Oakwood Medical 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.

Summary of findings

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Summary of findings

Overall summary

Oakwood Medical Centre is a GP surgery which provides primary medical care and a range of services including maternity care, sexual health and minor surgery clinics to over 7000 people in the Enfield area of north London. It is open Monday- Friday 8am to 6.30 pm and on Saturday mornings. Outside of these times an out of hours service is available.

Before our inspection we talked to a range of health and social care professionals in the community who engaged with patients from Oakwood Medical Centre. These included pharmacists, community matron and care home managers. We talked to three members of the Patient Participation Group (PPG). On the day of the inspection we observed staff talking to patients and spoke to three non-clinical staff including the practice manager, two nurses and three doctors including the clinical lead. We reviewed practice management and staff files, and 17 comment cards which patients had posted on the reception desk.

The regulated activities we inspected were diagnostic and screening procedures, family planning, surgical procedures, treatment of disease and disorder or injury and maternity and midwifery services.

The practice had systems in place to protect patients from avoidable harm and abuse. Significant adverse events (SAEs) were reviewed and key learning points shared with staff. Care and treatment was delivered in line with recognised best practice standards such as NICE guidelines. The practice worked effectively with other healthcare providers in the community such as care homes. Staff approached people in a person centred way and they tried to accommodate people's different needs. One patient with learning disabilities found it difficult to remember their medical appointments so staff telephoned them on the day to remind them to attend.

There were systems in place to monitor and improve quality. The practice had received adverse comments in patient surveys about telephone access to the surgery and the appointments system. In response to this staff had introduced a number of changes such as extending surgery hours, online booking and more staff at peak times to answer phones. The practice actively involved patients by responding to their comments on the NHS Choices website and responding to suggestions made by the PPG and in patient surveys.

There was a clear leadership and governance structure and staff aimed to provide a person-centred service.

Older people were offered annual health checks and worked with multidisciplinary teams to improve and coordinate their care.

People with long term conditions such as diabetes and learning disabilities received regular reviews of their health and medication at the practice.

The practice provided regular family planning and sexual health clinics as well as appointments for teenagers who requested confidential advice on contraception and sexual health.

The practice responded to the needs of working age people and those recently retired by changing and reviewing the appointments system to improve access.

Staff accommodated and changed their procedures to serve the needs of vulnerable people who had poor access to primary care.

A nurse-led service was provided for people with poor mental health and clinical staff worked closely with the local community mental health teams and psychiatrists.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The provider had systems in place to protect patients from avoidable harm and abuse. Staff were familiar with safeguarding policies and procedures. Safeguarding information was followed up and shared with relevant organisations. Significant adverse events (SAEs) were reviewed and key learning points shared with staff.

Infection control procedures were implemented by staff throughout the practice and shortfalls identified during an audit were actioned. Staff were trained in basic life support and had dealt with medical emergencies appropriately.

Appropriate recruitment checks were carried out on staff before they started to work at the practice.

Are services effective?

Clinical staff received updates relating to best practice or safety alerts electronically or when attending meetings and training. They used these updates to carry out monitoring and reviewing of patient care and treatment which led to improvements for patients for example with regard to access to appointments.

Staff were appropriately qualified and had opportunities to develop their skills and knowledge. They had annual appraisals although non-clinical staff had no formal supervision meetings. Staff felt supported and valued. Although there were separate clinical and practice meetings there was communication and sharing of information between staff.

The practice worked effectively with other healthcare providers in the community. There was regular liaison and staff attended multidisciplinary meetings to coordinate effective care for patients. This included carrying out audits. Care and treatment was delivered in line with recognised best practice standards such as NICE guidelines.

A range of healthy living clinics were held at the surgery and patients had access to information on health promotion and advice.

Are services caring?

Staff approached people in a person centred way and they tried to accommodate people's different needs. They used interpreting services for patients with a poor understanding of English. One patient with learning disabilities found it difficult to remember their medical appointments so staff telephoned them on the day to remind them to attend.

Summary of findings

Patients and relatives described the staff as respectful, helpful and caring. Newly bereaved relatives were treated with compassion and they were also sent letters of condolence.

Confidentiality was respected and information about patients was communicated electronically or by letter and not on the telephone. The practice took steps to maintain patient confidentiality when they were in the reception and waiting areas.

Are services responsive to people's needs?

The provider understood the diverse needs of the different populations they served. They trained staff and provided services to accommodate those needs. They had regular multi-disciplinary meetings at the surgery to ensure that appropriate patient information was shared between the services

The practice had received adverse comments in patient surveys about telephone access to the surgery and the appointments system. In response to this they had introduced a number of changes such as extending surgery hours, online booking and more staff at peak times to answer phones. More recent surveys indicated that the situation with regards to access to the service had improved.

The complaints system was advertised to patients. Complaints and incidents were discussed at team meetings and changes implemented where necessary.

Are services well-led?

There was a clear leadership and a governance structure with areas of responsibility for clinical staff. Staff understood practice values and aimed to provide a person-centred service. They felt supported and able to make suggestions and give feedback. Staff had yearly appraisals and opportunities for learning and development.

There were systems in place to monitor and improve quality. The practice actively involved patients by responding to their comments on the NHS Choices website and responding to suggestions made by the PPG and in patient surveys.

The practice management understood and identified particular risks with regard to their practice population which they told us was steadily increasing, and they had implemented a number of measures to mitigate this risk.

Summary of findings

The six population groups and what we found

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

Older people

The service was responsive to the needs of older people. There was good access to the surgery and its facilities for those with mobility or hearing difficulties. Surgery staff had an effective relationship with staff in care homes and carried out home visits when necessary.

All people in this age group were offered a health check and the surgery was trying to reduce emergency admissions to hospital. Clinical staff worked with the multidisciplinary teams to improve and coordinate care. Patients said staff treated them with respect and took time to explain their care and treatment.

People with long-term conditions

The service was responsive to the needs of people with long term conditions. People with long term conditions such as dementia and diabetes were offered regular health checks and medication reviews. The practice provided specialist staff and clinics. Patients told us they were happy and felt involved with their care and treatment.

Mothers, babies, children and young people

The service was responsive to the needs of mothers, babies, children and young people. Staff had an effective working relationship with community midwifery services and the health visitor. The practice responded to the needs of mothers and babies by providing facilities for them such as a separate room for breastfeeding babies. Staff were fully engaged with safeguarding procedures and flagging those vulnerable children and families on their database so that relevant staff had access to up to date information.

The service provided appointments for teenagers who requested confidential advice on contraception and sexual health. They held regular family planning and sexual health clinics.

The working-age population and those recently retired

The practice was responsive to working age people and those recently retired. The appointments system was continually under review and changes had been implemented to improve the service this group. The service provided early morning appointments from 8am and later appointments up to 6.30. There was a Saturday morning clinic.

Summary of findings

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

The practice provided responsive services to people in vulnerable circumstances. There were no barriers to accessing Oakwood Medical Centre for people such as those who were homeless. Staff changed their procedures to accommodate the needs of this group of patients.

The practice identified adults with learning disabilities and a dedicated nurse offered them an annual health check. At the check the nurse would speak to the person and their carer/relative (if available) and give them advice and information on other facilities they could access such as day centres.

People experiencing poor mental health

The practice provided responsive services for people experiencing poor mental health. They offered a nurse-led service for some of these patients and worked closely with the local community mental health teams and psychiatrists.

The relative of one patient with poor mental health felt the doctor had gone out of their way to access further support and services for their relative.

Summary of findings

What people who use the service say

We spoke to three patients as part of the inspection and they were complimentary about the staff and the service they received. They told us they received good care and treatment as well as emotional support when they needed it. People said it was sometimes difficult to get through on the phone but that the appointments system had changed and was now available online. One person had been unable to get an appointment on the day they phoned but when staff told them the doctor would telephone them back, they did so.

We also looked at the last two annual patient surveys carried out by an independent research company and found that the practice scored above the benchmark in most areas. Patients felt that doctors and nurses spent time with them, were polite and considerate and involved them in decisions about their treatment. The practice was rated less well for access to the service with regards to the ease of getting through on the telephone. However, this situation had improved according to the latest survey. 17 patients completed comment cards which were left in the reception area and all of them were complimentary about the staff and the service they received citing staff as being polite and helpful.

Areas for improvement

Good practice

Our inspection team highlighted the following areas of good practice:

The practice used a “Breach board” to to monitor capacity and demand for routine appointments. Staff used the board to record how many times they were unable to meet patient’s needs for an appointment. This system enabled the staff to implement changes in the future planning of appointments, for example by offering longer appointments to patients with complex needs.

The practice nurse had undertaken specialist training in mental health and so was able to provide a service for those patients with poor mental health whose condition was stable.

Oakwood Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection was carried out by a CQC inspector and a GP.

Background to Oakwood Medical Centre

Oakwood Medical Centre is a GP surgery with 3 partner GPs and 3 salaried GPs. It offers a number of services such as family planning and minor surgery. They hold several specialist clinics including smoking cessation and well-woman. The surgery also runs a comprehensive programme of health promotion and education.

It is open Monday- Friday 8am to 6.30 pm and on Saturday mornings. After normal practice hours there is an out of hours service which provides cover for the practice.

The practice provides primary care for over 7,000 patients within the Enfield Clinical Commissioning Group (CCG) area of north London. The practice list size has increased over the last six years and has a high proportion of care homes for older people and those with poor mental health. Data from Public Health England indicates the practice has a higher than CCG average of over 65 year olds and under 18 year olds. The population groups the practice served is very diverse and there is a higher than average deprivation rate affecting children.

The main concern identified prior to the inspection was poor telephone access to appointments. A positive aspect was that the practice was clinically well organised.

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.

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 service and asked other organisations to share what they knew about the service. We reviewed the comments people had made on the NHS Choices website. We asked the practice to put comment cards in the

Detailed findings

reception area, where patients and carers/relatives could share their views and experiences of the practice. We spoke to three patients who were members of the Patient Participation Group (PPG).

We carried out an announced inspection on 28 May 2014. The inspection took place over one day and the inspection team comprised a lead inspector and a GP. Before the inspection we talked to a range of health and social care professionals in the community who dealt with patients from Oakwood Medical Centre. These included pharmacists, community matron and care home managers. We talked to three members of the Patient Participation Group (PPG). On the day of the inspection we observed staff talking to patients and spoke to three non-clinical staff including the practice manager, two nurses and three doctors including the clinical lead. We reviewed practice management and staff files, and 17 comment cards which patients had posted on the reception desk.

Are services safe?

Summary of findings

The provider had systems in place to protect patients from avoidable harm and abuse. Staff were familiar with safeguarding policies and procedures. Safeguarding information was followed up and shared with relevant organisations. Significant adverse events (SAEs) were reviewed and key learning points shared with staff.

Infection control procedures were implemented by staff throughout the practice and shortfalls identified during an audit were actioned. Staff were trained in basic life support and had dealt with medical emergencies appropriately.

Appropriate recruitment checks were carried out on staff before they started to work at the practice.

Our findings

Safe patient care

The practice had effective arrangements in place for reporting safety incidents. We reviewed three recent significant adverse events (SAEs) which had been filed. Details that were recorded included the key risks and learning outcomes for staff. One SAE concerned a delayed referral of a patient to a hospital. Changes had been implemented following this so that all doctors completed their own referrals at the time of the consultation or at the end of surgery. They were also recorded in a record book, which was checked every week by a member of administrative staff, and this acted as a back- up system to ensure referrals were made in an organised and timely manner. Actions had then been reviewed to check that improvement had been sustained.

Staff were clear about the process for reporting SAEs and told us they discussed them if appropriate at team meetings or in discussion with individual staff members.

Learning from incidents

Staff described learning that took place from incidents. On one occasion a letter had been sent in error to a newly deceased patient which had caused distress to bereaved relatives. Staff confirmed that when they were notified of the death of a patient, a message was sent to all staff to ensure records were appropriately updated to ensure future correspondence would not be sent out inappropriately.

Safeguarding

Clinical and non-clinical staff had undertaken a formal safeguarding course within the last year as well as in-house training. Training records showed that doctors were trained to Level three (the highest level) and nursing staff to Level two for safeguarding children, which followed national guidelines. They had also undertaken vulnerable adults safeguarding training. There were clear safeguarding policies and procedures in place and all staff were able to describe the different forms of abuse and how they would report a concern.

Staff knew who the safeguarding lead and deputy leads were for both children and vulnerable adults. Incidents had been reported and also information received from external sources such as the Health Visitor. The safeguarding children's lead attended quarterly safeguarding meetings

Are services safe?

with other agencies and cases were followed up proactively. Information about children who did not attend hospital appointments for example, was examined and, where necessary, alerts put on the practice database which then flagged up other child family members who may be vulnerable. This approach meant that there was a focus on early identification of children who may be at risk of abuse.

Monitoring safety and responding to risk

There was a business continuity plan in place to deal with emergencies which might interrupt the smooth running of the service. The clinical lead told us that they tried to ensure continuity of care by reducing the use of locum doctors. We were told they were only used in emergencies and to cover planned absences.

Medicines management

All staff we spoke to described the procedure for ordering repeat prescriptions. They always made sure that they had the previous written consent of the patient if someone else came to collect the prescription on their behalf. The prescription box was stored overnight in a locked cupboard.

Medicines (including those used for immunisation) were stored in clean fridges and temperatures were monitored on a daily basis to ensure the medicines were fit for use. We saw records of those temperature checks and staff were aware of what action to take if the fridges were not operating at the correct temperatures.

Cleanliness and infection control

Oakwood Medical Centre was clean and tidy throughout. It had been decorated in the last few years and easy to clean flooring had replaced carpeting. All the treatment rooms appeared clean and staff described how they used sanitiser to wipe down couches and equipment between patients. There were alcohol hand gel dispensers throughout the premises and guidance on hand-washing techniques displayed at wash hand basins.

Sharps were handled and disposed of safely and accessible sharps waste bins were located away from where patients sat. We saw evidence that the infection control lead and deputy had carried out a recent infection control audit of the surgery. They identified some shortfalls, such as lack of a separate waste bin to dispose of soiled baby nappies and no staff rota to check on the toilet facilities during the day. These issues had since been actioned.

Comment cards we reviewed and patients we spoke to were happy with the general cleanliness and décor of the practice. Staff were knowledgeable about the importance of hygiene and infection control.

Staffing and recruitment

Appropriate checks had been carried out before recruiting staff. We looked at recent staff recruitment records for a GP and a nurse. People's identity had been verified and eligibility to work in the UK. There were employment and character references. The provider also made checks that the member of staff had indemnity insurance and was a member of their professional body and on the GPs performer's list. This helped to ensure that new staff met the requirements of their professional bodies and had the right to practice. However, the GP record we looked at did not have a current criminal records check (Disclosure and Barring Service DBS). Applicants were required to supply their own DBS certificate and this doctor had recently worked at the practice as a locum and had a criminal records check at that time. We saw evidence that the GP had applied for a new DBS.

Dealing with Emergencies

Clinical and non-clinical staff had undergone training in basic life support. All staff including non-clinical staff were able to describe how they would react in the event of an urgent or medical emergency. Staff described an incident when a patient had collapsed in the waiting area. They said they accessed the emergency equipment to deal with the situation and erected a screen to preserve the dignity of the patient.

Fire safety drills and checks of the alarm system were carried out regularly. Staff had received training and three members of staff were nominated as fire safety wardens.

Equipment

Emergency equipment included oxygen and a defibrillator. There was also an anaphylaxis kit which was clearly labelled and accessible. These kits were regularly checked to ensure they were in working order and emergency medicines we saw were all within their use-by date. Two members of staff were responsible for carrying out these checks and when they were not available another staff member took over the role.

Are services effective?

(for example, treatment is effective)

Summary of findings

Clinical staff received updates relating to best practice or safety alerts electronically or when attending meetings and training. They used these updates to carry out monitoring and reviewing of patient care and treatment which led to improvements for patients for example with regard to access to appointments.

Staff were appropriately qualified and had opportunities to develop their skills and knowledge. They had annual appraisals although non-clinical staff had no formal supervision meetings. Staff felt supported and valued. Although there were separate clinical and practice meetings there was communication and sharing of information between staff.

The practice worked effectively with other healthcare providers in the community. There was regular liaison and staff attended multidisciplinary meetings to coordinate effective care for patients. This included carrying out audits. Care and treatment was delivered in line with recognised best practice standards such as NICE guidelines.

A range of healthy living clinics were held at the surgery and patients had access to information on health promotion and advice.

Our findings

Promoting best practice

Care and treatment was delivered in line with recognised best practice standards such as NICE guidelines.

Clinical staff received updates relating to best practice or safety alerts electronically or when attending meetings and training. They used these updates to carry out monitoring and reviewing of patient care and treatment which led to improvements for patients. For instance, the practice had recently signed up to Coordinate my Care (CMC) and patient records were updated with information on their end of life care. This approach meant that care for was coordinated with

The clinical team were using a new local referral pathway for acute assessment of older people to provide prompt and appropriate care as well as reduce unplanned admissions to hospital. It meant that GPs could phone and speak with a consultant and have a patient assessed the same or next day at the unit with transport provided to take them to the unit if necessary. The practice had referred 11 patients to the unit but it was too early to evaluate the outcomes for patients.

The practice nurse described how in the immunisation clinic she gave patients advice based on evidence based guidelines but if they chose not to accept this advice she respected their wishes. Both clinical and non-clinical staff were familiar with the principles of the Mental Capacity Act 2005 and one doctor told us they had carried out assessments for those people who lacked the capacity to consent. Care home staff we spoke to told us that best interest meetings which involved relatives and the doctor had taken place where a patient had lacked capacity. One relative of a patient described how their doctor had gone out of their way to access agencies that would provide specialist treatment for a relative with mental health needs.

We saw that staff carried out assessments of people's health care needs. People with diabetes were seen by a specialist diabetic nurse who attended the practice every week.

Patients we spoke to and those who responded on comment cards were happy with their care and treatment.

Are services effective?

(for example, treatment is effective)

Management, monitoring and improving outcomes for people

The practice continually monitored outcomes for patients and attended monthly peer group meetings with neighbouring surgeries and the Clinical Commissioning Group (CCG). They received information at the meetings about issues such as prescribing medication/ admissions of their patients at hospital accident and emergency departments, and used it to try to improve patient outcomes by carrying out their own clinical audits and reviews.

The lead clinician told us the practice had recently carried out a medication audit. They had reviewed patient records to ensure that medication was only being prescribed when linked to a particular care pathway and this reasoning was clearly annotated in the records. This meant that patients should only be prescribed with medication which was necessary for their care and treatment. Another audit had revealed that a large proportion of older patients had not attended for a medication review. It was decided to carry out a medication review whenever they attended for another issue and in this way increase the number of patients undergoing a review.

Staffing

We spoke to the practice nursing staff who were available on the day of the inspection. They told us they received appropriate and effective professional support. One staff member said they had asked for and received training over and above that necessary for their role. They had undertaken specialist training in mental health and so were able to provide a service for those patients with poor mental health whose condition was stable. They discussed cases and concerns with doctors and relevant other practice staff and attended clinical meetings with the doctors. One staff member said they felt they had a voice within the practice but that sometimes it was difficult to exchange information and coordinate these meetings as the GP partners all worked on a part –time basis.

All staff we spoke to said they received an annual appraisal and protected time for training. Clinical staff and the practice manager had appraisals by clinicians. We reviewed staff files and found evidence of detailed appraisals which included learning and development and targets. Staff had received mandatory training and up to date training in safeguarding, infection control and basic life support. New staff received a handbook and had induction periods and doctors underwent a three month probation with close supervision on a weekly basis. There were both clinical and practice team meetings and staff were encouraged to email or ask for items to be put on the agenda. There was also feedback from one meeting to the other so that staff were kept informed of matters affecting all areas of the practice. However non-clinical staff did not have formal supervision meetings and the provider may wish to note that they were not able to demonstrate that that they were adequately supervising staff because there were no records of these meetings.

Nurses also attended clinical meetings within the practice which were held every two to four weeks. GPs had "touch base" sessions during the day to enable discussion of complex cases and provide support. The practice manager arranged consultants to attend and address the meetings and this formed part of the continuing professional development of clinical staff.

Working with other services

As part of this inspection we spoke to health and social care professionals in the community such as pharmacists, care home managers and community matron. The pharmacists said there were few problems with prescriptions and medication reviews. Any queries could be resolved over the phone. The care homes and community matron described a good working relationship with the practice and that they found it easy to access them by telephone. Practice staff confirmed that they received regular consultation updates from the out of hours provider by fax.

The practice placed patients receiving end-of –life care on the CMC register to ensure there was effective communication between services regarding these patients. A member of administrative staff had been specially trained as an advocate and contact for the carer. The aim was to improve care and decrease admissions to hospital for this group of patients. There were multidisciplinary meetings with district nurses and the health visitor and they confirmed that the practice manager sent them the minutes of those meetings. There had been very regular meetings with the district nurses but a recent change of district nursing staff meant there had not been one for some time. However, there was regular meeting and liaison with the health visitor.

Are services effective?

(for example, treatment is effective)

Health, promotion and prevention

New patients were offered a consultation to ascertain details of their past medical and family histories. Nursing staff used these to carry out additional screening checks for cholesterol and sugar levels (which can be an indicator for diabetes), for those who did not have a chronic illness. Although there were no formal audits on the effectiveness of this screening, nurses told us that they picked up a significant number of patients with abnormal results and were able to refer them more quickly for further treatment. Other patient screening which the practice carried out was monitoring blood pressure and body mass index. There was a healthcare monitor machine in the waiting area for patients to use themselves and gave information to them on their height and weight. For those patients who were found to be in need of healthy living advice, they were referred to a "health trainer" at a nearby facility for weight loss. One patient we spoke to confirmed they had been referred to the trainer.

There were up to date leaflets and posters with information such as smoking cessation and sexual health available in the waiting area. There was also a television showing a health advice programme. There was up to date information on the practice website.

Healthy living clinics were held at the practice and included smoking cessation, well-woman and child health.

Are services caring?

Summary of findings

Staff approached people in a person centred way and they tried to accommodate people's different needs. They used interpreting services for patients with a poor understanding of English. One patient with learning disabilities found it difficult to remember their medical appointments so staff telephoned them on the day to remind them to attend.

Patients and relatives described the staff as respectful, helpful and caring. Newly bereaved relatives were treated with compassion and they were also sent letters of condolence.

Confidentiality was respected and information about patients was communicated electronically or by letter and not on the telephone. The practice took steps to maintain patient confidentiality when they were in the reception and waiting areas.

Our findings

Respect, dignity, compassion and empathy

During the inspection we observed staff in the reception area speaking to people respectfully and trying to accommodate their needs. Patients we spoke to all told us that staff treated them with respect and dignity. One person related that a member of the reception staff had once spent 45 minutes helping them to choose a hospital to attend for further treatment and that they listened to them helpfully and sympathetically. Comments made on the cards included staff were professional and caring.

Condolence letters were routinely sent to the family of patients who died and staff described instances when they had taken time to comfort a bereaved relative and give them a cup of tea. Leaflets on bereavement and a local support group were available for people.

Staff approached people in a person centred way and they tried to accommodate people's different needs. One person who was homeless had wanted to register with the surgery. As they did not have a home address they were offered to put down the surgery as their address. They later requested that surgery staff communicated with them at the address of their friend and so in this way was able to access the service. One patient with learning disabilities found it difficult to remember their medical appointments and staff telephoned them on the day to remind them to attend. One staff member told us that they took more time and spoke clearly to people who were hard of hearing.

The practice manager and staff described how they maintained patient confidentiality. A television showing health promotion information was kept on in the waiting area with the sound on to help to mask sound from the consulting rooms. Although the main surgery reception was next to the patient waiting area, patients could ask to speak to a member of staff confidentially at the private reception area which was clearly marked.

Confidentiality was respected and information about patients was communicated electronically or by letter and not on the telephone. Reception telephones had been relocated to the first floor to provide a calmer environment and create a greater level of confidentiality for patients.

Are services caring?

Paper records were stored securely on the first floor of the surgery and computer records could only be accessed with secure login details which were given to authorised staff members.

Patients were able to request to be seen by a male or female doctor. A chaperone policy was in place and information regarding it was displayed in treatment rooms. A patient could request to have someone present in the room during an examination.

Involvement in decisions and consent

Patients and their relatives were able to contact the surgery when needed to speak to someone about their care. However staff told us that they always ensured when people other than patients came to collect prescriptions or referral letters they asked to see letters of consent signed by the patient before releasing the documents. Patients described being supported to understand their diagnosis and being given options for care and treatment.

For people whose understanding of English was poor, the practice used a service called Language Line when necessary and a loop system was available for those who were hard of hearing and used a hearing aid. Between them the practice staff spoke and understood a number of different languages.

Staff took all reasonable steps to enable people to make decisions about their own care and treatment wherever possible. They understood the principles of the Mental Capacity Act 2005 and had access to the community psychiatric team and other professionals.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The provider understood the diverse needs of the different populations they served. They trained staff and provided services to accommodate those needs. They had regular multi-disciplinary meetings at the surgery to ensure that appropriate patient information was shared between the services.

The practice had received adverse comments in patient surveys about telephone access to the surgery and the appointments system. In response to this they had introduced a number of changes such as extending surgery hours, online booking and more staff at peak times to answer phones. More recent surveys indicated that the situation with regards to access to the service had improved.

The complaints system was advertised to patients. Complaints and incidents were discussed at team meetings and changes implemented where necessary.

Our findings

Responding to and meeting people's needs

Staff understood the different needs of the population that the practice served and accommodated those needs. For instance, the surgery covered a high number of mental health units. The practice nurse has undertaken specific training in mental health and provided a service for those patients whose condition was stable. They liaised regularly with the community psychiatric nurse and this supported continuity of care for this group of patients which was especially important.

Patients with specific needs were coded on the database to ensure that all staff were aware of their circumstances. For older patients the practice was introducing an annual physical health check and targeting weight loss and bowel problems within this group. At the present time there was no named GP for this group of patients.

Oakwood Medical Centre had a maternity protocol in place and held regular maternity care clinics. They also tried to organise child immunisation clinics at the same time to make it easier for mothers with young children so they need only attend the surgery once. Pre-school booster appointments during school holidays were also provided in the afternoon rather than morning as staff had identified that there was a higher attendance for appointments later in the day.

The practice nurse told us they had a good working relationship and regularly liaised with community healthcare staff such as the health visitor and community matron. They had regular multi-disciplinary meetings at the surgery to ensure that appropriate patient information was shared between the services.

Access to the service

Before our inspection we reviewed comments made by patients on the NHS Choices website and results of a patient survey carried out in 2013. These sources indicated that patients found it difficult to make an appointment and their experience of the appointment system was poor. We discussed this with the practice manager who told us they were aware of this and had worked closely with the CCG to implement changes and make improvements in this area. Within the last six months they had set up online appointment booking and repeat prescription requests. One patient we spoke to told us they had successfully used

Are services responsive to people's needs?

(for example, to feedback?)

this system and found that it worked well. The practice had identified peak times for telephone calls and more staff answered the phones during these times. There was extra GP surgery time of four hours per week with appointments available in the middle of the day. The practice analysed missed "did not attend" (DNA) appointments and for those patients who gave mobile telephone numbers there was a texting service to remind people about their appointments, which also had the facility for them to cancel the booking. This had improved DNA rates and also the ability of the practice to improve access for patients.

All three partner GPs had undertaken specific training in telephone triage and this was introduced to meet the demands of same day appointments. This had changed recently as demand became too high so that it was now offered to patients in the afternoon only. Staff felt that this worked well and one patient told us that on one occasion when they had phoned they had been advised that a doctor would call them back. They confirmed that this had happened and so were happy with the service. Administrative staff used a "clicker" if they were unable to meet patients' needs for an appointment and these were counted up at the end of the day and marked on a "Breach board". This system enabled the staff to monitor capacity and demand for routine appointments. This had helped in future planning of appointments. Patients with complex needs for example, could be offered 15 minute instead of the usual 10 minute appointments so that they would have enough time with the doctor to attend to their needs. The practice manager told us they continued to monitor and respond to comments on the NHS choices website and discussed the issue with the PPG.

The practice had a clear, up to date practice leaflet containing information about the services provided and also clear and accurate information on its website. The surgery had telephone access and surgeries offered between 8am and 6.30pm Monday to Friday to accommodate the needs of working people especially. There were appointments available on Saturday mornings. During the out of hours period people could access the NHS 111 telephone service.

We spoke to healthcare community staff who told us that they found the service easy to access at all times and that doctors attended home visits when necessary.

Concerns and complaints

Information on how patients could make a complaint, including appropriate contact details and clear timescales, were on display in the waiting area and contained in the practice leaflet. Staff were aware of the complaints policy and how to respond if a patient made a complaint. They told us that complaints and serious incidents were discussed at team meetings and changes made where appropriate. Following one error staff now always booked appointments and checked information by confirming a patient's name and date of birth. We reviewed documentation containing details of complaints and the action taken to resolve the issue. People's complaints were investigated and resolved, where possible, to their satisfaction.

As well as national patient surveys, the practice carried out its own surveys which could be completed online. A "tracker" IPad was available at the reception desk so that patients could record their comments electronically. Staff told us there had been poor uptake of this facility by patients and they had not yet analysed the results of this. The practice manager responded to comments on NHS choices sometimes inviting people to speak to them regarding their complaint. The practice had an engaged and active PPG and responded to their suggestions for improving the quality of care. For instance, the PPG had asked that health checks for over 75 year olds should be offered and this had now been implemented.

Staff were familiar with the whistleblowing policy which contained details of external organisations they could contact if they should have any concerns regarding senior staff.

Are services well-led?

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

Summary of findings

There was a clear leadership and a governance structure with areas of responsibility for clinical staff. Staff understood practice values and aimed to provide a person-centred service. They felt supported and able to make suggestions and give feedback. Staff had yearly appraisals and opportunities for learning and development.

There were systems in place to monitor and improve quality. The practice actively involved patients by responding to their comments on the NHS Choices website and responding to suggestions made by the PPG and in patient surveys.

The practice management understood and identified particular risks with regard to their practice population which they told us was steadily increasing, and they had implemented a number of measures to mitigate this risk.

Our findings

Leadership and culture

Staff were able to express the practice values and told us they wanted to provide a patient-centred service they would be happy for their family to receive. Senior management said they wanted to improve the service and to do that it was important to value staff and create a good working environment. They said they worked hard to have a relationship of respect and equality throughout the whole team. Staff felt supported and valued. They said there was an open culture where they felt able to have their voice heard. Many of the staff had worked at the practice for a more than ten years which meant that patients were provided with continuity of care as far as possible.

Governance arrangements

When we asked practice staff about governance arrangements they were clear about who was responsible for each area. There were notices in staff working areas and treatment rooms listing the leads and deputy leads in areas such as safeguarding and infection control.

The clinical lead emphasised the importance of quality and used performance management to improve quality of care and consistency for patients. They had a "buddy" system so that each partner GP mentored a salaried GP. New doctors received an induction and review at three months and again after six months. There were weekly clinical supervision meetings during which they could discuss complex cases. Each GP completed their own referrals of patients to other services. One doctor told us they received feedback and suggestions about these referrals. This meant that there were checking systems in place.

Systems to monitor and improve quality and improvement

Clinical staff including the practice manager attended monthly peer group meetings and also had their own clinical meetings within the practice. They were aware of the differing needs of the population served by the practice and had set up a risk stratification tool on their patient database to identify and flag different groups of patients so they could monitor and improve their management. For instance, patients over 65 with one or more long term conditions and multiple A & E attendances/ GP consultations could be managed more effectively.

Are services well-led?

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

We saw the minutes of three clinical meetings and found they also reviewed safeguarding information, SAEs and lessons learned. There were ongoing systems to monitor the safe running of the practice such as fire safety checks and equipment servicing.

Patient experience and involvement

The practice monitored patient comments on the NHS choices websites and carried out their own patient survey results. They held regular PPG meetings and actioned issues raised by patients. We looked at minutes of two recent meetings which demonstrated that the matters discussed were wide ranging. They covered matters such as the CCTV in the car park which had been upgraded in response to concerns raised by the PPG to an explanatory report on an older person's assessment unit which had been set up at a local hospital. The PPG had requested that all people over 75 years old be offered a health check. The practice had considered this and decided to include it as one of their key performance indicators for 2014.

Patient surveys were followed up with action planning to address issues identified. The main issue in the last few years had been low satisfaction with the appointments system which had now been significantly changed. The most recent survey indicated an improvement in patient satisfaction levels and there was commitment from senior management to continue listening to patients and involving them.

Staff engagement and involvement

The practice management had systems in place which enabled learning and feedback was shared with staff. Clinical staff had a "day book" which was used to exchange information and message each other. Staff were able to request items to be put on the meeting agendas and the open door policy enabled them to discuss issues with members of practice management.

Staff received yearly appraisals which were detailed and gave staff the opportunity to discuss their work and leaning and development in the future. Staff told us they felt supported and made suggestions without fear discrimination. One member of staff told us they had never been refused training they had asked for.

Practice management staff attended locality and peer group meetings which provided opportunities for shared learning.

Learning and improvement

The practice manager described their individual targets and other staff told us they had protected learning time and that information was shared and cascaded.

There was a commitment at all levels of practice staff to learn from feedback, complaints and incidents. There was an emphasis on management to work with stakeholders particularly the CCG and PPG, to improve the service.

Identification and management of risk

The senior management team was aware of future risks and were succession planning as two of their staff were shortly taking maternity leave. They had carried out comprehensive risk assessments and flexible working for pregnant staff.

They understood and identified particular risks with regard to their practice population which was steadily increasing. For example, their area had a high number of care homes for older people which meant that people were sometimes admitted to the home and shortly afterwards to hospital before the GPs had time to assess them. They had implemented a number of measures to mitigate this risk such as referring people to the older persons assessment unit and signing up to Coordinate my Care (CMC).

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

The service was responsive to the needs of older people. There was good access to the surgery and its facilities for those with mobility or hearing difficulties. Surgery staff had an effective relationship with staff in care homes and carried out home visits when necessary.

All people in this age group were offered a health check and the surgery was trying to reduce emergency admissions to hospital. Clinical staff worked with the multidisciplinary teams to improve and coordinate care. Patients said staff treated them with respect and took time to explain their care and treatment.

Our findings

During our inspection we found that the practice provided safe, effective, responsive, caring and well-led services for older people. All the patient areas of the surgery were on the ground floor and were accessible for those who had mobility difficulties or were wheelchair users. A loop system had been fitted for those patients who may be hard of hearing. Staff we spoke with at two care homes told us they had a good relationship with Oakwood Medical Centre and doctors attended for home visits when requested.

The practice was proactive in trying to reduce the number of unplanned admissions to hospital of patients who were over the age of 75. They had a system in place to identify this group of patients which they used to contact people and invite them for a health check. They also referred people to an older persons assessment unit. They were considering having a named accountable GP and putting care plans in place for older patients.

Administrative staff had been trained to act as advocates and contacts for carers. They had found a discrepancy between the number of patient deaths and those with end of life plans and were analysing the database to identify those patients in need of palliative care. There was regular contact with the palliative care and district nursing teams which gave clinical staff the opportunity to discuss and review people's care and treatment needs.

People told us they were happy with the service provided and were treated with respect. They said staff took time with them when needed to discuss their care and treatment. People told us they could have same day appointments or telephone consultations if there were no appointments left.

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

The service was responsive to the needs of people with long term conditions. People with long term conditions such as dementia and diabetes were offered regular health checks and medication reviews. The practice provided specialist staff and clinics. Patients told us they were happy and felt involved with their care and treatment.

Our findings

During our inspection we found the practice provided responsive services for people with long term conditions. The practice provided specialist clinics to undertake reviews for people with diabetes and asthma. New patients were screened by nursing staff for cholesterol and sugar levels to identify those who may be at risk of developing long term conditions. This helped to prevent patients developing conditions or manage their conditions more effectively. People were signposted to other support services for example for people who had partners with dementia.

Information on helping people to manage their conditions was available in the waiting area and staff printed information where necessary from their computer database system to give them. People told us they were happy with their care and treatment and felt staff engaged and involved them. People were offered access to other healthcare services such as the health trainer.

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

The service was responsive to the needs of mothers, babies, children and young people. Staff had an effective working relationship with community midwifery services and the health visitor. The practice responded to the needs of mothers and babies by providing facilities for them such as a separate room for breastfeeding babies. Staff were fully engaged with safeguarding procedures and flagging those vulnerable children and families on their database so that relevant staff had access to up to date information.

The service provided appointments for teenagers who requested confidential advice on contraception and sexual health. They held regular family planning and sexual health clinics.

Our findings

We found the practice provided responsive services for mothers, babies, children and young people. Clinical staff had frequent communication with community midwifery services and the health visitor. They audited maternity referrals to ensure continuity of care and held family planning clinics.

There were regular mother and baby clinics and staff tried to coordinate these with child immunisation clinics so that mothers did not have to attend multiple times for these services. The practice responded to the needs of mothers and babies and had provided a breastfeeding and nappy changing room for them.

The child safeguarding lead attended quarterly safeguarding meetings with multidisciplinary teams to share information and improve the safety of vulnerable children. All staff were aware of safeguarding procedures and informed appropriate authorities when necessary. They used the practice database to highlight vulnerable children and their families so that all relevant staff would have access to up to date information.

The service provided appointments for teenagers who requested confidential advice on contraception and sexual health. They held regular family planning and sexual health clinics.

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 was responsive to working age people and those recently retired. The appointments system was continually under review and changes had been implemented to improve the service this group. The service provided early morning appointments from 8am and later appointments up to 6.30. There was a Saturday morning clinic.

Our findings

We found the practice provided responsive services for working people (and those recently retired). These times suited the needs of some working people. Patients we spoke to told us that they were satisfied with the appointments system. Staff told us they now offered more appointments during the day and telephone triage with a doctor if there were no same day appointments left.

Within the last six months the practice was able to offer online appointment booking and online repeat prescription requests, which made it easier for people to access the service. There was a text alert for those patients who submitted mobile phone details to remind them of their appointments. This text service could also be used by patients to cancel their appointment.

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

The practice provided responsive services to people in vulnerable circumstances. There were no barriers to accessing Oakwood Medical Centre for people such as those who were homeless. Staff changed their procedures to accommodate the needs of this group of patients.

The practice identified adults with learning disabilities and a dedicated nurse offered them an annual health check. At the check the nurse would speak to the person and their carer/relative (if available) and give them advice and information on other facilities they could access such as day centres.

Our findings

We spoke to reception staff who described how they had helped people to access the service. They had made arrangements for a homeless person to register with them and used a mutually agreed person to act as a contact between the surgery and homeless person. Staff took time to listen to patients such as those with learning disabilities, and understood their needs. One staff member agreed to telephone a patient with learning disabilities on the day of their appointment so that they would be reminded to attend.

There were posters and leaflets in the waiting area advising people and their families of services and support for people with learning disabilities.

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

The practice provided responsive services for people experiencing poor mental health. They offered a nurse-led service for some of these patients and worked closely with the local community mental health teams and psychiatrists.

The relative of one patient with poor mental health felt the doctor had gone out of their way to access further support and services for their relative.

Our findings

During our inspection we found that the practice took measures to safeguard people experiencing poor mental health with regard to their prescriptions. One doctor and a nurse had specialist interest and training in mental health. Patients with poor mental health, whose condition was stable, were able to access the nurse-led clinic for treatment. Both staff members worked closely with the community psychiatric team and psychiatrists.

We spoke to the manager of a residential care home for people with poor mental health including those with a diagnosis of schizophrenia. They told us that they had good communication with and response, in the event of emergencies, from Oakwood Medical Centre. They confirmed that they worked closely with the practice and the community mental health team. The relative of one patient with poor mental health commented that the GP had gone out of their way to access agencies that would provide specialist treatment for their relative.

Patients with poor mental health were offered an annual health review and attended the surgery for other conditions such as diabetes.