be seen. The practice operated extended opening hours one evening a week. The practice website invited patients over 45 to arrange to have a health check with a healthcare assistant if they wanted. A cervical screening service was available.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for people whose circumstances may make them vulnerable. The practice had a vulnerable patient register to identify these patients. Vulnerable patients were reviewed weekly at team meetings and monthly at the multidisciplinary team meetings. A GP specialised in the treatment of patients with a history of drug and/or alcohol abuse and offered support and treatment. A counsellor was available one morning a week. The practice do not provide primary care services for patients who are homeless as none are known, however, staff said they would not turn away a patient if they needed primary care and could not access it. The GPs provide a temporary service to a local hostel were patients are transient. Staff told us that there were a few patients who had a first language that was not English. Patients with interpretation requirements were known to the practice and staff knew how to access these services. Patients with learning disabilities were offered and provided a health check every year during which their long term care plans were discussed with the patient and their carer if appropriate.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for providing care to people experiencing for mental health. The practice hosted support services for patients with poor mental health in one of their treatment rooms. There was signposting and information available to patients. The practice referred patients who needed mental health services as well as support services being provided at the practice. The community mental health services attended multi-disciplinary team meetings with the staff from the practice every three months.

Summary of findings

Patients suffering poor mental health were offered annual health checks and testing for depression and anxiety as recommended by national guidelines. GPs and nurses had training in the Mental Capacity Act (MCA) 2005 and an understanding or appropriate guidance available in relation to the Act when caring for patients with Dementia.

Summary of findings

What people who use the service say

We looked at patient feedback from the national GP survey from 2013. Ninety-nine patients were sent the survey, which was 33 for each GP at the practice. The surveys reported that access to the practice was very good and patients could see a GP quickly. 97% of patients felt that the GP was good at providing or arranging treatment. There was very positive feedback about the way staff spoke with and supported patients. All of the feedback was positive.

We spoke with nine patients during the inspection and collected 47 completed comment cards which had been left in the reception area for patients to fill in before we visited. On 45 of the 47 of the comment cards the feedback was positive. Patients said their care was very good, they had been listened to, and they could access the practice easily. They told us that they found the reception staff to be helpful and caring. Visiting professionals commented that they found the staff at the practice to be helpful and professional. The two negative comments referred to communication between the practice and the patient but stated that these problems had been addressed by the practice manager.

Outstanding practice

The practice has arranged for screening services such as ultra sound and testing for bone density to come to the practice so patients do not have to travel to the hospital.

Patients that have been bereaved receive a telephone call from the GP after six weeks and subsequently a card reminding them of the support available, on the first anniversary of the death of a loved one.

Highlands Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The team also included, a GP specialist advisor a practice manager specialist advisor, and an expert by experience (a person with experience as a patient or carer) who took part in the inspection by talking to patients and observing the surroundings.

Background to Highlands Health Centre

Highlands Health Centre provides primary medical services to people living in the town of Ivybridge and the surrounding villages.

At the time of our inspection there were approximately 3,775 patients registered at the Highlands Health Centre. There are two full time GP partners, one male and one female, who both held managerial and financial responsibility for running the business. In addition there is one female salaried GP who worked part time. The GPs were supported by two registered nurses, two clinical assistants, a practice manager, and additional administrative and reception staff.

Patients using the practice also have access to community staff including district nurses, health visitors, and midwives.

Highlands Health Centre is open from 8:30am until 6pm Monday to Friday. Late evening pre booked appointments are available on a Tuesday until 8:15pm for patients that find it difficult to visit the GP during the day. During evenings and weekends, when the practice is closed, patients are directed to an Out of Hours service delivered by another provider.

The CQC intelligent monitoring placed the practice in band six. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

Why we carried out this inspection

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

How we carried out this inspection

Before visiting the practice, we reviewed a range of information we held about the service and asked other

Detailed findings

organisations, such as the local clinical commissioning group, local Health watch and NHS England to share what they knew about the practice. We carried out an announced visit on 23 October 2014.

During our visit we spoke with two GPs, the practice manager, two registered nurses, administrative and reception staff. We also spoke with nine patients who used the practice. We observed how patients were being cared for and reviewed comments cards where patients shared their views about the practice, and their experiences. We also looked at documents such as policies and meeting minutes as evidence to support what staff and patients told us.

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 living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Good

Are services safe?

Our findings

Safe Track Record

Systems were in place for reporting and responding to incidents. All safety alerts were dealt with by the GPs, nurses and reception team. Patients told us they felt safe when attending the practice. The practice had chaperone policy in place. A chaperone is a third person of the patient's choice, who may accompany them during consultation, treatment or physical examination.

The GP told us that when they received MHRA alerts (medical alerts about medicines safety) they searched their patient records to check whether any patients would be affected, to ensure they took appropriate actions to protect patients. The lead GP also shared medical alert information with other clinical staff in the practice.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. We saw records of significant events that had occurred during 2014. Team meeting minutes showed significant events were discussed to identify concerns and share learning with the staff. The significant events log was discussed at staff meetings to identify trends. Complaints were discussed at team meetings and some were recorded as significant events. There was evidence that appropriate learning had taken place where necessary and that the findings were disseminated to relevant staff. All staff were aware of the system for raising issues to be considered at the meetings, and said they felt able to do so.

Reliable safety systems and processes including safeguarding

Children and adults were protected from the risk of abuse because the practice took steps to identify and prevent abuse from happening. There were systems in place to identify patients who may be at risk of abuse. A GP took the lead for safeguarding in the practice and staff knew to refer any concerns to them. The GPs held a weekly meeting to discuss vulnerable patients. The health visitor also attended these meetings to discuss vulnerable patients on the lists.

All staff had received an appropriate level of training for protecting vulnerable children and adults. The administrative and reception staff were trained at level one standard, the nursing staff level one and two and the GPs level three. The practice safeguarding policies and flow charts displayed in the office and consulting rooms provided guidance to staff on how to raise safeguarding concerns. We spoke with staff about identifying and preventing abuse. They had a good understanding of the different types of abuse and were able to describe the procedure to be followed if they suspected or witnessed any concerns. All staff said they would raise their concerns with the GP safeguarding lead or another GP if they were not available. The practice provided safeguarding information for patients in the waiting room about how to respond to concerns involving abuse.

Medicines Management

The GPs were responsible for prescribing medicines at the practice. There were no nurse prescribers employed. The control of repeat prescriptions was managed well. Patients were not issued any medicines until the prescription had been authorised by a GP. Patients were satisfied with the repeat prescription processes. They were notified of health checks needed before medicines were issued. Patients explained they could use the prescription drop-off box at the practice, send an e-mail, or use the on-line request facility for repeat prescriptions.

Safe management of medicines were in place. The practice nurse was responsible for the management of medicines within the practice and there were up-to-date medicines management policies. Staff were able to show us where medicines were stored and explain their responsibilities. Medicines were kept securely in a locked cupboard. Controlled drugs were stored in the locked cupboard and only GPs had access to these. Expiry date checks were undertaken regularly and recorded.

Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance. We saw up to date evidence that nurses had received appropriate training to administer vaccines. Fridge temperatures were also checked daily to ensure medicines were stored at the correct temperatures.

Cleanliness & Infection Control

The practice nurse was the lead for the prevention of infection control. There were policies and procedures in

place and regular infection control and cleaning audits were undertaken. On our visit to the practice we inspected the building and looked at areas where care and treatment were delivered.

The treatment rooms used by the nurses had washable flooring and there were sinks for hand washing with a supply of hand wash and paper towels. There was a supply of disposable gloves and aprons with foot operated waste bins. All surfaces could be thoroughly cleaned and we were told by the infection control lead that this procedure was carried out after each consultation. Each of the examination beds had disposable paper covers that were changed after every use. Modesty curtains were cleaned monthly. Equipment used by the nurses was single use and disposed of appropriately after each patient.

The GP consultation rooms each had an examination couch with protective paper covering for preventing the spread of infection. Each had a separate hand washing sink with soap dispenser and paper towels. We noted that one GP's consulting room did not have a modesty curtain; they explained and showed to us a separate examination room that was used for intimate examinations. We were told by the nurses that the GPs were responsible for their own consultation/treatment room cleanliness. The rooms we looked at were visibly clean.

Dedicated sharps boxes were available in all the treatment rooms and were used appropriately. A contract was in place for the collection and safe disposal of clinical waste. There were systems in place to manage clinical waste.

A legionella test on the water supply had been recently carried out.

Equipment

Fire alarms and equipment was tested and serviced on an annual basis. Records demonstrated that staff had received training in fire safety. First aid kits and emergency equipment were in good order and stored appropriately where they could be reached easily in an emergency.

Equipment such as the weighing scales, blood pressure monitors and other medical equipment were serviced and calibrated where required.

The practice had systems in place to monitor the safety and effectiveness of equipment. Checks were performed on oxygen cylinders and the defibrillator. All portable appliance testing, water safety, fire safety and other equipment checks had been undertaken with appropriate certification and validation checks in place.

Staffing & Recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. A meeting was held between the practice manager and the partners and a decision made as to what hours would be required. GPs would be involved in all processes along with the practice manager.

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure there was enough staff on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave.

Monitoring Safety & Responding to Risk

Monitoring and assessing of risks took place. For example, we saw a fire risk assessment and a Health and Safety risk assessment for the premises. We saw portable appliances were tested in line with Health and Safety Executive guidance to ensure they were safe.

The practice showed us the clinical audits that had been undertaken in the last year. We noted these were discussed at clinical team meetings. GPs told us the audits would be repeated where necessary to identify if improvements to patient care had been made as a result of the audits. We saw audits on the use of a specific medicine and specific concerns with the health needs of the practice population. Patients with long term conditions received care and treatment which reflected national guidance. This included regular health checks to ensure patients with health conditions were assessed regularly. The regularity of these reviews reflected intervals recommended by the National Institute for Health and Care Excellence (NICE).

Good

Are services safe?

The Quality and Outcomes Framework (QOF) is a voluntary system for the performance management and payment of GPs in the National Health Service. QOF data showed the practice monitored the health and wellbeing of patients who experience poor mental health. This included regular medicine checks and physical health checks.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). All staff asked knew the location of this equipment and records we saw confirmed these were checked regularly. Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis (an adverse reaction to medicines) and hypoglycaemia (low blood sugar).

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Areas identified included power failure, adverse weather, unplanned sickness and access to the building and clear instruction was given to rectify these. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact in the event of failure of the heating system.

A fire risk assessment had been undertaken that included actions required to maintain fire safety. We saw records that showed staff were up to date with fire training and that regular fire drills were undertaken.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

There were examples where care and treatment followed national best practice and guidelines. For example, emergency medicines and equipment held within the practice followed the guidance produced by the Resuscitation Council (UK). The practice followed the National Institute for Health and Care Excellence (NICE) guidance and shared the appropriate learning at the clinical governance meetings. The GPs at the practice also held a "journal club" where they discussed and kept up to date with new guidelines for care and treatment for patients.

The practice had palliative care registers which contained the names of patients who were at the end of their life. These patients were discussed with external services to ensure patients received the care and treatment they needed and ensured continuity of patient care. The practice had a learning disability register which was kept up to date by checking it with the local social care teams. The practice offers patients with a learning disability an annual review of their care.

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

Management, monitoring and improving outcomes for people

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. These roles included data input, clinical review scheduling, adult and child protection alerts management and medicines management. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to carry out clinical audits.

The practice showed us six clinical audits that had been undertaken in the last year. Examples of clinical audits included audits to confirm that the GPs who undertook minor surgical procedures were doing so in line with their registration and NICE guidance.

The GPs told us clinical audits were often linked to medicines management information, for example we saw an audit regarding the prescribing of quinine (a medicine used to treat leg cramp) and its effectiveness. The medicine was discontinued and non medicinal advice was given such as muscle massage. Following the audit the GPs carried out a further audit to review patients who were prescribed these medicines and ensure that the medicine had not been started in new presentations of leg cramp. GPs maintained records showing how they had evaluated the service and documented the success of any changes.

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. The IT system flagged up relevant medicines alerts when the GP went to prescribe medicines. We were shown evidence to confirm that following the receipt of an 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.

Effective staffing

Staffing at the practice included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. A good skill mix was noted amongst the GPs each having their own specialist interests such as diabetes, female sexual health and drug and alcohol misuse. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation (only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

All staff undertook annual appraisals with the practice manager and a GP which identified learning needs. Mandatory training was provided on-line. Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses. For example keeping up to date with wound dressings.

Good

Are services effective?

(for example, treatment is effective)

The nursing staff received their clinical appraisal from a GP at the practice. The nurse told us that they had the opportunities to update their knowledge and skills and complete their continuing professional development in accordance with the requirements of the Nursing and Midwifery Council. Both the practice nurses had received extensive training for their roles, for example, seeing patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease as well as the administration of vaccines and undertaking cervical smears.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. Blood results, X-ray results, letters from the local hospital including discharge summaries, out of hour's providers and the 111 service were received both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and actioning any issues arising from communications with other care providers on the day they were received. The partner GPs were responsible for seeing these documents and results and for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances within the last year of any results or discharge summaries which were not followed up appropriately.

The practice worked effectively with other services. A weekly meeting was held with the health visitor to discuss vulnerable adults and children. Once a month there was a multidisciplinary team meeting to discuss high risk patients and patients receiving end of life care. This included the multidisciplinary team such as physiotherapists, occupational therapists, health visitors, district nurses, community matrons and the mental health team.

Information Sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local out of hour's provider to enable patient data to be shared in a secure and timely manner. Patients' blood test results were sent electronically to the practice so that they could be actioned in a timely way.

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

Patients told us the GP and nurses always explained what they were going to do and why. Patients were able to discuss their treatment with the GP or nurse and told us they never felt rushed during a consultation. Patients said they were involved in the decisions about their treatment and care. Staff told us in order to ensure patients made informed decisions; they would provide written information to patients. We noted there was variety of health information in the waiting area.

All GPs had sound knowledge of the Mental Capacity Act 2005 and its relevance to general practice. GPs told us they had access to guidance and information for the MCA 2005. They were able to describe what steps to take if a patient was deemed to lack capacity. Patients who lacked capacity to make their needs fully known had their interests protected, for example by a family member, or a carer who supported them. We were told by patients that they were able to express their views and were involved in making decisions about their care and treatment. Verbal consent would be obtained for vaccinations and smear tests and recorded on the computerised notes. One GP we spoke with told us they obtained written consent for minor surgery procedures.

Health Promotion & Prevention

There was information on various health conditions and self-care available in the reception area of the practice. The practice website contained information on health advice and other services which could assist patients. The website also provided information on self-care. The practice offered new patients a health check with a healthcare assistant or with a GP if a patient was on specific medicines when they joined the practice.

The practice offered patients who were eligible, a yearly flu vaccination. This included older patients, those with a long term medical condition, pregnant women, babies and young children. For patients over the age of 78 years a vaccination against shingles was also available. The practice did not hold clinics for this but offered these

Good

Are services effective?

(for example, treatment is effective)

vaccinations when staff had the opportunity at appointments or by contacting patients via text, phone or email. Patients with long term medical conditions were offered yearly health reviews. Diabetics were offered six monthly reviews.

The practice recognised the needs of patients and their difficulty with transport to the hospital for appointments. They had arranged for screening for certain conditions to be taken at the practice. This included an ultrasound service, a bone density clinic, and a cardiac rehabilitation clinic weekly. Outside agencies used the consulting rooms at the practice.

A travel health advice and vaccination consultation service was available. This included a full risk assessment based on the area of travel and used the 'Fit for travel' website. Vaccinations were given where appropriate or patients were referred on to private travel clinics for further information and support if needed.

There was information on how patients could access external services for sexual health advice. Younger patients could request testing for Chlamydia and this was advertised on the patient website.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

Patients completed CQC comment cards to provide us with feedback on the practice. We received 47 completed cards and all were positive about the care and treatment experienced. Patients said they felt the practice offered very good services and staff were considerate, helpful and caring. They said staff treated them with dignity and respect. Patients were complimentary about their experiences with reception staff.

Staff took steps to protect patients' privacy and dignity. Curtains were provided in treatment and consultation rooms so that patients' privacy and dignity was maintained during examinations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We observed staff were careful to follow basic precautions when discussing patients' treatments in order that confidential information was kept private. There were additional areas available should patients want to speak confidentially away from the reception area. We heard, throughout the day, the reception staff communicating pleasantly and respectfully with patients.

Care planning and involvement in decisions about care and treatment

Patients we spoke to on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards was also positive and aligned with these views.

A GP told us how treatment plans were in place for patients planning for their end of life care, and that where the patient lacked capacity to make decisions, family and carers were involved with the decision making process.

Translation services were available for patients who did not have English as a first language. Notices in the reception areas informed patents this service was available. A hearing loop was available for patients that were hard of hearing and the practice had connections with the royal national institute for the blind who would provide copies of leaflets in braille if this was required.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke to on the day of our inspection and the comment cards we received were complimentary about the support they received. A patient told us that if they forgot or missed an appointment then the reception staff would phone them as a reminder.

Posters and leaflets were available in the waiting areas of the practice to signpost patients to a number of support groups and organisations in the area. The practice arranged for services to attend the practice so tests could be carried out locally instead of journey to the hospital. For example ultra sound testing and clinics for testing bone density.

The practice discussed patients who had recently died in multi-disciplinary team meetings to identify and review whether their care was appropriate and whether their wishes were respected. We discussed with the practice manager the issue of support for bereaved relatives and carers following the death of a patient. They told us how the GP would telephone the bereaved patient after six weeks to offer support and on the first anniversary the practice would send a card, again to offer support.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We saw from the practice website that they published the results of their patients' satisfaction survey and responded to any issues. During the morning session one of the GPs was running late with their appointments. A receptionist explained this to waiting patients and apologised for the delay and placed a sign at reception to make patients aware. Patients told us that they received text messages from the practice to remind them they were due to attend an appointment. They also told us that they were also sent a reminder text if they had forgotten to attend for an important blood test.

GPs had their own patient lists for patients over 75 years of age. The practice did age searches on the computer system regularly on their patient population to allocate any patients over 75 a GP. All patients who needed to be seen urgently were offered same-day appointments. Longer appointments were available for patients if required, such as those with long term conditions. Telephone consultations enabled patients who may not need to see a GP the ability to speak with one over the phone. This was a benefit to patients who worked full time or could not attend the practice due to limited mobility. Feedback from the national patient survey suggested patients were seen quickly at the practice when they needed an appointment.

The practice offered home visits to patients who required them if requested before 10am. This provided older patients, mothers with young children, carers or patients in vulnerable circumstances an opportunity to see a GP when they may have difficulty attending the practice.

The practice had patient registers for learning disability and palliative care. There were regular internal as well as multidisciplinary meetings to discuss patients' needs. The practice worked collaboratively with other care providers such as local care homes and district nurses.

The practice provided accommodation for external services within the practice, such as mental health services, drug and alcohol counselling services. The practice worked well with the midwife who provided appointments at the practice. GP's provided six week postnatal checks for new mothers.

There was an online repeat prescription service for patients. This enabled patients who worked full time to access their prescriptions easily. Patients could also drop in repeat prescription forms to the practice to get their medicines. Patients told us the repeat prescription service worked well at the practice. The practice communicated with pharmacies that delivered for patients who found it difficult to collect their prescriptions.

Access to the service

The Highlands Health Centre's appointment system enabled patients to see a GP or nurse the same day if they phoned the practice before 10am. There was also a telephone consultation system available for patients where they could request a call back from a GP. Patients told us they could see a GP when they needed. The practice operated extended opening hours on a Tuesday evening with a GP. This benefitted patients who worked full time or those with children who needed to attend out of school and working hours.

The practice had level access for patients using wheelchairs and patients with pushchairs. The front door and corridors were wide and all consultation and treatment rooms were on the same floor level allowing easy access for wheelchair users. A separate play area with a selection of toys for distraction was available for younger children.

The practice had the medical equipment it required to provide the services it offered. Clinical treatment rooms had the equipment required for minor surgery and other procedures which took place.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. The system for raising complaints was advertised on the practice website and in the reception area. The practice manager responsible for dealing with complaints from patients. We saw records showing that four complaints had been received this year and that they were acknowledged and responded to. Some complaints triggered the practice's significant event process. All were discussed in staff meetings to identify any learning outcomes and share these with staff. We saw from meeting minutes that complaints were discussed periodically to identify long term concerns or trends.

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. They were providing an open and welcoming environment with holistic care. We found details of this in the health centre's charter. These values were clearly displayed in the waiting areas and in the practice patient information leaflet. The practice charter included treating patients as individuals being treated with courtesy and respect at all times.

Governance Arrangements

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

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice had an on going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example the nurses had completed an audit on the length of time wounds took to heal following minor surgery at the practice. This was going to be repeated to demonstrate continued effectiveness of treatment. Also the GPs undertook continual audits on the effectiveness of named medicine being prescribed to patients as well as end of life care to ensure that patient care was managed as well as possible.

Leadership, openness and transparency

The practice had a clear leadership structure which had named members of staff in lead roles. For example, there was a lead nurse for infection control, a lead GP for safeguarding and a lead GP for prescribing. Staff spoke about effective team working, clear roles and responsibilities but within a supportive non-hierarchical organisation. They all told us that felt valued, well supported and knew who to go to in the practice with any concerns. Staff told us there was an open culture within the practice and they had opportunities to raise issues at team meetings.

The practice manager and their deputy were responsible for human resource policies and procedures. Staff were aware of where to find these policies if required.

Practice seeks and acts on feedback from users, public and staff

The practice used an outside organisation to obtain feedback from their patients. A recent survey showed that patients were satisfied with how the practice was managed and with the care they received. There were comments about confidentiality at the reception check in desk and the practice used its website and newsletter to ask patients for their suggestions on how to improve this.

The practice had a virtual Patient Reference Group (PRG) The group consists of over forty members and included employed, unemployed, retired, parents of young families, single and married people. They were contacted either by e-mail or telephone to comment on these results and to give regular feedback.

Staff told us they felt involved in the running of the practice. GPs and nurses told us they were encouraged to provide clinical leadership and share learning among the staff group at the practice.

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Staff appraisals included a personal development plans. Staff told us that the practice was very supportive of training and that they had staff away days where guest speakers and trainers attended.

The practice had systems to learn from incidents which potentially impacted on the safety and effectiveness of patient care and the welfare of staff. Clinical team meetings were used to disseminate learning from significant events and clinical audits. Staff told us changes to protocols and policies were made as a result of learning outcomes from significant events, national guidance and audits.

Are services well-led?

Good

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

The GPs met regularly for journal meetings where they shared new learning with each other and discussed ways in which it could improve outcomes for effective care within the practice.