Oaklands Health Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

We carried out an announced comprehensive inspection at Oaklands Health Centre on 14 January 2015. Overall the practice is rated as good.

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

It was also good for providing services for the care of older people, the care of patients with long-term conditions, the care to working-age people (including those recently retired and students), the care of families, children and young people, the care of patients whose circumstances may make them vulnerable and the care of patients experiencing poor mental health (including people with dementia).

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand. It was available in a wide variety of languages.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. Staff and patients were actively involved in the decision making about how the practice could improve.

Summary of findings

We saw several areas of outstanding practice:

- There were protected "slots" in the appointments system to ensure that end of life and palliative care patients would be seen when they called for an appointment.
- The practice participated in a national scheme to help identify the types of viral infection prevalent across the country at a particular time.
- The practice had set up a "dressing station" within the surgery building where community nurses could manage the care of patients, usually elderly, with pressure sores and such like.
- An integrated family support officer from a local agency attended relevant meetings where patients who needed multi-disciplinary care were discussed.
- Nursing homes had an allocated GP to manage care of residents and there was a ward round each week.
- Reception staff routinely called patients who had memory problems to remind them of their appointments.
- The practice held a "super flu" Saturday event, at this about 2500 patients were vaccinated this meant a wide coverage early on in the flu season to ensure maximum patient care.
- Communication with staff was excellent. There was a weekly meeting which took place during the lunch break so there were no distractions. Staff were involved in the decision making about improvements to the way the practice was run.

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

Importantly the provider should:

- Review the manner in which patient group directions were filed so as to avoid any confusion to staff using them.
- Review its auditing activity to ensure its effectiveness and to more closely reflect the population it served.

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 to 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 enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. Where data showed patient outcomes were not at or above average for the locality the practice was aware of this and had taken action. There was evidence of appraisals and personal development plans for all staff. There was some outstanding practice such as close working with the community and with the patient participation group to provide improved services. Staff worked with multidisciplinary teams.

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 decisions about their care and treatment. Information to help patients understand the services available was easy to understand and available in a wide range of languages. We also saw that staff treated patients with kindness and respect, and maintained confidentiality. There was some outstanding practice such as reception staff routinely called patients who had memory problems to remind them of their appointments.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and made changes, such as a new appointments system, to meet those needs. There was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat

Summary of findings

patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints with staff and other stakeholders.

Are services well-led?

Outstanding 

The practice is rated as outstanding for being well-led. The practice had a clear vision with quality and safety as its top priority. The vision had been produced with the engagement of the PPG and was regularly discussed with staff. High standards were promoted and owned by all practice staff and teams worked together across all roles. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. Communication with staff was excellent and staff, and patients, were involved in the decision making that drove improvement at the practice. The practice used technology to inform and assist patients. It had a very active PPG. There was a low turnover of staff.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It had protected appointments for patients with these conditions. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. There was a weekly ward round by GPs at the nursing homes within the practice locality. Where nationally reported data showed that outcomes for patients were below average for conditions commonly found in older people, the practice was addressing this.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Where patients suffered from more than one long term condition, staff addressed all conditions during one appointment rather than the patient having to attend a clinic for each condition. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. There was a quiet room where breastfeeding mothers could feed their children. We saw good examples of joint working with midwives, health visitors and school nurses which included shared services with a local family centre.

Summary of findings

Working age people (including those recently retired and students)

Good

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

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability. It had carried out annual health checks for people with a learning disability and all of these patients had received a follow-up. It offered longer appointments for vulnerable patients. Staff were aware of asylum seekers who might need access to health care.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia. It was able to arrange out patients appointments at the practice for patients who found it difficult to attend hospital for these services. Where nationally reported data showed that outcomes for patients were below average for mental health conditions the practice was addressing this.

Summary of findings

What people who use the service say

We spoke with nine patients. We received 35 completed comment cards.

All the patients we spoke with were pleased with the quality of the care they had received. All but one said that it had been easy to make appointments with a GP and that they were seen at, or close to, the time of their appointment. Several patients commented though the appointments system was new they felt that it would improve access to GPs particularly with their preferred GP.

There is a survey of GP practices carried on behalf of the NHS twice a year. In this survey the practice results are compared with those of other practices. A total of 256 survey forms were sent out and 124 were returned. The practice had good results from the survey, some results exceptionally so. For example in the section "speaking with our seeing your usual GP" the practice was above the average for the clinical commissioning group and nationally. In the section concerning the ease of contacting the practice by telephone the practice was also rated significantly better that the CCG average.

The survey did identify that more patients did not get to see their preferred GP than was the case nationally. The practice was aware of this and had recently brought in a new appointments system that was designed to improve on this.

Areas for improvement

Action the service SHOULD take to improve

- Review the manner in which patient group directions were filed so as to avoid any confusion to staff using them.
- Review its auditing activity to ensure its effectiveness and to more closely reflect the population it served.

Outstanding practice

- There were protected "slots" in the appointments system to ensure that end of life and palliative care patients would be seen when they called for an appointment.
- The practice participated in a national scheme to help identify the types of viral infection prevalent across the country at a particular time.
- The practice had set up a "dressing station" within the surgery building where community nurses could manage the care of patients, usually elderly, with pressure sores and such like.
- An integrated family support officer from a local agency attended relevant meetings where patients who needed multi-disciplinary care were discussed.
- Nursing homes had an allocated GP to manage care of residents and there was a ward round each week.
- Reception staff routinely called patients who had memory problems to remind them of their appointments.
- The practice held a "super flu" Saturday event at this about 2500 patients were vaccinated this meant a wide coverage of the patient population early on in the flu season to ensure maximum patient care.
- Communication with staff was excellent. There was a weekly meeting which took place during the lunch break so there were no distractions. Staff were involved in the decision making about improvements to the way the practice was run.

Oaklands Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector and included a GP specialist advisor and a practice manager.

Background to Oaklands Health Centre

The Oaklands Health Centre is a GP practice located in a part urban area of Hythe Kent It provides care for approximately 11,500 patients. The practice has a high level of older patients. It has twice the national average of patients over 65 and over 75 years and two and a half times the national average of patients over 85 years. The number of patients in nursing homes is four times the national average figure. It is not an area of high depravation or of high unemployment.

There are four GP partners, two female and two male there are two male and one female salaried GPs. There are five nurses and two healthcare assistants (HCA). The practice has a general medical services (GMS) contract with NHS England for delivering primary care services to local communities. The practice is accredited as a training practice but has no GP trainer at the moment and therefore no registrars (GPs under training).

Services are delivered from:

Oaklands Health Centre

Stade Street,

Hythe,

Kent,

CT21 6BD

Tel: 01303 235300

The practice has opted out of providing out-of-hours services to their own patients. There is information available to patients on how to access out of hours care.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

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

This provider had not been inspected before and that was why we included them.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice. This included demographic data, results of surveys and data from the Quality and Outcomes Framework (QOF). QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice.

Detailed findings

We asked the local clinical commissioning group (CCG), NHS England and the local Healthwatch to share what they knew about the service.

The visit was announced and we placed comment cards in the practice reception so that patients could share their views and experiences of the service before and during the inspection visit. We carried out an announced visit on 14 January 2015. During our visit we spoke with a range of staff including GP partners, salaried GPs nurses and healthcare assistants, receptionists and administrators. We spoke with patients who used the service.

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

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

We also looked at how well services 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

The practice used a range of information to identify risks and improve patient safety. For example, significant events or incidents and national patient safety alerts as well as comments and complaints received from patients or other providers. The staff we spoke with understood the policy relating to significant events and were aware of their responsibilities to raise concerns. They knew how to report incidents and near misses. There was a wide range of significant events recorded by the practice.

For example we saw that there had been a confidentiality issue regarding a patient's condition. Lessons had been learned from this and changes made to the way alerts were placed on the patients' records to reduce the risk of a similar event happening again.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last year. There was regular reporting of events, 10 events being reported in that period. There was an open approach to reporting incidents and there was evidence of learning from them.

Learning and improvement from safety incidents

The practice had systems for reporting, recording and monitoring significant events, incidents and accidents. Staff completed a template form, the form was forwarded to the practice manager and investigated. The incidents we looked at had been investigated in a comprehensive and timely manner.

The significant event log included details of any action plans to reduce risks and who was responsible for their implementation. Significant events were discussed at regular meetings, usually monthly. Learning from these meetings had included blocking the "print button" to certain records to prevent sensitive information being printed before the individual checking that this was a proper course of action. In another case the use of two carers at a care home where flu vaccinations were being administered led to a mistake. After discussing the matter with the care home it was decided that in future only one carer would be involved in the process.

Where there had been errors that impacted on patients, records showed that they were provided with an explanation of what had happened and, where appropriate, a written apology.

National patient safety alerts were dealt with by the practice manager. They were sent on to the GPs and nurses for clinical matters and other staff as necessary. We followed through two recent alerts and saw that they had been dealt with in accordance with the instructions within the alert. Alerts were discussed at practice meetings.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at the practice training records. All the GPs were trained to the appropriate level (level 3) in safeguarding children. GPs had also completed training in safeguarding adults. There was a lead GP for safeguarding both children and adults. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They knew who the lead was for safeguarding and to whom these should be reported. Staff had been trained to the appropriate level, level 2 for nurses and level 1 for others. There were notices and flow charts at various places within the practice to remind and inform staff about the processes to be followed in reporting a safeguarding. This information had been updated in July 2014. GPs told us about a specific incident that had been correctly reported and investigated in accordance with the protocols. There were examples of both children and adult safeguarding referrals. The lead GP for safeguarding was aware of vulnerable children and adults in the practice and regularly liaised with other agencies such as the local authority and local social services. An officer from the local authority safeguarding team regularly attended the relevant part of the practice meetings.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended appointments, for example, children subject to child protection plans. This system was also used for patients who needed particularly close monitoring of their blood and there was a prescribing lead administrator who supervised the management of patients using controlled drugs or special medicines.

Good

Are services safe?

There was a chaperone policy. There were posters about chaperoning displayed on the waiting room noticeboard and in consulting rooms. There were sufficient staff trained to act as chaperones and the entire chaperone staff were due to have a refresher chaperone course in January 2015. Where a chaperone was used this was noted on the patient's record.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, there were both physical checks and remote sensors to monitor this. There was guidance on the action to take in the event of a potential failure. There had been a power failure which had affected the storage of the vaccines and medicines. This had been recorded as a significant incident and staff had followed the correct policy.

There was a stock control process to ensure that medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

The patterns of hypnotics, sedatives and anti-psychotic prescribing were within the range that would be expected for such a practice. The nurses and the health care assistant administered vaccines using patient group directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of directions for various medicines had been signed by the staff concerned. The manner in which the directions were filed could cause some confusion to staff using them and practice should review this. There was evidence that nurses and the health care assistant had received appropriate training to administer vaccines.

Cleanliness and infection control

The premises were clean and tidy. The treatment and consulting rooms were clean, tidy and uncluttered. The rooms were stocked with personal protective equipment (PPE) including a range of disposable gloves, aprons and coverings. We saw that antibacterial gel was available in the reception area for patients and antibacterial hand wash, gel and paper towels were available in appropriate areas throughout the practice. The fittings within the building were modern and compliant with recent guidance.

The practice had a lead for infection control who had undertaken an accredited two day course to enable them to provide advice on the practice infection control and carry out staff training. We spoke with the infection control lead. All staff received induction training about infection control specific to their role and received annual updates. Audits had been carried out and these had resulted in changes such as changes to the type of soaps used by the staff. There had been audits of individual consulting and treatment rooms. This had identified that some of rooms needed more modern waste bins and work was on-going to identify what product the practice was going to buy. There were notices in the consulting and treatment rooms as to what action to take in the event of a needle stick injury.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, PPE was available to staff and staff were able to describe how they would use the equipment to comply with the practice's infection control policy such as the use of disposable couch coverings and the treatment of hazardous waste.

We saw there were cleaning schedules and cleaning records were kept. We saw that, for example, the privacy curtains around the couches were disposable and had stickers indicating when they should be changed. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

Equipment

Staff told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly. All portable electrical equipment was routinely tested and there was a schedule for ensuring that was done when required. Although the equipment we looked at appeared in good working order there was no comprehensive equipment register and the practice could not be satisfied that all the equipment had been checked and calibrated according to the manufactures instructions. After the inspection we were informed by the practice that on the 22 January all the equipment was serviced and calibrated by an independent contractor.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. We looked at staff files and saw that there

Good

Are services safe?

was proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service. The practice had a policy that set out the standards for recruiting staff.

We saw there was a rota system in place for all the different staffing groups to ensure that there were enough staff on duty. The rota system ensured that staff, including GPs, nurses and administrative staff covered each other's annual leave.

Monitoring safety and responding to risk

The practice had a health and safety policy to help keep patients, staff and visitors safe. Health and safety information was displayed for staff to see. A fire risk assessment had been undertaken that included actions required in order to maintain fire safety. Records showed that staff were up to date with fire training. There were regular fire evacuation drills.

There was a system governing security of the practice. For example, visitors were required to sign in and out using the dedicated book in reception. The staff reception area in the waiting room was always occupied and the door shut to prevent unauthorised access.

Arrangements to deal with emergencies and major incidents

The practice had arrangements to manage emergencies. Records showed that all staff had received training in basic life support (BLS). There was BLS refresher training scheduled for the final week in January 2015. Emergency equipment was available including access to medical oxygen and to an automated external defibrillator (used to attempt to restart a person's heart in an emergency). Staff knew the location of this equipment. The practice should review the location of emergency equipment. The emergency medicines included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. We checked the emergency medicines, they were in date and reviewed regularly.

There were contingency plans to deal with a range of emergencies such as power failure, adverse weather, unplanned sickness and access to the building. The practice had experienced a major flood during the previous year. The contingencies plans had been severely tested and were adequate. The plans had been upgraded to reflect the lessons learned, the most significant of which was to plan for more time for other agencies such as insurance companies and builders to respond to the practice's requests.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs, nursing staff and healthcare assistants (HCA) we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. The practice nurses had carried out reviews of certain diabetic patients and patients on high doses of certain medicines. Those showed that the practice was aware of changing guidelines, from both NICE and the CCG, and responded to them. Other examples included HCAs using ambulatory (or home) blood pressure monitoring to ensure that blood pressure is worked out from measurements that are as accurate as possible. This follows NICE guidance for the clinical management of primary hypertension in adults.

We talked with the GPs and nurses and they said that they completed assessments in accordance with NICE guidelines, this included the regular reviews of patient care and treatment as indicated by the guidance. Staff used other guidance and the practice computer system gave GPs and nurses access to these. For example there was a range of guidelines for different long-term conditions and guidelines for different cancer referral routes.

There were regular meetings of GPs and nurses where new guidelines were disseminated, recent safety alerts cascaded and the practice's performance discussed. Where the practice identified problems specific GPs or nurses were tasked to address them. Staff also took the opportunity to talk about complex cases. All the staff we spoke with were open about asking for and providing colleagues with advice and support. There were GP leads for various specialist areas such as mental health, end of life care and learning disability and the practice nurses supported this work.

The available data showed that the practice's performance for some prescribing, in particular for some antibiotics and painkillers, was not in the same range as other local practices. We discussed this with the practice GP lead for prescribing. In the case of antibiotics this was partly an historical issue. There had been several meetings with the prescribing advisor for the clinical commissioning group (CCG) and there was now more awareness of the issue amongst the practice GPs leading to a reduction in the prescribing of the medicines at issue. In the case of pain killers the practice believed that it was the high number of elderly patients, at two and a half times the national average, that was at the core of the issue. The practice were aware that that their prescribing of these medicines was outside the normal range and they were addressing this.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

There was regular monitoring to assure and improve outcomes for patients. There was some auditing. There had been an audit of patients prescribed a particular statin (statins are a group of medicines that can help lower the level of cholesterol in the blood) who were also prescribed certain other drugs used to treat high blood pressure. The audit had been undertaken following a medicine safety alert. A total of 46 of patients had been identified. They had been written to and informed that their statin had been switched to a recommended alternative. The audit was re-run a few months later and only two patients were found to be within the alert category. Action had been taken in both cases.

Another audit was driven by the local CCG and concerned switching patients from named (more expensive) medicines to generic (cheaper) equivalents. Some prescribing audits had been undertaken within the practice and the some audit results shared at meetings. However the results were not always shared. There was no evidence of a structured approach for example, audits aimed at the practice's larger patient groups, there was no audit plan for the practice. Those audits which had been commenced did not always have follow up or re-audit cycles to show that change, where it had been implemented, had been effective. The practice should review its effectiveness in this area.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of

Good

Are services effective?

(for example, treatment is effective)

preventative measures). The practice had reviewed its QOF outcomes against certain areas, such as care of dementia patients, and was not satisfied about its recorded performance. In these cases an individual GP or nurse was tasked to secure improvement. In the case of dementia, for example, this process had been followed with staff receiving education and direction. The current performance against this QOF outcome was markedly improved.

In other areas the QOF results did not reflect the work the practice had done. For example in the treatment of atrial fibrillation; one QOF outcome showed that the practice was effective in seeing the affected patients (96% seen in the last 12 months), but a related outcome showed that they were not. However the second outcome was effectively a measure of those patients prescribed anti-coagulants, such as warfarin. The practice determined the treatment of the patients but the actual prescribing was delivered by a community pharmacy. Thus QOF gave the impression that the practice was ineffective in their treatment of these patients when it was not.

There was a protocol for repeat prescribing which followed national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines.

The practice had achieved and implemented the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. One of the GPs was the lead for end of life care. There were care plans for these patients and an alert on the electronic record to inform staff of the importance the practice placed on this. There were protected “slots” in the appointments system to ensure that end of life and palliative care patients would be seen.

Effective staffing

Practice staff included medical, nursing, managerial and administrative staff. We reviewed staff training records. There was an overall training plan. We saw that mandatory training such as safeguarding, basic life support and infection prevention control had been completed by all staff. The areas of training that were considered to be most important for the safety of patients and staff had therefore been completed. Staff had completed fire safety training.

We noted a good skill mix among the doctors with GPs having qualifications in child health and in surgery. There was GP with an interest nutritional health and a GP with an interest in psychiatry. All GPs were up to date with their yearly continuing professional development requirements and all had been given a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All the staff we spoke with about their appraisal said that they had found the process useful. It had helped to identify training needs and provided an opportunity for staff to discuss problems with their manager. The practice was accredited as a training practice but had no GP trainer at the time of the inspection and therefore no registrars (GPs under training).

Working with colleagues and other services

The practice worked with other service providers to meet patient’s needs and manage those of patients with complex needs. It received blood test results, X-ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. Results were received throughout the day and were frequently checked. Where there had been a breakdown in the system the practice had investigated and had acted to reduce the risk of this happening again. The GPs who saw the documents and results were responsible for the action required. All staff we spoke with understood their roles and felt the system worked well.

The practice was commissioned for the new enhanced service designed to prevent unplanned admission to hospital (Enhanced services require an enhanced level of service provision above what is normally required under

Good

Are services effective?

(for example, treatment is effective)

the core GP contract). The practice reviewed the information from hospital admissions and used codes to mark patients' records so that they could be identified and offered additional support to reduce future admissions.

The practice used clinically recognised risk stratification tools to identify patients with complex needs to ensure that there were multidisciplinary care plans documented in their case notes. The practice held multidisciplinary team meetings monthly to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented. The practice were aware that, because palliative care patients were allocated more than one nurse from the local hospice services, extra attention was needed to ensure patients had the correct care.

The practice participated in a national scheme to help identify the types of viral infection prevalent in country at a particular time. Samples from patients with viral infections were sent, with their consent, for analysis to a central agency so that there monitoring of national trends.

The practice had set up a "dressing station" within the surgery building where community nurses could manage the care of patients, usually elderly, who had pressure sores and such like. This also resulted in a much more efficient use of expensive dressings and savings to the local health economy.

The practice worked with a local diabetic charity to provide retinal screening services to patients where this was indicated. Retinal screening is designed to detect early signs of damage to the retina of the eye which can result in blindness.

An integrated family support officer from a local agency attended relevant meetings where patients who needed multi-disciplinary care were discussed. A more holistic package was therefore available to address social and family issues as well as patients' medical needs.

The practice had introduced an innovative method of storing and accessing patients' records. This allowed for a quicker and more efficient means of transferring records between practices when patients moved between them. The practice had recently made their experience in this field available to other practices who might wish to adopt a similar approach.

Information sharing

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record 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.

Regular meetings with the local district nurse and community matron services had just been instituted, at the practice's initiative, to discuss patients with complex needs. Information from the out-of-hours service (OOH) was received by fax or by e-mail and was scanned into patients' notes.

Consent to care and treatment

Some GPs had received training in the Mental Capacity Act 2005 (MCA) and were aware of the implications of the Act. Reception staff were aware of the need to identify patients who might not be able to make decisions for themselves and to bring this to notice. We were told about an example of the treatment of a patient who did not have capacity to make the decisions needed. The patient was involved in the process, as far as was practicable. The patient, the patient's family and the health professionals made the decisions between them in the best interest of the patient. There was information on the practice computer system showing best interest and MCA pathways to help GPs and nurses follow the correct procedures.

The practice had a consent policy that governed the process of patient consent and guided staff. The policy described the various ways patients were able to give their consent to examination, care and treatment as well as how that consent should be recorded. We saw that consent was specifically recorded for invasive procedures such as minor surgery including procedures such as joint injections. There were leaflets available to help patients understand the procedures, and consent was obtained in advance.

Patients with mental health problems and those with dementia were supported to make decisions through the use of care plans, in which they were involved. These plans showed the patient's preferences for treatment and decisions. Records showed that historically the practice had been poor at this, however particular attention had been paid to these areas and now about 90% of patients in these two groups had been reviewed within the last year.

Good

Are services effective?

(for example, treatment is effective)

Health promotion and prevention

We were told that all new patients were offered a health check. They were given a questionnaire and an appointment with the nursing staff which included a new patient check. Those on repeat medications were referred to the appropriate specialist nurse appointment in the first instance and to a GP if necessary. The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. We were told of several instances where these checks had led to the early diagnosis of long term conditions.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability. They were all offered an annual physical health check. The practice had a number of residential homes for the elderly and nursing homes for the elderly within their practice area. Both nursing and residential homes had an allocated a GP, this assisted with continuity of care, particularly for those patients who could not get to the practice. In addition nursing homes had a weekly ward round.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was in line with the average nationally for child vaccinations. For vaccinations for patients over 65 years and for patients under 65 whose condition meant that they were at in increased risk if they caught influenza the practice's performance markedly better than the national average.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey and information from the patients submitted to the practice under the recently instituted NHS "friends and family" test. We spoke with patients and read the comment cards that patients had completed. The evidence from all of these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. A number of questions in the national patient survey cover the care patients received in the practice. The responses to these questions were all at or close to the national averages. The answers also showed that patients felt GPs and nurses were good at listening to them, explaining test and results and giving them enough time to discuss their care.

Patients completed 35 CQC comment cards to tell us what they thought about the practice. We also spoke with nine patients during our inspection. Both the comment cards and what the patients said were positive. There no negative comments. It showed that patients felt they were satisfied with the care provided by the practice and said that their dignity and privacy were respected. General themes commented on were that the practice was very caring and efficient, it was easy to get an appointment particularly in an emergency and several cards mentioned how helpful the reception staff were.

Patient confidentiality was respected. There was a reception area with ample seating. The reception staff were pleasant and respectful to the patients. We saw that they were careful to maintain patient confidentiality and there was a notice at reception asking patients to keep back from the reception when a patient was being dealt with so as to respect their confidentiality. There was a private area where patients could talk to staff if they wished and there were notices telling patients about this facility. There was a notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Telephone calls coming into the practice were answered in another room by separate staff. Patients could not therefore overhear conversations between receptionists and patients. It allowed the receptionists and the telephone staff to concentrate on their separate tasks with less distraction.

All consultations and treatments were carried out in the privacy of a consulting room. We saw that staff always knocked and waited for a reply before entering any consulting or treatment rooms. All the consulting rooms had substantial doors and it was not possible for conversations to be overheard. The rooms were, if necessary, fitted with window blinds. The consulting couches had curtains and patients said that the doctors and nurses closed them when this was necessary.

The practice was sensitive to confidential issues. There had recently been an audit that had involved a medicine used to treat a sexual condition. All the patients involved were telephoned by their GP to discuss possible changes to their treatment rather than being sent letters as would normally have been the case.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. Data from the national patient survey showed 82% of practice respondents said the GP involved them in care decisions and 98% felt the same about the nurse who spoke with them. Both these results were slightly above average both locally and nationally.

The practice used the electronic care record to alert staff to patients with certain conditions. Where patients had a number of conditions staff tried to make a single, extended, appointment so that that individual's needs could be attended to in one visit. This avoided patients making repeated visit to separate clinics for each condition. There was additional nurse training and support so that nurses were able to maintain this approach.

The practice had access to translation services and there were notices in the reception areas informing patents this service was available. There was a protocol for staff to follow if they needed to engage the services of an interpreter. The practice website could be translated into a range of languages as selected by the user. There was a hearing loop for those with hearing difficulties.

Patient/carer support to cope emotionally with care and treatment

There was support and information provided to patients and their carers to help them cope emotionally with their

Good

Are services caring?

care, treatment or condition. We heard staff explaining to patients how they could get access to services such as those related to specific disabilities. There were notices in the patient waiting room and on the patient website which directed patients to support groups and organisations for carers. There was a protocol for staff to follow to help identify carers. Patients we spoke with, some out whom were also carers said that the practice was very supportive of carers. Where patients had been identified as having memory problems, staff would ring them prior to the appointment to remind them of it. In the case of these, and other identified patients, the practice would ring them, if they had not attended to ensure that they were alright and to identify the reason why the appointment had been missed.

The practice recognised that, with a large population of elderly patients, isolation was a factor in their care. The patient participation group held monthly coffee mornings, in the practice's meeting rooms, where patients were encouraged to attend for social reasons. We spoke with patients who told us of the help and friendship that they had received through these events and how this had helped them to manage their health.

There was a structured approach to caring for patients with new diagnoses of life changing conditions such as cancer. The two weeks waiting time for access to cancer services was carefully monitored and followed up when it appeared that the patient would not receive the service in time.

The practice had a protocol to guide to staff when dealing with bereavement. There was a letter of condolence from the practice. There was information displayed, privately, so that staff were aware when a family had suffered bereavement. The notes of the deceased family and partner (if any) were updated so that staff were aware of the family's loss and could respond sympathetically.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and there were systems to address identified needs in the way services were delivered. For example, the practice was aware of local developments, such as planned new housing. It had considered the impact of several possible housing developments, each with different population groups, on the practice and how it might need to be structured.

The practice had learned from patients' feedback and surveys that the appointment system was not sufficiently responsive to patients' needs. There had been an assessment of how effectively the appointments system had been working. This had been completed during the autumn of 2014. As well as analysis of the use of appointments, patients had been asked their views directly, in the form of questionnaires and the patient participation group (PPG) had been consulted. A new appointment system had been instituted with changes to core hours and to the availability of immediate and longer term appointments. The system had only been in use a few days at the time of our inspection but early indications were that the patients felt it better suited their needs.

The practice had an active patient participation group (PPG) which was called the Friends of Oaklands Health Centre. It had been started in 2007. We spoke with three members of the group. The group reported that the practice was very open to suggestions. The PPG has asked the practice to contribute to meetings such as an Alzheimer's educational event and the practice had helped by assisting with guest speakers. The practice and the PPG worked together to run a "super flu Saturday". At this session about 70% of all the patients who were recommended to receive an annual flu vaccination were vaccinated. The PPG provided tea and biscuits and helped to manage the large number of patients. At this event about 2500 patients were vaccinated this meant a wide coverage of patients early on in the flu season to ensure maximum patient care.

The practice worked closely with a local family centre providing support and activities where patients' needs sometimes overlapped. There were arrangements to ensure that patients could access services at either place and at times that were most suitable to them. For example there was a mother to mother support group for pregnant and breastfeeding women, with a community midwife in attendance.

There was a young persons' clinic that included contraception services and advice on long-acting reversible contraception methods. There was Chlamydia screening for patients up to 25 years old.

Tackling inequity and promoting equality

Patients with disabilities could access the practice. There was a ramp leading to the front door so that patients in wheel chairs and mothers with prams could use it. The waiting area easily accommodated wheelchair users. The reception desk had a lowered section so that wheelchair users could talk to staff confidentially and with dignity. There were toilets for the use of disabled patients and baby changing facilities. There was a quiet room where mothers could feed their babies.

There was a register of patients who had illnesses which made them particularly vulnerable, for example a learning disability, dementia or end of life care. When staff accessed the notes of such patients a message was displayed on the computer screen to inform the staff member of the diagnosis. Thus they were better able to manage their interaction with that person by taking into account any difficulties that the patient might have, such as difficulties in communication, memory or understanding. Reception staff routinely called patients who had memory problems to remind them of their appointments.

Access to the service

Primary medical services were provided Monday to Friday between the hours of 8.30am and 6 pm. On Tuesdays and Wednesdays the practice was also open from 6.30pm until 8pm, this was for appointments only and was designed to cater for patients who found it difficult to get to the practice during normal working hours. There was a duty doctor available throughout the day including at lunchtimes, though other staff did not see patients at lunchtimes.

Patients were allocated a GP and their appointments were with this GP unless urgent or the GP was unavailable for some time, such as on leave. There were pre-bookable

Good

Are services responsive to people's needs?

(for example, to feedback?)

appointments, up to several weeks in advance, and appointments available on the day. There were telephone consultations available, on the day, for patients where this was appropriate.

Information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were available for patients who needed them and those with long-term conditions. There was a range of standard longer appointments. For example patients with a single long-term condition received a 20 minute appointment and those with two conditions a 30 minute appointment. Nurses conducted reviews at patients' homes (or nursing homes) when this was necessary.

Other patients, such as those with mental health problems could ask for longer appointments. We heard reception staff booking these appointments and they accommodated patients needs were at all possible. Where patients were vulnerable and found it difficult to attend hospital the practice was able to organise out-patients appointments with other providers such as counselling or psychiatry at the surgery. Patients who had a care plan had priority in the allocation of appointments and reception staff identified these patients from as "flag" on their computer record.

Patients we spoke with were generally satisfied with the appointments system. They knew that a new system had just started and felt that this would improve access for them. These patients and the comment cards showed that patients felt that could see a doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the day of contacting the practice. For example, we heard a patient call reception in the morning for an appointment and receive one in the mid afternoon of that day.

Listening and learning from concerns and complaints

There was a complaints policy which included the timescales by which a complainant could expect to receive a reply. The practice manager was designated to manage complaints. Information was available to help patients understand the complaints system. There were leaflets, notices and material on the website. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice, however all felt that if they had to make a complaint they would be listened to and the matter acted upon.

We looked at the record of complaints. The complaints were broken down into themes such as communication/ attitude, general administration and clinical issues. This allowed the practice to monitor specific areas and learn from them. Using this approach the practice reviewed complaints annually to detect themes or trends.

Records showed how complaints had been handled and how the patients had been informed about the outcome. There had been learning from complaints. For example a patient commented on an individual's attitude. The practiced had looked at the records of the incident, decided the complaint was justified and worked with the staff member to improve performance. The patient was informed about the action taken and was satisfied with it.

The complaints log showed the dates when various complaints had been discussed by the partners in the practice. The minutes of staff meeting also reflected learning from complaints. Complainants where offered an apology were the circumstances warranted it.

Are services well-led?

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The staff we spoke with told us that they felt well led and described a practice that was open and transparent. Staff consistently said that they understood what the practice stood for, for example trying to ensure that patients saw their own (preferred) GP whenever possible, being responsive to the patients' needs and putting care at the centre of their activity. This was summed up in the practice's mission statement which, as well as high quality care, included treating others fairly and being treated fairly.

The practice ethos also encompassed being part of the community and the practice was involved in community activities, such as running coffee mornings with the patient participation group (PPG), involvement in local family centre and the local town summer fetes. All the staff we spoke with knew and understood the vision and values and knew what their responsibilities were in relation to them.

Governance arrangements

Clinical governance was covered in a range of activity. There were policies and procedures and these were available to staff on the desktop on any computer within the practice. We looked at some of these including recruitment, chaperoning, induction, safeguarding, bereavement and complaints. There was evidence that staff had read the policies. The policies we looked at were in date and had dates assigned for their review.

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 with responsibility for safeguarding. The staff we spoke with were all clear about their own roles and responsibilities. Staff told us that the GPs had different areas of responsibility and they knew who to go to in the practice with any concerns. Partners were approachable. Staff felt valued and well supported.

The practice used the Quality and Outcomes Framework (QOF) to measure some areas of its performance. The QOF data had caused some concern to the practice. In part this was explained because a severe flood in 2014 had occurred during the time when the practice was preparing and submitting the annual QOF information. Staff who would have been doing this work were engaged in ensuring that services were maintained for patients.

The practice acknowledged that this was only part of the reason and various members of staff had been allocated different QOF areas to monitor. This had led to an improved performance in specific areas such as dementia and mental health. It had also led to a general improvement in numbers of patients with long-term conditions being called in for annual reviews. We spoke with the practice about this and the factors leading to improvement included; annual invitations, based of the month of the patients birth, to health reviews, contacting patients who had missed their reviews and the use of text messaging to remind patients of their reviews. At risk patients were sent second and third recall invites to try and ensure that their long-term conditions were managed.

The practice had arrangements for identifying, recording and managing risks. These included fire, flood and damage to the building. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. For example there was a fire risk assessment which showed the various actions taken to mitigate the risks.

Communication with staff was excellent. There was a weekly staff meeting which took place when the practice was closed so there were no distractions. It was attended by all the staff on duty at the time. During these discussions staff were provided with information about the practice including training opportunities, any changes within the practice. Staffing issues were discussed openly including the impact of events on the individual, the team and practice performance. For example following the flood staff were regularly rotated around reception duties because these were particularly stressful at that time. This was corroborated by staff members who said they had told managers of the pressure of working on reception during the disruption the flood had caused. The managers had listened to their concerns and ensured that this difficult work was evenly distributed.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly. For example there were clinical meeting twice a month. There were regular meetings of administrative staff. There were fixed agenda items for different meetings.

Are services well-led?

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

Clinical meeting included significant events, NICE guidelines, medicines management and nursing and doctor issues. Other meeting agendas included general administration, scanned documents and QOF performance. The partners held fortnightly meetings where business and long-term strategic issues were discussed.

We noted that the meetings were effective and issues were resolved. Staff were able to influence the way the practice was run. For example minutes showed staff stating that GPs needed feedback about technical aspects of the patient record system and that that feedback had taken place. In another example staff were updated about the change in status of asylum seekers from a nearby town and the need to be alert to any health needs that arose from this.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies for example disciplinary procedures, induction policy, and recruitment, intended to support staff. There was a handbook that was available to all staff, which included sections on equality and harassment and bullying at work. The practice had a whistleblowing policy. Staff we spoke with knew where to find these policies if required.

There had been a severe flood to the building in February 2014. It had originated on the top floor during a weekend and had inundated the building. From talking with staff and patients and reading comments it was clear that it had placed great strain on the practice. However the practice had continued to serve the patients. Volunteers from the PPG helped direct patients to temporary treatment and consulting rooms and staff were flexible in working procedures. Patients and staff alike felt this was an excellent example of leadership and team work within the practice. We heard and saw many comments to the effect that without this team spirit the practice could not have maintained the level of service provision that it did.

Seeking and acting on feedback from patients, public and staff

The practice obtained feedback from patients through a variety of means, including complaints, patients' surveys, the PPG and through suggestion boxes in the waiting room. There was an action plan resulting from this feedback.

There were three areas for action; prescriptions online, text reminders and online appointments. The actions taken to promote them included; flyers to be attached to prescription returns, promotion at coffee mornings and use of the practice's newsletter.

We looked in detail at the process by which the new appointments system was designed. There was a series of meetings during which all the available staff were canvassed. It was a difficult problem solving exercise and staff were asked to "put their thinking caps on". Views were collected at meetings, through e-mails and informally. Staff said that they felt comfortable making suggestions and it was clear that they were listened to by the managers. As the development progressed it was fed back to staff, and the PPG, so that they were engaged in the process. From talking with staff and patients it was clear that this major change had been carried through with so little disruption because of the involvement of the staff and patients in its implementation.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. From staff files we saw that regular appraisals took place which included a personal development plan. Staff were very positive about the practice commitment to development. Administrative staff told us about the addition responsibilities that were part of their development and there were leads for various functions including for scanning and documentation, prescribing and medical audit. There was a very low turnover of staff.

The practice was an accredited training practice. There was no qualified GP trainer at the practice at the time of the inspection so there were no GPs under training. However, as a training practice, it was subject to scrutiny and inspection by Health Education Kent, Surrey and Sussex (called the Deanery) as the supervisor of training. Therefore GPs' communication and clinical skills were regularly under review.