Otford Medical Practice

Quality Report

Leonard Avenue
Otford
Sevenoaks
Kent TN14 5RB
Tel: 01959 524633
Website: www.otfordmedicalpractice.nhs.uk

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

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Overall summary

Otford Medical Practice is a GP practice providing primary care services for around 10,500 patients.

There are six partners in the practice, three of whom work full-time and three who work part-time. There is also two part-time salaried GPs. The partners are supported by a practice manager, a nursing team of four registered nurses and a health care assistant.

The main practice is in the village of Otford and there is a branch surgery in the neighbouring village of Kemsing – Kemsing Village Surgery.

We only visited the main site in Otford for this inspection.

As part of the inspection we talked with the local Clinical Commissioning Group, the local Healthwatch, a representative of the Patient Participation Group, patients who were at the practice on the day of the inspection, GPs, other clinical and non-clinical staff at the practice.

All of the patients we spoke with were very positive about the care and treatment they received and they were complimentary about the staff at the practice. We received positive comments from patients who had completed comment cards prior to our inspection visit. Most of these stated that they were happy with the support, care and treatment provided all staff. Patients told us they experienced difficulties in booking appointments via the telephone system in use at the practice. This was also highlighted in the patient survey in 2013. The management team of the practice has recognised this as an issue and are researching how this element of the practice can be improved.

We found that the practice was well-led and provided caring, effective, and responsive services to a wide range of patient population groups, including those of working age and recently retired, mothers with babies, young children, and young patients, older patients (over 75), patients with long-term conditions, people in vulnerable circumstances and those patients experiencing mental health problems.

We had concerns about safeguarding as non clinical staff did not have criminal records checks via the Disclosure and Barring Services (DBS) and no risk assessments were in place as to why this decision had been made.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

We found that the services provided by the practice were safe. However, we had concerns relating to safeguarding as we found that non-clinical staff had not been subject to a criminal records check via the Disclosure and Barring Service (DBS). There were no risk assessments in place to provide evidence of how a decision was made if it was deemed that a DBS check was not necessary.

Patients we spoke with and those that completed comment cards said they felt safely cared for and had no concerns about their care or treatment. We found that systems were in place to ensure staff learned from significant events/incidents. There were child and adult safeguarding policies and procedures in place. Medicines were kept safely and there were formal processes in place to ensure the security of medicines and prescription pads. The practice was clean and there were systems in place to minimise the risk of infection to patients, staff and other visitors to the practice, although there were areas were improvements could be made. We found that the practice had effective recruitment procedures in place to ensure that people employed were of good character, had the skills, experience and qualifications required for the work to be performed. The practice had both an emergency and business continuity plan in place. Service and maintenance contracts were in place with specialist contractors, who undertook regular safety checks and maintained specialist equipment.

Are services effective?

Patients experienced an effective practice. We found that there were processes in place to monitor the delivery of treatment. Clinical audits were used to review and improve outcomes for patients. We found that the practice had achieved high scores against the Quality and Outcomes Framework (QOF) audits. The practice had effective audits and systems for managing, monitoring and improving outcomes for patients. There were processes in place for managing clinical staff performance and professional development. We found the practice had well established processes in place for multi-disciplinary working, with other health care professionals and partner agencies.

Are services caring?

Patients experienced a caring practice. We found that patients' needs were assessed and care and treatment provided was discussed with patients and delivered to meet their needs. Patients spoke positively about their experiences of care and treatment at

Summary of findings

the practice. Patients' privacy and dignity was respected and protected and their confidential information was being managed appropriately. Patients told us that they were involved in decision making and had the time and information to make informed decisions about their care and treatment. Appropriate procedures were in place for patients to provide written and verbal consent to treatment.

Are services responsive to people's needs?

We found that the practice was responsive to patients' needs. The practice, along with the support of their Patient Participation Group, enabled patients to voice their views and opinions in relation to the quality of the services they received. Information about how to complain was made readily available to patients and other people who use the practice (carers, visiting health professionals). Complaints were appropriately responded to and in accordance with the practice's complaints policy.

Improvements could be made in relation to accessing appointments at the practice. Patients told us they had difficulties getting through to the practice by phone in order to make an appointment. The GP partners were aware of this issue and had discussed and it was part of an action plan of improvement.

Are services well-led?

The practice was well-led. There were clear lines of accountability and responsibility within the practice. We found that the management team provided open, inclusive and visible leadership to the staff. There were appropriate systems in place to share best practice guidance, information and changes to policies and procedures to the staff. Governance arrangements were in place, to continuously improve the practice. Both patients and staff were encouraged and supported to be actively involved in the quality and monitoring of services provided, in order to ensure improvements were made if required. Risks to the practice and service provision had been appropriately identified and action taken to reduce or remove the risk had been undertaken. Improvements could be made in relation to identification and managing risks.

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

We found that the practice was responsive to the needs of older patients.

Plans were underway for every patient who was over 75 to have an allocated GP. This population group was being contacted to inform them which GP they were to be allocated to and to inform them that they may see any GP, not just the one allocated to them.

We saw that the practice ran specialist clinics in order to provide older people with annual flu vaccinations. The practice also offered reviews and assessments to check that vital signs and lifestyle choices as well as weight, blood pressure and diet, for example, were within the expected range for people in this population group.

We found the practice to be caring in the support it offered to older people. We saw that there were appropriate and effective treatments, along with ongoing support for those patients diagnosed with dementia. The practice had systems in place to enable it to be responsive to meet the needs of older people and to recognise future demands in service provision for this age group.

People with long-term conditions

We found the practice to be caring in the support it offered to patients with long-term conditions. practice offered annual flu vaccinations routinely to patients with long term conditions. The practice was caring in the support it offered to patients with long-term conditions and the care provided was effective. Treatment plans were monitored and kept under review by a multi-disciplinary team. The practice was responsive in prioritising urgent care that people required and the practice was well-led in relation to improving outcomes for patients with long-term conditions and complex needs

Mothers, babies, children and young people

We found that the practice was caring in relation to mothers, babies, children and young people. The practice offered dedicated clinics to patients in this population group. We saw that referrals to other community based services were made, in order to provide these patients with additional support. The practice was responsive in prioritising appointments for mothers with babies and young

Summary of findings

children. The practice was well-led in relation to nominating a named GP to have overall responsibility for children's safeguarding matters and systems were in place to make appropriate referrals to safeguarding specialists, health visitors and other support providers

The working-age population and those recently retired

The practice had responded to meeting the needs of people in this population group by starting to review how to provide services that were more accessible to working age patients. The practice was well-led in relation to improving outcomes for patients of working age and those recently retired

People in vulnerable circumstances who may have poor access to primary care

We found that the practice was caring about vulnerable patients. We saw that there were effective support systems in place for vulnerable patients and to be responsive to providing care and treatment at patients' homes, where they had difficulty in attending the practice. We saw that the practice had procedures in place for vulnerable patients to consent to treatment. There was a wide range of services and clinics available to support and meet the needs of this population group. We saw that the premises were accessible and suitable for patients with reduced mobility and provided enough space for wheelchair users

People experiencing poor mental health

We found the practice had a caring and responsive approach to patients who experienced mental health problems. There were effective procedures in place for undertaking routine mental health assessments of patients in this population group. Appropriate systems and methods of referral were in place in order to provide patients with mental health problems to other specialist practice providers for ongoing support.

Effective systems were in place to monitor and assess patients who lacked mental capacity to make informed decisions for themselves. We found that patients' carers were supported to make decisions for patients they held responsibility for. Carers' views and opinions were considered when care and treatment was required. Appropriate referral systems were in place, when support was required by the GPs in order to assess patients mental capacity. The management team of the practice provided a well-led approach in relation to identifying and managing risks to patients who experience mental health problems.

Summary of findings

What people who use the service say

We spoke with four patients at the surgery, received comment cards from five people and we looked at feedback the practice had received through complaints, compliments and the patient survey coordinated by the Patient Participation Group (PPG).

All of the patients we spoke with were very positive about the care and treatment they received and they were particularly complimentary about the staff at the practice. We were told by patients that staff were caring, supportive and sensitive to their needs.

We received positive comments from patients who had completed comment cards prior to our inspection. Most of these stated they were happy with the support, care and treatment provided by all staff. We had four comments about the reception staff being very helpful and friendly. However, one person commented negatively on the attitude of the reception staff.

We spoke with the practices PPG representative, who told us about the effective systems in place for making sure they had a supportive, engaging and effective working relationship with the practices' management team.

The patient survey for 2013 highlighted that the current telephone system in place meant that patients and carers experienced problems in booking appointments. Patients we spoke with during our visit told us they found the telephone system frustrating and this increased their anxiety levels when they already felt unwell.

Patients told us they felt listened to during consultations. They also told us they had no concerns or complaints about the practice but knew how to raise concerns and complaints if they needed to.

Areas for improvement

Action the service MUST take to improve

The practice must have formal risk assessments in place for non-clinical staff to assess the need for criminal records checks with the Disclosure and Barring Service.

The practice must have a robust programme of audits in place to monitor infection control practices. They must also have a detailed cleaning schedule to verify that all areas of the practice were appropriately cleaned by the relevant person as required by the Hygiene Code.

Action the service COULD take to improve

The practice could take action to improve the telephone booking system for patients.

The practice could provide safeguarding training for all non-clinical staff to ensure that they are aware of the process to follow if they suspect any form of abuse.

Good practice

Our inspection team highlighted the following areas of good practice:

The practice had clear processes in place for how they managed issues around gaining and documenting consent from patients who were unable to read or write.

Mental capacity assessments were carried out by the doctors and recorded on individual patient records.

Otford Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC Lead Inspector and a GP. The team included a specialist advisor.

Background to Otford Medical Practice

Otford Medical Practice is a GP practice based in the village of Otford which medical services provided by a team of eight GPs, a practice manager, four practice nurses and a healthcare assistant.

Otford Medical Practice is the main surgery and there is a branch surgery at Kemsing called Kemsing Village Surgery. Both the surgeries serve patients living in the Otford and Kemsing area. There were approximately 10,500 people on the list at the time of our inspection.

The practice serves a population with low levels of deprivation. Both Otford Medical Practice and Kemsing Village Surgery are wheelchair accessible. Opening times for Otford Medical Practice are Monday to Friday 8.30am to 6pm.

Services were also provided from the branch surgery in Kemsing village. Staff told us that patients could choose which surgery to visit for their consultation.

Services were provided to a range of patient population groups.

Why we carried out this inspection

We inspected this service as part of our new inspection programme to test our approach going forward. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

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

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

The inspection team always looks at the following six population areas at each inspection:

- Vulnerable older people (over 75s)
- People with long term conditions
- Mothers, children and young people
- Working age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problem.

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations such as the local Healthwatch and local Clinical Commissioning Group to share what they knew about the practice.

Detailed findings

We carried out an announced visit on 20 May 2014. During our visit we spoke with a range of staff including two GPs, a practice nurse and reception staff as well as the practice manager. We spoke with four patients. We observed how people were being cared for and talked with carers and/or family members. We saw how telephone calls from patients were dealt with. We toured the premises and looked at records. We reviewed five comment cards where patients and members of the public shared their views and experiences of the practice. We also spoke with a representative from the Patient Participation Group. We observed how patients were supported by the reception staff in the waiting area before they were seen by the doctors.

Are services safe?

Summary of findings

We found that the services provided by the practice were safe. However, we had concerns relating to safeguarding as we found that non-clinical staff had not been subject to a DBS check. There were no risk assessments in place to provide evidence of how a decision was made if it was deemed that a DBS check was not necessary.

Patients we spoke with and those that completed comment cards said they felt safely cared for and had no concerns about their care or treatment. We found that systems were in place to ensure staff learned from significant events/incidents. There were child and adult safeguarding policies and procedures in place. Medicines were kept safely and there were formal processes in place to ensure the security of medicines and prescription pads. The practice was clean and there were systems in place to minimise the risk of infection to patients, staff and other visitors to the practice, although there were areas were improvements could be made. We found that the practice had effective recruitment procedures in place to ensure that people employed were of good character, had the skills, experience and qualifications required for the work to be performed. The practice had both an emergency and business continuity plan in place. Service and maintenance contracts were in place with specialist contractors, who undertook regular safety checks and maintained specialist equipment.

Our findings

Safe patient care

We saw that systems were in place to process urgent referrals to other care/treatment services and to ensure test results were reviewed in a timely manner once they had been received by the practice. There was a duty doctor system in place to check test results and clinical information on a daily basis.

We found there were regular meetings held by different staff groups. We were told by a GP and the practice manager that there was a palliative care meeting held every three months, which was attended by the GPs, a palliative care nurse and the district nurses. The practice manager told us all staff met quarterly to discuss the practice and any issues. We were told that the regularity of these meetings was to be changed, as so many new staff had been appointed at the practice. The meetings were planned to be held on a six weekly basis. In addition, the GPs meet weekly, as did the nurses and we were told by the GP and practice nurse that these meetings were more informal and minutes were not kept. Meetings were also held between the clinical staff and a health and social care worker, who attended the practice regularly to discuss with the GPs and district nurses patients who often attended the hospital. This meant that information received from other health and social care professionals was used to improve patient safety.

We saw that safety alerts were received by the practice manager and cascaded electronically to the GPs. We looked at audits related to safety alerts and saw that these provided a clear audit trail of actions taken by the GPs to ensure patients' safety. This meant that data collected from incidents/events and alerts was monitored, assessed and used to improve patient safety.

Learning from incidents

We found that systems were in place to ensure staff learned from significant events. There was an open and inclusive style of management where staff felt confident to report incidents, significant events and errors. We saw that these issues were reported to the practice manager who created a report that was subsequently discussed by the doctors. We were told by GPs that every two months adverse event meetings were held at the practice, in order to review all of the significant events in a formal manner. We saw from meeting notes that the chair of the adverse event meetings

Are services safe?

was rotated between the GPs. Minutes were taken at these meetings and they included evidence of discussions in relation to prescription errors, missing letters or faxes concerning the clinical care of the patient, actions taken to address issues and lessons learnt from the incident/event.

We saw that there was a disaster recovery plan in place. We saw that a recent example of an incident fell outside of the scope of the plan but that the plan had not been updated to include this type of incident, should it occur again. Improvements could be made in relation to the disaster recovery plan as we found that it had not been updated since the unexpected incident had occurred.

Safeguarding

The practice has a GP who has been designated to be the lead in overseeing safeguarding matters. There was a protocol and contact numbers for child protection referrals available to all staff. We saw that there were contact numbers for adult protection referrals but there was no reference to these within the protocol. Clinical staff we spoke with told us that they were aware of the protocol and the procedure to report any concerns.

We saw that local authority protocols were referred to by accessing the online database 'DORIS' (Document Organisation, Referral and Information Service - a web-based database).

We saw evidence that clinical staff had received training in safeguarding children and adults. However, we saw from records that administrative staff had not been provided with training in safeguarding children and adults. The practice held a safeguarding meeting every two to three months that included the Health Visitor and School Nurse. This meant that other health care professionals, who had contact with vulnerable children and adults, were involved in safeguarding the patients from the risk of harm and abuse.

We found that there were child and adult safeguarding policies and procedures in place. Clinical staff were knowledgeable and had received training in both safeguarding adults and children. From staff recruitment files we found clinical staff had been subject to a Disclosure and Barring Service (DBS) check. We found that on some occasions non-clinical staff supported GPs with intimate clinical examinations of patients but that they had not received training in chaperone procedures or been subject to a DBS check. There were no risk assessments in place to provide evidence of how a decision was made, if it was deemed that a DBS check was not necessary.

Monitoring safety and responding to risk

The practice had systems and procedures in place for responding to medical emergencies. Staff we spoke with and training records confirmed that all clinical staff had received training in emergency life support. Staff told us they were aware of the emergency procedures to follow.

We saw that weekly clinician meetings were held and minutes of these meetings detailed how decisions were made about house calls and duty doctor arrangements to ensure there were sufficient hours provided for patient appointments, including emergency appointments.

We spoke with both clinical and non-clinical staff who were knowledgeable about prioritising appointments and worked with the GPs to ensure patients were seen according to the urgency of their health care needs. There was a duty doctor system in place to ensure that the practice could provide greater flexibility amongst the GPs to respond to cover absent GPs (for example those who worked part time), busy periods and any emerging risks to patients throughout the day.

We spoke to GPs and non-clinical administrative staff about the computer based safety alert system in place. We were told that this enabled staff to summon assistance if needed. This meant that the practice was able to respond quickly when an emergency situation occurred.

Medicines management

The practice had a named prescribing lead who was responsible for the management of medicines. We spoke with a GP and members of the non-clinical team, who told us there was a system in place for checking repeat prescriptions. Repeat prescriptions were issued according to medicine review dates and checks were made to ensure that patients on long-term medicines were reviewed on a regular basis. People told us that they had not experienced any difficulty in getting their repeat prescriptions.

We found that there was a process in place to help monitor the security of prescription pads for use in the printers and those held by GPs in their bags for home visits. This meant that the risk of medicines being accessed inappropriately was being effectively monitored.

Are services safe?

We viewed the refrigerator for the storage of medicines that required storage at a certain temperature. We found that the temperature of the refrigerator containing such medicines was within the range specified by the manufacturer and the temperature was monitored and documented. We saw that the refrigerator was kept locked when not in use. This helped ensure that refrigerated medicines were kept safely and securely.

We looked at the way in which medicines and equipment used for medical emergencies were maintained. Single use equipment remained wrapped in its original packaging and was in date. We found medicines for use in an emergency were kept securely. The practice had oxygen and an automated external defibrillator (AED) for use in an emergency. Medicines were within their usable date and that clear records were kept to identify the stocks held and to demonstrate that expiry dates were routinely checked. Emergency medicines and equipment were monitored and maintained appropriately in order to ensure they were fit for purpose. We saw that records were kept in relation to the routine checking of equipment for use in a medical emergency.

Cleanliness and infection control

We found all the areas of the practice were clean and tidy. We saw that liquid hand wash and disposable towels had been provided in the public toilets. We saw a notice about the importance of effective hand washing displayed in public areas. This meant that people had information about the importance of hand washing to reduce the spread of infection.

Clinical rooms had clinical waste bins, along with liquid soap and disposable paper towels. We found that the curtains used in clinical rooms were disposable and that there was a schedule in place for routinely changing these curtains. This meant that strategies were in place to ensure that people were not put at risk from the spread of infection.

We saw that sharps bins had been dated and information about safe disposable of clinical waste and sharps was displayed. In the consulting rooms we saw that disposable couch rolls were in place and could be changed for each patient. There was personal protective equipment (PPE) available in the clinical rooms. We saw from records that the practice had a contract in place for the safe disposal of clinical waste. This helped ensure the risk of infection was minimised.

The practice had an infection control policy in place. Staff told us they had received training in infection control, and we saw evidence of training updates in infection control for all members of the clinical staff team. However, we found audits were not routinely carried out to monitor infection control procedures. We found that there were no cleaning schedules to verify that all areas of the practice had been appropriately cleaned and who was responsible for cleaning specific areas of the practice, for example the practice or cleaning staff.

Staffing and recruitment

The practice had a recruitment policy that reflected the recruitment and selection processes completed by the practice. We looked at six staff files and saw that appropriate checks had been carried out. All clinical staff had a completed Disclosure and Barring Service (DBS) check. The practice manager told us that checks with the General Medical Council (GMC) and to the Nursing & Midwifery Council (NMC) were routinely in place. This meant that there was a system to ensure staff maintained their professional registration.

We spoke with the GPs and practice manager about staffing levels within the practice. They told us there were strategies in place for the clinical team to safely cover staff shortages and absences with minimal or no use of locum or agency staff. There were sufficient staff at the practice and patients did not have any difficulties accessing a GP or nurse appointment and received appointments times appropriately. Patients told us they never had to wait for long periods of time, unless they had requested to see a specific GP or nurse.

Dealing with Emergencies

The practice had both an emergency and business continuity plan in place. We found that the plan included details of how patients would continue to be supported during periods of unexpected and/or prolonged disruption to services. For example, extreme weather that caused staff shortages and any interruptions to the facilities available.

Equipment

We saw that processes and systems to keep the premises and building safe for patients, staff and visitors were in place. Records showed there were service and maintenance contracts with specialist contractors, who undertook regular safety checks and maintained specialist equipment. The premises had an up-to-date fire risk

Are services safe?

assessment and regular fire safety checks were recorded. We saw that training had been provided to staff in respect of fire safety awareness. This meant that equipment and the premises were appropriately checked to ensure they promoted staff, patient and visitors safety. There was a planned maintenance plan in use by the practice which took into account accessing equipment in the event of equipment becoming faulty. Records of portable appliance testing (PAT) of electrical appliances were seen during our visit.

Are services effective?

(for example, treatment is effective)

Summary of findings

Patients experienced an effective practice. We found that there were processes in place to monitor the delivery of treatment. Clinical audits were used to review and improve outcomes for patients. We found that the practice had achieved high scores against the Quality and Outcomes Framework (QOF) audits. The practice had effective audits and systems for managing, monitoring and improving outcomes for patients. There were processes in place for managing clinical staffs performance and professional development. We found the practice had well established processes in place for multi-disciplinary working, with other health care professionals and partner agencies.

Improvements could be made in relation to non-clinical staff training and development. There were good systems around safeguarding but non-clinical staff had not received formal training in chaperoning and safeguarding children and adults.

Our findings

Promoting best practice

The practice used national guidance and professional guidelines to promote best practice in the care it provided. We were told by GPs that patients received care according to national guidelines. We saw that relevant guidelines and national strategies were made available to staff.

We were shown records of medicine audits that had been carried out following the receipt of national guidelines and standards provided to the practice by NHS commissioners and other stakeholders. For example, we saw that a change had been made to the prescribing regime for patients with a specific medicine for osteoporosis, following an update in best practice guidelines. This meant that patients were offered care and treatment in accordance with nationally recognised standards.

Management, monitoring and improving outcomes for people

The practice manager, GPs and non-clinical staff told us that registers were kept to identify patients with specific conditions/diagnosis. For example, patients with dementia, heart disease, diabetes. We saw that these registers were used to inform clinical audits, which were undertaken within the practice. From minutes of clinical meetings we saw that information from audits were shared and discussed amongst relevant staff. Actions were agreed with regards to changes to specific treatments and therapies, if required in order to improve outcomes for patients.

We found that the practice had achieved high scores against the Quality and Outcomes Framework (QOF) audits. However, we found that the practice had not investigated where they had scored below the national average, for prescribing non-steroidal anti-inflammatory (NSAIDs) as set by the General Practice Outcomes Standards (GPOS). We were assured by the GPs that they would look into this themselves, conduct an audit and take appropriate action as required.

We were told by a GP that they performed their own audits which they used as evidence for their appraisal. We were shown records of these audits which included looking at the use of hormone replacement therapy (HRT) and the assessment of thrombosis risk. From the audit we saw that this had resulted in a small number of patients being advised to stop their HRT. We saw further audits for the

Are services effective?

(for example, treatment is effective)

review of patients prescribed specific medicines. This also had resulted in changes in treatment for some patients. Similar audits had been conducted in relation to the screening of patients under 25 years of age for sexually transmitted diseases.

Staffing

We saw from records and from information shared by staff we spoke with, that there were processes in place for managing staff performance and professional development. For example, the practice had a lead nurse, who was responsible for managing and mentoring the nursing team. This lead nurse was also responsible for appraising the other nurses at the practice annually. We were shown by a GP that they had completed Basic Life Support (BLS) and safeguarding children and adult training. We saw examples of specialist training in diabetes and updates in childhood immunisations. We were told by clinical staff that they attended external meetings and events to help further enhance their continuing professional development. This meant that clinical staff were supported to develop.

We saw from clinical staff records that they received regular training updates. We were told by clinical staff that they received annual appraisals and informal supervision. Due to the non-clinical team having changed in the last six months, we saw that staff had not required appraisals but had received informal supervision. We discussed this with the practice manager who told us that once the latest member of staff had reached the end of their six month probation period, all non-clinical staff would have an appraisal and dates set for regular supervision in order to see how they are developing in their role. All the staff we spoke with felt they received the support they required. This meant that staff were given the training and support to enable them to perform their roles effectively.

We found staff had access to safeguarding children and adult protocols and procedures and non-clinical staff could access support from clinical staff. We saw that an induction programme had been undertaken by six non-clinical members of staff who had recently joined the practice. However, from this record we saw safeguarding and chaperone training had not been included. There were good systems around safeguarding but non-clinical staff had not received formal training in chaperoning and safeguarding children and adults.

Working with other services

We saw from minutes of meetings that the practice had well established processes in place for multi-disciplinary working with other health care professionals and partner agencies. These processes ensured that links with the palliative care team, health visitor, district nurses and a health and social worker, remained effective and promoted patients care, welfare and safety. Multi-disciplinary meetings were held routinely and included clinicians from the practice and all member of the multi-disciplinary team who were involved in patients care and treatments.

Health, promotion and prevention

The non-clinical administrative staff told us about the processes for informing patients that needed to come back to the practice for further care or treatment. We saw that the computer system was set up to alert staff when patients needed to be called in for routine health checks or screening programmes for example.

Patients we spoke with told us that they were contacted by the practice to attend routine checks and follow-up appointments regarding test results.

We saw a range of information leaflets and posters in the waiting room for people to get information about the practice and about promoting good health. Information about how to access other healthcare services was also displayed. This helped patients access the services they needed and promoted their welfare.

Are services caring?

Summary of findings

Patients experienced a caring practice. We found that patients' needs were assessed and care and treatment provided was discussed with patients and delivered to meet their needs. Patients spoke positively about their experiences of care and treatment at the practice. Patients' privacy and dignity was respected and protected and their confidential information was being managed appropriately. Patients told us that they were involved in decision making and had the time and information to make informed decisions about their care and treatment. Appropriate procedures were in place for patients to provide written and verbal consent to treatment.

Our findings

Respect, dignity, compassion and empathy

The majority of patients we spoke with and those who completed comment cards told us that they felt the staff at the practice were polite. Comments from patients were positive in relation to staff and the care and treatment that they received.

We checked to see how the practice maintained patients' privacy and dignity. Patients told us that staff always considered their privacy and dignity. From our tour of the premises we saw notices informing patients that they could ask for a chaperone to be present, during their consultation if they wished to have one. The clinical staff we spoke with demonstrated how they ensured patients privacy and dignity both during consultations and treatments. Examples of this were ensuring that curtains were used in treatment areas to provide privacy and to ensure that doors to treatment/consultation rooms were closed.

We found that systems were in place to ensure that patients' privacy and dignity were protected at all times. We saw that the practice had a confidentiality policy in place, which detailed how staff should protect patients. Staff we spoke with, both clinical and non-clinical were aware of their responsibilities in maintaining patient confidentiality. The practice manager told us that if patients wished to speak to reception staff in confidence, that a private room would be made available for patients and staff to use. We spoke with patients and were told that they felt their consultations were always conducted appropriately.

We saw that the practice had a chaperone policy in place that set out the arrangements for patients who wished to have a member of staff present during intimate clinical examinations or treatment. Although clinical staff (nurses and the HCA) were preferred to perform this role, non-clinical staff (Administrators) could be called upon to do this. There was no evidence of training for non-administrative in relation to chaperoning patients. This meant that systems for ensuring patients who were chaperoned by administrative staff were not always effective.

Involvement in decisions and consent

We looked at how the practice involved patients in the care and treatment they received. We found that patients'

Are services caring?

involvement in care and treatment was appropriate. We were told by patients that we spoke with that they felt listened to and included in their consultations. They told us they felt involved in the decision making process in relation to their care and treatment, that GPs and nurses took the time to listen to them, and explained all treatment options. They said they felt they were able to ask questions if they had any. We were told by staff that patients could see the doctor of their choice, although they acknowledged that patients sometimes had to wait a longer period of time if they wanted to see a specific doctor. We saw a range of information leaflets and posters in the waiting room for people to get information about the practice and about promoting good health.

The practice had procedures in place for patients to consent to treatment and a form was used to gain the written consent of patients when undergoing specific treatments, for example, minor operations. We saw from the consent form in use, that there was space on the form to indicate where a patient's carer or parent/guardian had signed on the patient's behalf. A GP described how they managed issues with gaining consent from patients who were unable to read or write. The process in place was clear and we were told by the GP that all partners at the practice were aware they should document clearly the reason why written consent had not been obtained and the reason for accepting verbal consent. This meant that consent to care was appropriately obtained and recorded.

We spoke with GPs about how patients who lacked capacity to make decisions and give consent to treatment were managed. They told us that mental capacity assessments were carried out by the doctors and recorded on individual patient records. We were told about an incident involving a patient that lacked capacity. A further assessment had been undertaken to establish who would be an appropriate person to act on the patients behalf. Another GP told us they had been involved in assessing the mental capacity of a patient who was resident in a local rest home. They explained that this related to an application for lasting power of attorney for a relative to hold. They told us that they referred the patient to a local psycho-geriatrician, in order to provide a more detailed assessment about the patient before a decision could be reached. GPs told us that mental health reviews were undertaken when patients visited the practice for routine checks. This meant that procedures in place ensured patients who lacked capacity were appropriately assessed and referred where applicable.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

We found that the practice was responsive to patients' needs. The practice, along with the support of their Patient Participation Group, enabled patients to voice their views and opinions in relation to the quality of the services they received. Information about how to complain was made readily available to patients and other people who use the practice (carers, visiting health professionals). Complaints were appropriately responded to and in accordance with the practice's complaints policy.

Patients told us they had difficulties getting through to the practice by phone in order to make an appointment. The GP partners were aware of this issue and had discussed it and it was part of an action plan of improvement.

Our findings

Responding to and meeting people's needs

We were told by GPs and the practice nurse about how patients' needs and potential risks were assessed during initial consultations. We were told that individual clinical and treatment pathways were agreed and recorded on the computerised system. We were told by a GP and the practice manager that individual clinical and treatment pathways were discussed with other healthcare professionals during palliative care meetings, district nurse meetings and clinical meetings held between clinical staff and health and social care workers. The multi-disciplinary working ensured that patients received care and treatment from healthcare professionals that were aware of their individual clinical and care plans.

GPs described how they discussed with individual patients and carers, which consultant to refer them to based on the patients' needs and individual preferences. GPs told us that they only occasionally used the 'choose and book' method for referrals. They told us that they tended to refer patients locally, as this is what most patients preferred. Referrals to one of the London hospitals were made if requested by the patient or their carer.

We saw from records and from the information shared with us by staff, that the practice had well established links with local area commissioners. We were told by GPs and the practice manager that meetings took place on a regular basis to assess, review and plan how the practice could continue to meet the needs of patients and any potential demands in the future.

The practice had a Patient Participation Group (PPG) and meetings had been conducted to discuss terms of reference and the purpose of the group. We saw minutes of the meeting which detailed how the group would like to better gain feedback about the practice from patients. We saw that a questionnaire had been developed to distribute to patients and we saw an analysis of the results of previous questionnaires which were completed by patients. We were told by the PPG representative that they also had an 'online forum' which consisted of approximately 150 members. This was a method used by the practice to enable patients to feed into the PPG decision making processes, without having to attend the meetings. We saw that the practice had a website containing a section dedicated to the PPG, where recent

Are services responsive to people's needs?

(for example, to feedback?)

surveys, meeting minutes and the group's annual report could be accessed by patients and members of the public. Patients views were listened to and considered in relation to the quality of the services they received.

Clinical staff we spoke with told us that there was a wide range of services and clinics available to support and meet the needs of the varied patient groups. They told us that they would refer patients to community specialists or clinics, if appropriate. Examples of this were referring older people or their carers to groups who specialised in supporting patients and carers with dementia and mothers with babies or young children to the health visitor. We were told that the practice did not provide out of hours care and this was provided by another service provider, which patients could access via telephone.

The practice worked closely with the community nursing team, health visitor and the multi-disciplinary team to ensure the needs of patients were met. We were told by patients that when a referral was required, they were referred promptly.

Access to the service

From our observations we saw that the premises were accessible for disabled patients, with ramps to gain entry into the practice and parking spaces for people with disabilities close to the entrance door. There was a toilet available for people with disabilities and the reception desk was at a low level to accommodate patients using wheelchairs.

We found patients could book an appointment by telephone, online or in person. Patients we spoke with told us that they found the telephone appointment booking system did not work very well. The main complaints raised by patients concerned the telephone system. We discussed this with the practice manager who told us that the problem related to the internal telephone system which could no longer support keeping a patient on hold. We found that while the practice had recognised the problem with the telephone system and discussions had taken place about how this could be resolved; no solution had yet been agreed amongst the partners to fix it. Therefore patients continued to experience difficulty booking appointments via the telephone. However, the issue formed part of an action plan for improvement.

Patients we spoke with told us they did not experience problems when they required urgent or medical emergency appointments. They told us that once they made contact with the practice, staff dealt with these issues promptly and knew how to prioritise appointments for them. The reception staff that we spoke with had a clear understanding of the triage system. This was a system used to prioritise how urgently patients required treatment, or whether the GP would be able to support patients in other ways, such as a telephone consultation or home visit.

There was a system in place for patients to obtain repeat prescriptions. Patients told us that they had not experienced any difficulty in getting their repeat prescriptions. We were told by staff that they aimed to have repeat prescriptions ready within 48 hours of them being given in by the patient so that they received their prescriptions in a timely manner.

Concerns and complaints

The practice had a complaints policy in place. We saw practice meeting agendas in which complaints were included. Patients we spoke with told us that they had never had cause to complain but knew there was information in the waiting room about how and who to complain to should they need to. We saw that the complaints process was also included in the practice's patient information leaflet.

We saw records relating to five complaints which were made to the practice. The complaints were investigated and the outcome of each investigation was a sent to the respective complainant. We saw from letters sent to complainants that the contact details of the ombudsman was also included. This gave patients the option of taking their complaint further if they were not happy with the way in which the practice responded. We saw that the practice manager also kept a log of all informal complaints. We saw that the practice responded appropriately to complaints and concerns raised by patients.

Are services well-led?

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

Summary of findings

The practice was well-led. There were clear lines of accountability and responsibility within the practice. We found that the management team provided open, inclusive and visible leadership to the staff. There were appropriate systems in place to share best practice guidance, information and changes to policies and procedures to the staff. Governance arrangements were in place, to continuously improve the practice. Both patients and staff were encouraged and supported to be actively involved in the quality and monitoring of services provided in order to ensure improvements were made if required. Risks to the practice and service provision had been appropriately identified and action to reduce or remove the risk had been undertaken.

Our findings

Leadership and culture

We were told by all of the staff that we spoke with that there was an open and inclusive culture at the practice. Both clinical and non-clinical staff said that their views and opinions were valued. We saw from minutes of meetings that all staff were positively encouraged to participate in meetings and improve service provision. Staff meeting minutes confirmed that information and instructions were communicated by the GPs and practice manager to the staff.

Staff we spoke with told us that there was a clear management structure that included allocations of responsibilities. There were named staff to take on various roles, for example, there were leads for safeguarding, medicines and minor surgery. The practice had a stable clinical team but there had been changes in the non-clinical staff team over the last six months. New staff had been recruited in a timely manner. Patients did not experience any difficulties in services provided, as the potential impact of insufficient non-clinical staff had been minimised.

The staff we spoke with told us that they felt there was an open door culture within the practice, that they felt appropriately supported and were able to approach the senior staff about any concerns they had. We spoke with a person from the Patient Participation Group (PPG), who confirmed that staff at the practice were open to criticism and suggestions and valued feedback from patients and the PPG.

Governance arrangements

We looked at the governance arrangements in place at the practice and saw that these included the delegation of responsibilities to named GPs, for example, a lead for safeguarding, prescribing and minor surgery. We saw that the lead roles provided structure for staff in knowing who to approach for support and clinical guidance when required.

We saw from minutes of meetings that significant events were openly discussed at team meetings and team meetings were used as a platform to learn from incidents

Are services well-led?

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

and errors. We found that the practice openly shared relevant information with other stakeholders, when requested. This meant that a system of governance was in place.

Systems to monitor and improve quality and improvement

We looked at the systems in place to monitor and improve the quality of service provision. We found that the practice performed well in the Quality and Outcomes Framework audits (QOF), which meant that the practice was performing well against other GP practices. The practice used information from QOF audits to further monitor the quality of the services provided to patients. We saw that QOF audit results fed into clinical audits. However, whilst we found that clinical audits were effective when they were completed; audits were not routinely carried out to monitor infection control procedures and records management. This meant that systems were not always in place to identify risks to the quality of services.

Patient experience and involvement

Patient engagement was managed through the PPG and through comments and complaints raised with the practice manager. The PPG representative whom we spoke with during our visit told us that the management team were open and responsive to suggestions. They also told us the practice supported regular patient surveys to consider ways to improve the services provided. We saw a detailed action plan which was generated from the patient experience survey in 2013. This gave examples of where changes were required, such as investigating ways to improve the telephone system, options for showing the number of patients in the queue waiting to see the GP and a need to produce a directory of self-care support groups around Otford. We saw that the action plan included dates for completion and the names of staff responsible for carrying out the plan. In this way the practice ensured that patients experience was reviewed and their involvement was used to support changes made to improve service provision.

Staff engagement and involvement

We found that staff were encouraged to attend and participate in regular staff meetings. Minutes of meetings included discussions about changes to procedures, clinical practice, and staffing arrangements. All staff told us they felt part of the team. Staff told us that whilst there was strong leadership, the atmosphere at the practice was both open and inclusive. Staff told us that they were very happy working at the practice and felt listened to and valued. We saw that the practice had a whistleblowing policy in place which informed staff of the contact details of external authorities, if they wished to report concerns outside of the practice. Staff were encouraged to voice their ideas and opinions about how the services provided and run.

Learning and improvement

We looked at how the practice learnt from significant events, incidents and training and how these improved services provided to patients. Staff told us that training updates provided them with information on current best practice or how improvements could be made at the practice. They told us training was discussed openly at team meetings and we found that team meetings were used to learn and make improvements to the practice.

We saw from minutes of meetings and from the information shared with us by staff, that patient referrals were discussed confidentially at clinical team meetings. We found that areas of learning were discussed, considered and shared between clinicians. We were told by a GP that there were plans in place for the practice to become a designated 'learning practice' where trainee GPs would be offered placements to develop their knowledge, skills and clinical competencies. This was considered important to the practice in order to strengthen and support areas of learning and progression amongst all clinical staff.

We were told by GPs that meetings were held between them and the practice manager to discuss and recognise future demands that may be placed on the practice. Examples of these were explained as being; using information and intelligence to plan for the needs of an increasing older people population and those with long-term conditions, and the prevalence of certain conditions such as heart disease and dementia. The practice reviewed information to ensure that increased needs for service provisions had been considered and planned for.

Identification and management of risk

We saw from records and from information shared with us by staff, that there were systems and processes in place to manage risks. We saw that risk assessments were used to consider individual risks to patients. Records showed that assessments had been completed in order to consider and determine possible risks to the practice, such as business continuity and disruption, loss of the premises and loss of

Are services well-led?

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

facilities. We were told by a GP and the practice manager that the partners also discussed the business of the practice and concerns identified were used to inform risk assessment. We saw that an up to date fire risk assessment was in place and that all staff knew their roles and responsibilities in the event of a fire.

The practice had a whistleblowing policy and staff told us they were aware of the procedure to follow if they wished to raise concerns outside of the practice.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Summary of findings

We found that the practice was responsive to the needs of older people.

Plans were underway for every patient who was over 75 to have an allocated GP. This population group was being contacted to inform them which GP they were to be allocated to and to inform them that they may see any GP, not just the one allocated to them.

We saw that the practice ran specialist clinics in order to provide older people with annual flu vaccinations. The practice also offered reviews and assessments to check that vital signs and lifestyle choices as well as weight, blood pressure and diet, for example, were within the expected range for people in this population group.

We found the practice to be caring in the support it offered to older people. We saw that there were appropriate and effective treatments, along with ongoing support for those patients diagnosed with dementia. The practice had systems in place to enable it to be responsive to meet the needs of older people and to recognise future demands in service provision for this age group.

Our findings

Caring

We found the practice to be caring in the support it offered to older people. There were appropriate and effective treatments, along with ongoing support for those patients diagnosed with dementia, diabetes and other illnesses. We were told by a GP and the practice manager that individual clinical and treatment plans were discussed with other healthcare professionals during palliative care meetings, district nurse meetings and clinical meetings held between clinical staff and health and social care workers. This meant that patients received care and treatment from healthcare professionals that were aware of their individual needs.

Responsive

Plans were underway for every patient who was over 75 to have an allocated GP. This population group was being contacted to inform them which GP they were to be allocated to and to inform them that they may see any GP, not just the one allocated to them.

We were shown records of medicine audits that had been carried out following the receipt of national guidelines and standards provided to the practice by NHS commissioners/ stakeholders. For example, we saw that a change had been made to the prescribing regime for patients on a specific medicine for osteoporosis following an update in best practice guidelines. This meant that older people were offered care and treatment in accordance with nationally recognised standards.

The practice ran specialist clinics in order to provide older people with annual flu vaccinations. The practice offered reviews and assessments to check that vital signs and lifestyle choices as well as weight, blood pressure and diet, for example, were within the expected range for people in this population group.

The practice manager, GPs and non-clinical staff told us that registers were kept to identify patients over 75, with specific conditions, for example patients with dementia, heart disease and diabetes. We saw that these registers

Older people

were used to inform clinical audits which were undertaken within the practice. Actions were agreed with regards to changes to specific treatments and therapies, if required in order to improve outcomes for patients over 75.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Summary of findings

We found the practice to be caring in the support it offered to patients with long-term conditions. practice offered annual flu vaccinations routinely to patients with long term conditions. The practice was caring in the support it offered to patients with long-term conditions and the care provided was effective. Treatment plans were monitored and kept under review by a multi-disciplinary team. The practice was responsive in prioritising urgent care that people required and the practice was well-led in relation to improving outcomes for patients with long-term conditions and complex needs.

Our findings

Caring

We saw that there were appropriate and effective treatments, along with ongoing support for those patients diagnosed with dementia, diabetes and other illnesses. We were told by GPs how individual clinical and treatment plans were agreed and recorded. We were told by a GP and the practice manager that individual clinical and treatment plans were discussed with other healthcare professionals during district nurse meetings and clinical meetings held between clinical staff and health and social care workers. Patients with long-term conditions received care and treatment from healthcare professionals that were aware of their individual clinical and care pathways.

Responsive

The practice prioritised appointments for patients with long-term conditions. We were told that patients could be seen at the practice, receive home visits or telephone consultations and that patients could choose which option suited them according to how their condition made them feel on the day.

Effective

There were processes to ensure that links with district and community nurses and other nurse specialists, remained effective and promoted patients' care, welfare and safety. Multi-disciplinary meetings were held routinely and included clinicians from the practice and all members of the multi-disciplinary team who were involved in patients with long-term conditions care and treatments.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Summary of findings

We found that the practice was caring in relation to mothers, babies, children and young people. The practice offered dedicated clinics to patients in this population group. We saw that referrals to other community based services were made, in order to provide these patients with additional support. The practice was responsive in prioritising appointments for mothers with babies and young children. The practice was well-led in relation to nominating a named GP to have overall responsibility for children's safeguarding matters and systems were in place to make appropriate referrals to safeguarding specialists, health visitors and other support providers.

Our findings

Safe

We found that there were child safeguarding policies and procedures in place. Clinical staff were knowledgeable and had received training in safeguarding children. The practice held a safeguarding meeting every two to three months that included the health visitor and school nurse. There was a named GP who had overall responsibility for children's safeguarding matters. Systems were in place to make appropriate referrals to safeguarding specialists, health visitors and other support providers. The practice had mechanisms in place for alerting others that a child might be at risk of abuse.

Records of childhood vaccines that had been administered were appropriately maintained.

Responsive

The practice prioritised appointments for mothers with babies and young children. The practice offered dedicated clinics to patients in this population group. We were told that patients could be seen on any day by either one of the practice nurses or one of the GPs, if they were unable to attend the dedicated clinic. We were told that childhood immunisation clinics were well attended.

We saw that the practice had procedures in place for patients to consent to treatment and a form was used to gain the written consent of patients when undergoing specific treatments, for example, minor operations. We saw from the consent form in use, that there was space on the form to indicate where a person's carer or parent/guardian had signed on the patients behalf.

We saw that referrals to other community based services were made, when required, in order to provide these patients with additional support.

Mothers, babies, children and young people

Effective

We were told by a GP that they performed their own audits which they used as evidence for their appraisal. We saw audits that had been conducted in relation to the screening of patients under 25 years of age for a sexually transmitted disease.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Summary of findings

The practice responded to meeting the needs of people in this population group by starting to review ways to provide services that were more accessible to working age patients. The practice was well-led in relation to improving outcomes for patients of working age and those recently retired.

Our findings

Responsive

The practice had systems in place to respond to meeting the needs of people in this population group. They were reviewing how to provide services that were more accessible to working age patients. Plans were in place to provide a more flexible service at the branch surgery – Kemsing Village Surgery.

Although we found the practice did not offer extended hours or have weekend arrangements for patients who worked from 9am to 5pm, Monday to Friday, working age patients had access to appointments to speak with a GP and have telephone consultations.

The surgery provided health checks and smoking cessation clinics.

Well led

The practice had a Patient Participation Group (PPG). We spoke with a PPG representative who told us that they had an 'online forum' which consisted of approximately 150 members, this was a method used by the practice to enable patients of working age to feed into the PPG decision making processes.

People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Summary of findings

We found that the practice was caring about vulnerable patients. We saw that there were effective support systems in place for vulnerable patients and to be responsive to providing care and treatment at patients' homes, where they had difficulty in attending the practice. We saw that the practice had procedures in place for vulnerable patients to consent to treatment. There was a wide range of services and clinics available to support and meet the needs of this population group. We saw that the premises were accessible and suitable for patients with reduced mobility and provided enough space for wheelchair users.

Our findings

Effective

We saw that there were effective support systems in place for vulnerable people, for example, the practice offered care and treatment in patients' homes, where they had difficulty in attending the practice. We were told by GPs and the practice manager that visits to care homes were conducted for patients who were unable to attend the practice.

We were told by the practice manager that the practice provides care and treatment to travellers who live on a local static travellers site. The practice provided home visits, where required and liaised closely with community health workers and support groups, in order to ensure the needs and expectations of these patients were met.

We saw that the practice had procedures in place for vulnerable patients to consent to treatment and a form was used to gain the written consent of patients when undergoing specific treatments, for example, minor operations. A GP described how they managed issues with gaining consent from patients who were unable to read or write. The process in place was clear and we were told by the GP that all partners at the practice were aware that they should document clearly the reason why written consent had not been obtained and the reason for accepting verbal consent. This meant that consent to care was appropriately obtained and recorded for this particular group of patients.

Clinical staff we spoke with told us that there was a wide range of services and clinics available to support and meet the needs of this population group. They told us that they would refer patients to community specialists or clinics, if appropriate. Examples of this included referring vulnerable patients or their carers to groups who specialised in supporting vulnerable patients.

People in vulnerable circumstances who may have poor access to primary care

Responsive

From our observations we saw that the premises were accessible to disabled patients, with ramps to gain entry into the practice and designated parking spaces close to the entrance door. We saw that there were facilities available for patients with disabilities, for example a specially designed toilet and the reception desk was at a low level to accommodate patients using wheelchairs.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Summary of findings

We found the practice had a caring and responsive approach to patients who experienced mental health problems. There were effective procedures in place for undertaking routine mental health assessments of patients in this population group. Appropriate systems and methods of referral were in place in order to provide patients with mental health problems to other specialist practice providers for ongoing support.

Effective systems were in place to monitor and assess patients who lacked mental capacity to make informed decisions for themselves. We found that patients' carers were supported to make decisions for patients they held responsibility for. Carers' views and opinions were considered when care and treatment was required. Appropriate referral systems were in place, when support was required by the GPs in order to assess patients mental capacity. The management team of the practice provided a well-led approach in relation to identifying and managing risks to patients who experience mental health problems.

Our findings

Caring

We were told by GPs and the practice nurse about how the needs of patients with mental health problems, were assessed during initial consultation. They told us that individual clinical and treatment pathways were discussed with other mental health care professionals during clinical meetings held between practice staff and mental health workers. This ensured that patients received care and treatment from healthcare professionals that were aware of their individual clinical and care pathways.

Clinical staff we spoke with told us that there was a wide range of services and clinics available to support and meet the needs of this population group. They told us that they would refer patients to community specialists or clinics, if appropriate. Examples of this included referring patients or their carers to groups who specialised in supporting patients with mental health problems.

Effective

We spoke with GPs about how patients who lacked capacity to make decisions and give consent to treatment were managed. They told us that mental capacity assessments were carried out by the doctors and recorded on individual patient records. We were told of instances that required further assessment of patients where they lacked capacity. Practice staff had a clear understanding of the requirements of the Mental Capacity Act 2005 and had procedures in place which ensured that patients who lacked capacity were appropriately assessed and referred, where applicable.

The practice manager, GPs and non-clinical staff told us that registers were kept to identify patients with mental health problems. We saw that these registers were used to inform clinical audits, which were undertaken within the practice. From minutes of clinical meetings we saw that information from audits were shared and discussed and actions were agreed with regards to changes to specific treatments and therapies, in order to improve outcomes for patients with mental health problems.

People experiencing poor mental health

We saw a range of information leaflets and posters in the waiting room for people to get information about the practice and about promoting good health. Information about how to access other mental health services and support groups was also displayed.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers. **How the regulation was not being met:** Patients who use services were not protected against the risks associated with staff who were not of good character because non clinical staff carried out chaperoning duties without training or risk assessments in place, as to whether they required criminal records checks via the Disclosure and Barring Service. Regulation 21 (a) (i).

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers. **How the regulation was not being met:** Patients who use services were not protected against the risks associated with staff who were not of good character because non clinical staff carried out chaperoning duties without training or risk assessments in place, as to whether they required criminal records checks via the Disclosure and Barring Service. Regulation 21 (a) (i).

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control. **How the regulation was not being met:** Patients who use services were not protected against the risks associated with healthcare associated infection as there were no cleaning schedules or audits of processes

This section is primarily information for the provider

Compliance actions

as outlined in the 'Code of Practice for health and adult social care on the prevention and control of infections and related guidance'. (Hygiene Code). Regulation 12 (1) (c) (i) (ii).

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control. **How the regulation was not being met:** Patients who use services were not protected against the risks associated with healthcare associated infection as there were no cleaning schedules or audits of processes as outlined in the 'Code of Practice for health and adult social care on the prevention and control of infections and related guidance'. (Hygiene Code). Regulation 12 (1) (c) (i) (ii).