The OM 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.

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Om Medical Centre on 25 March 2015. Overall the practice is rated as good.

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, but no analysis had been carried out. The practice could not demonstrate that any learning had occurred from significant events and incidents.
- 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.
- Patients were able to book routine appointment s with the GP at a time that suited them. Urgent appointments were available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice sought feedback from staff and patients, which it acted on. Some audits had been carried out; we saw little evidence that audits were driving improvement in performance to improve patient outcomes.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. The practice could demonstrate that lessons were learned and communicated to support improvement. Information about safety was recorded. Significant events and incidents were monitored, reviewed and appropriately addressed. Risks to patients were assessed and managed. There were enough staff to keep people safe, but staff had not received the appropriate level of training with regard to safeguarding.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. Patients' 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. There was evidence of appraisals and personal development plans for all staff.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

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 engaged with the NHS England area team and clinical commissioning group (CCG) to secure improvements to services where these were identified. 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

Summary of findings

facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised.

Are services well-led?

Good

The practice is rated as good for well-led. The practice had a vision and a strategy to deliver this. Staff were clear about the vision and their responsibilities in relation to this. There was a leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity. There were systems to monitor and improve quality and identify risk. The practice sought feedback from staff and patients and this had been acted on. The practice had a patient participation group (PPG) who met frequently. Staff had received inductions and regular performance reviews.

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. Nationally reported data showed that outcomes for patients were good for conditions commonly found in 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 was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

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. 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 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 to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw examples of joint working with midwives, health visitors and school nurses.

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

Summary of findings

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 reflected the needs for this age group.

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, travellers and those with a learning disability. The practice had carried out annual health checks for people with a learning disability and 99% of these patients had received a follow-up and offered longer appointments for people with a learning disability.

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). 98% of people experiencing poor mental health had received an annual physical health check. 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.

Summary of findings

What people who use the service say

We spoke with five patients. We received 2 completed comment cards.

Both patients who commented were pleased with the quality of the care they had received. The themes running through the comment cards and the patient interviews were that the staff were very kind and considerate. Patients commented on how referrals were made quickly and with the patients' involvement

There is a survey of GP practices carried out on behalf of the NHS twice a year. In this survey the practice results are compared with those of other practices. A total of 367 survey forms were sent out and 109 were returned. The main results from the survey were:

- Patients said that they usually wait 15 minutes or less after their appointment time to be seen and the practice scored 64% a higher score than the local CCG average of 60% and in line with the national average of 65%
- Patients said they described their experience of making an appointment as good. The practice scored 81% which was higher than the local CCG average of 65% and the national average of 73%
- Patients said that they found it easy to get through on the phone and scored 70% which was higher than the local CCG average of 65% and in line with the national average of 73%
- Patients said that their overall experience of the practice was good scoring 79% which was in line with the local CCG average of 78% but slightly lower than the national average of 85%
- 59% of patients indicated that they would recommend the practice to others which was lower than the local CCG average at 67%. And lower than the national average at 78%

Patients said that they had confidence and trust in the last GP they saw of spoke to with the practice scoring 91% which was in line with the local CCG average of 92% and slightly lower than the national average at 95%

The OM Medical 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.

Background to The OM Medical Centre

The OM Medical Centre is responsible for providing care to 5000 patients across two practices. The practice had a higher than average working age population.

The OM Medical Centre provides primary medical services in Sheerness, Kent. The practice is open between 8.30am and 6.30pm Monday, Tuesday, Wednesday and Friday, and 8.30am to 12.30pm on Thursday. Patients are directed to Shiva Medical Centre on Thursday afternoons.

Services are delivered from:

The OM Medical Centre

Wood Street

Sheerness

Kent

ME12 1UA

Shiva Medical Centre

Broadway

Minster

Kent

ME12 3RL

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 through the NHS 111 service.

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 received a comprehensive inspection before and that was why we included them.

How we carried out this inspection

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:

Detailed findings

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 25 March 2015. We reviewed information provided on the day by the practice and observed how patients were being cared for. We spoke with six patients, five members of staff and one GP. We spoke with a range of staff, including receptionists, the practice manager and the practice nurse. We talked with carers and/or family members and reviewed the personal care or treatment records of patients. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice had systems to monitor patient safety utilising all the data and information available to them. Reports from NHS England indicated that the practice was in line with national standards for maintaining patient safety. Information from the General Practice Outcome Standards showed it was rated as a highly achieving practice. Information from the Quality and Outcomes Framework (QOF), which is a national performance measurement tool, showed that in 2013-2014 the provider was appropriately identifying and reporting significant events.

There was a system to report, investigate and act on incidents of patient safety, this included identifying potential risk. Staff we spoke with knew to report concerns and incidents. We reviewed significant events which had been recorded and saw that action had been taken.

Staff had access to multiple sources of information to help enable them to maintain patient safety and keep up to date with best practice. The practice had systems to respond to safety alerts. We looked at one safety alert from March 2014, relevant to general practice and saw that it had been received, recorded and dealt with properly. Staff we spoke with felt confident that they could raise any safety issues with the GPs and nursing staff.

The practice investigated complaints and responded to patient feedback in order to maintain safe patient care. The practice had additional systems to maintain safe patient care specifically of those patients over 75 years of age, patients with long term health conditions, patients with learning disabilities, vulnerable children and patients with poor mental health. The practice maintained a register of patients with additional needs and / or who were vulnerable and closely monitored their needs in conjunction with other health and social care professionals where required. For patients who required annual reviews as part of their care the practice operated a system to help ensure reviews took place in a timely manner.

Learning and improvement from safety incidents

The practice had a system for reporting and recording significant events. Investigations had been carried out and the impact of each event had been analysed resulting in the changes required and learning was routinely shared with staff. Staff told us the practice was open and willing to learn when things went wrong and provided examples of where they had been supported following significant events.

Staff told us they received updates on safety alerts relevant to their roles via emails. Action had been taken and the outcomes were recorded and audited. Staff told us they received regular updates as part of their on-going training and self-directed learning.

Reliable safety systems and processes including safeguarding

All staff we spoke with were able to tell us how they would respond if they believed a patient or member of the public were at risk. Staff told us that if they had concerns they would seek guidance from the GP who was the safeguarding lead or seek support from a colleague as soon as possible.

The practice had a detailed child protection and vulnerable adults policy and procedure that included reference to the Mental Capacity Act 2005.

Where concerns already existed about a family, child or vulnerable adult, alerts were placed on patient records to help ensure information was shared between social and health care professionals promoting continuity of care.

The GP who was the safeguarding lead had completed training to level three and working closely with the practice manager who linked with the local authority safeguarding team. Staff at the practice were knowledgeable about the contribution the practice could make to safeguarding patients. We were provided with examples of where staff had been proactive in safeguarding patients and worked alongside the school health team and social workers.

The practice had a chaperone policy. Staff who acted as chaperones had received relevant training and were clear of their roles and responsibilities. Records demonstrated that all staff who acted as chaperones had criminal records checks through the Disclosure and Barring Service (DBS).

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 were refrigerators in the treatment rooms for any items requiring cold-storage and we saw that there was monitoring of

temperatures. When vaccines were transported between the premises a validated cool box was used, this helped to maintain the cold chain, ensuring that these medicines would be safe and effective to use.

There were processes to check 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.

Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance. We saw up to date copies of patient group directions and evidence that nurses had received appropriate training to administer vaccines. There were also appropriate arrangements for the nurses to administer medicines that had been prescribed and dispensed for patients including administration protocols.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. For example, how staff who generate prescriptions were trained and how changes to patients' repeat medicines were managed safely and effectively. All prescriptions were reviewed and signed by a GP before they were given to the patient or dispensed.

Prescription pads and blank prescription forms for printing were stored securely, and serial numbers were recorded on receipt and when they were issued to the GPs. The practice did not hold controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse).

Cleanliness and infection control

The practice was clean and tidy. There was a dedicated lead for infection control and they had carried out regular audits to help ensure the practice had complied with recognised standards. All the patients we spoke with were happy with the level of cleanliness within the practice.

The practice had up to date policies and procedures to govern infection control. These included protocols for the safe storage and handling of specimens and for the safe storage of vaccines. These provided staff with clear guidance for sharps, needle stick and splashing incidents which were in line with current best practice.

Certification held in staff files showed that staff had received infection control training. All staff

we spoke with were clear about their roles and responsibilities for maintaining a clean and safe

environment. Rooms were well stocked with gloves, aprons, alcohol gel, and there were sufficient hand washing facilities throughout the practice.

The practice only used single use instruments that were stored correctly. Stock rotation was employed to reduce the risk of out of date sterile items being used.

Maintenance was managed by the building management team as was clinical waste. The practice met with the building management team routinely and was able to raise any concerns as and when required.

We looked in two consulting rooms. Both the rooms had hand washing facilities and work surfaces which were free of damage, enabling them to be cleaned thoroughly. The dignity curtains in each room were disposable and were clearly labelled as to when they required replacing.

Equipment

The practice manager had an equipment log to help ensure all equipment was effectively maintained in line with manufacturers' guidance and calibrated where required. We saw maintenance contracts for all equipment. Staff we spoke with told us they had access to the necessary equipment and were trained in its use. Checks were carried out on portable electrical equipment in line with legal requirements.

Staffing and recruitment

There were formal processes for the recruitment of staff to check their suitability and character for employment. The practice had a recruitment policy which was up-to-date. We looked at the recruitment and personnel records of four staff. Recruitment checks had been undertaken that included a check of the person's skills and experience through their application form, personal references, identification, criminal record checks through the Disclosure and Barring Service (DBS) and general health status, including, where relevant, an immunisation record.

Where relevant, the practice also made checks that members of staff were registered with their professional body and on the GP performers list. This helped to evidence that staff met the requirements of their professional bodies and had the right to practise.

Good

Are services safe?

We were satisfied that (DBS) checks had been carried out appropriately for all staff to help ensure patients were protected from the risk of unsuitable staff.

Monitoring safety and responding to risk

The practice had systems, processes and policies to manage and monitor risks to patients, staff and visitors to the practice. The practice had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative. The computers in the reception and consulting rooms had a panic alert system for staff to call for assistance.

Identified risks were included on a risk log, reviewed and managed by the practice manager who liaised with the buildings manager when required.

The practice manager had clear staffing levels identified and procedures to manage expected absences, such as annual leave, and unexpected absences due to staff sickness; this was recorded within the business continuity plan. Staff told us they worked together to manage staff shortages and plan annual leave so as not to leave the practice short of staff, only using locum staff when absolutely necessary.

Arrangements to deal with emergencies and major incidents

Staff told us and records confirmed that they were trained in basic life support. Emergency equipment and emergency medicines were available at all three practices. This included access to medical oxygen and an automated external defibrillator (AED) (used to attempt to restart a person's heart in an emergency). Staff told us that these medicines and equipment were checked regularly and records confirmed this.

There were inventories of emergency medicines and emergency equipment. For example, we saw that emergency equipment included oropharyngeal airways (devices used to maintain a patient's airway in an emergency) and a pocket face mask (used by staff to deliver rescue breaths to patients who were not breathing). All emergency medicines that we looked at were within their expiry date.

The practice had a business continuity plan to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of the building management, clinical commissioning group (CCG) and associated health and social care professionals.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and regular fire drills were carried out.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GP and nursing staff 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 staff we spoke with and the evidence we reviewed confirmed that these approaches were designed to help ensure that each patient received support to achieve the best health outcome for them. Staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate. Patients with chronic diseases such as asthma received a health review on an annual basis. The national Quality Outcome Framework (QOF) data demonstrated that 92.3% of patients on the diabetes register had received a dietary review. For patients with asthma 72.7% of patients on the register had received an assessment of the efficacy of their asthma control.

The GP and nurse were aware of the issues and discussed the challenges of the population group in complying with healthy lifestyle advice. The nurse provided us with a number of examples of patient education they were providing during consultation for chronic illness and healthy lifestyle changes such as healthy diet and exercise regimes.

The practice maintained a register of patients with a learning disability to help ensure they received the required health checks. All patients with learning disabilities had annual reviews carried out by the nurse or GP who explained to us they used the nationally recognised Cardiff Health Check to help ensure a comprehensive review was carried out encompassing emotional and physical wellbeing.

The GP carried out annual physical health reviews for patients diagnosed with schizophrenia, bi-polar and psychosis and provided health improvement guidance. The QOF data provided evidence that the practice responded to the needs of people with poor mental health, above the average for the local clinical commissioning group (CCG), by ensuring, for example they had access to health checks annually.

Practice data demonstrated that child development checks were offered at intervals that were consistent with national guidelines and policy. For children of refugees or new into the country, where records were not clear and up to date for child immunisation, there was a policy as well as guidance from the Health Protection Agency to help ensure children attending the practice had access to appropriate vaccinations.

Information available to staff, minutes of meetings and our discussions with staff demonstrated that care and treatment was delivered in line with recognised best practice standards and guidelines. Staff told us they received updates relating to best practice or safety alerts via emails and nursing staff told us they received regular updates as part of their on-going training.

Clinical staff were able to clearly describe to us how they assessed patients' capacity to consent in line with the Mental Capacity Act 2005. The practice worked within the Gold Standard Framework for end of life care and held a register of patients requiring palliative care.
Multi-disciplinary care review meetings were held with other health and social care providers.

Management, monitoring and improving outcomes for people

Assessments of care and treatment as well as support provided, enabled patients to self-manage their condition, such as diabetes or chronic obstructive pulmonary disease (COPD).

A range of patient information was available to patients which helped them to understand their conditions and treatments. Staff said they could openly raise and share concerns about patients with colleagues to help enable them to improve patients' outcomes.

The practice monitored patient data which included full clinical audit cycles that demonstrated changes to patient outcomes. Clinical audit is a process or cycle of events that help ensure patients receive the right care and the right treatment. The practice used the information they collected for the Quality and Outcomes Framework (QOF) and their performance against national screening programmes to monitor outcomes for patients. QOF was used to monitor the quality of services provided. The QOF report from 2013-2014 showed the practice was supporting patients well with long-term health conditions such as asthma and heart failure. They were also monitoring that

Good

Are services effective?

(for example, treatment is effective)

childhood immunisations were being taken up by parents. NHS England figures showed in 2013, 93% of children at 24 months had received the measles, mumps and rubella (MMR) vaccination. Information from the QOF 2013-2014 indicated the practice had maintained this high level of achievement.

The practice had systems to monitor and improve the outcomes for patients by providing annual reviews to check the health of patients with learning disabilities, patients with chronic diseases and patients on long-term medication.

Patients told us the staff at the practice managed their conditions well and if changes were needed they were fully discussed with them before being made.

Effective staffing

We saw examples of the induction training staff underwent on commencement of employment with the practice and there was specific orientation information available for locum GPs. Staff told us that they received yearly appraisals and GPs said they carried out relevant appraisal activity that now included revalidation with their professional body at required intervals. We saw records that confirmed this.

There was evidence in staff files of the identification of training needs and continuing professional development. The practice had processes to identify and respond to poor or variable practice including policies such as the management of sickness and absence policy as well as a disciplinary procedure.

Working with colleagues and other services

Staff at the practice worked closely as a team. The practice worked with other agencies and professionals to support continuity of care for patients and help ensure there were care plans for the most vulnerable patients. The GP and the practice manager arranged mutli-disciplinary meetings where required. Communication on a daily basis with community midwives, health visitors and district nurses took place by telephone and fax. The practice worked with other service providers to meet patients' needs and manage those of patients with complex conditions.

The practice 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. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system worked well.

For patients at the end of their life the practice worked closely with the palliative care team to help ensure co-ordinated care. Patients who required emotional support were referred to counselling services.

Information sharing

The practice used an electronic system to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to help enable patient data to be shared in a secure and timely manner. There were also electronic systems for making referrals such as the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that this system was easy to use.

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

The practice provided the 'out of hours' service with information, to support patients and uphold their wishes. For example, patients receiving 'end of life care.' Information received from other agencies, such as accident and emergency or hospital outpatient departments, was read and actioned by the GP on the same day. Information was scanned onto electronic patient records in a timely manner.

The practice worked within the Gold Standard Framework for end of life care, where they provided a summary care record and information that was shared with local care services and out of hour providers. For the most vulnerable two percent (a nationally agreed percentage) of patients over 75 years of age, and patients with long-term health

Good

Are services effective?

(for example, treatment is effective)

conditions, information was shared routinely with other health and social care providers through multi-disciplinary meetings to monitor patient welfare and provide the best outcomes for patients and their families.

Consent to care and treatment

The practice operated a policy and procedure for staff in relation to consent. The policy incorporated implied consent, how to obtain consent, consent from under 16's and consent for immunisations. There were policies and procedures for staff to refer to with regard to the Mental Capacity Act 2005 (MCA) and staff had completed MCA training. Clinical staff had an understanding of the principles of gaining consent, were able to identify clearly their roles and responsibilities in line with the MCA and were able to describe how they implemented it in their practice. When interviewed, staff gave examples of how a patient's best interests were taken into account if they did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There were forms for which consent other than implied consent was recorded. These forms, once signed were scanned into patients' notes.

Health promotion and prevention

New patients looking to register with the practice were able to find details of how to do so on the practice website or by asking at reception. New patients were provided with an appointment for a health check with the health care assistant and any health concerns detected were reported to a GP and followed up in a timely way.

The practice had a range of written information for patients in the waiting area, including information they could take away, on a range of health related issues, local services and health promotion. Staff promoted healthy lifestyles during consultations. The electronic records system alerted clinicians patients they were consulting with that smoked or had weight management needs. Health promotion formed a key part of patients' annual medication reviews and health checks. The practice offered NHS Health Checks to all its patients aged 40 to 75 years. The practice used recognised guidance to help ensure patients were followed up in a timely manner if any risk factors for disease were identified at the health check.

The nurses provided lifestyle advice to patients which included dietary advice for raised cholesterol, alcohol screening, weight management, sexual health and smoking cessation.

The practice offered a full range of immunisations for children, travel vaccines and influenza vaccinations in line with current national guidance. There was a clear policy for following up non-attenders for vaccinations and screening by the practice staff.

The practice's performance for cervical smear uptake was 82.8%, which was in line with national averages and slightly higher than the CCG average.

The practice was proactive in following up patients when they were discharged from hospital. When the practice received a discharge letter from the hospital, the reception staff made contact with patients to establish if they required a telephone consultation or home visit. Any patient discharged from hospital aged 75 or known to be vulnerable received a telephone call from the GP on the day they were discharged.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

During our inspection we observed staff to be kind, caring and compassionate towards patients. We saw reception staff taking time with patients and trying, where possible, to meet their needs. We spoke with 15 patients and reviewed 32 comment cards. . All were positive about the level of respect they received and dignity offered during consultations.

Information about patients' records confidentiality, including details of other health and social care professionals who could access such records, was available to patients in the reception area as well as on line. Patients had the option to decline permission for the practice to share information in this way. We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. We saw all phone calls from and to patients were carried out in a private area behind reception. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

We spent time with reception staff and observed courteous and respectful face to face communication and telephone conversations. Staff told us that a private room was available near the reception desk should a patient wish a more private area in which to discuss any issues. All the patients we spoke with gave positive feedback about the helpfulness and support they received from the reception staff.

The results from the National GP Patient Survey 2013 showed 94% of respondents found the receptionists at this practice helpful. Staff were able to clearly explain to us how they would reassure patients who were undergoing examinations, and described the use of chaperones as well as modesty sheets to maintain patients' dignity. We found all rooms had dignity screens or lockable doors to maintain patients' dignity and privacy whilst they were undergoing examination or treatment.

Care planning and involvement in decisions about care and treatment

- Patients told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they chose to receive. Patients told us they felt listened to and supported by staff and had sufficient time during consultations in order to make an informed decision about the choice of treatment they wished to receive. Patient comment cards also indicated patients had sufficient time during consultations with staff and felt listened to. The results from the National GP Patient Survey 2013 showed 81% of respondents say the last GP they saw or spoke to was good at listening to them, compared to the local CCG average of 83%. Also 73% of respondents stated the GP they saw or spoke to was good at involving them in decisions about their care and treatment, compared to the local CCG average of 76%

We saw from The Quality and Outcomes framework (QOF) data for 2013/14, 96.4% of patients with poor mental health had a comprehensive care plan documented in the records agreed between individuals, their family and/or carers as appropriate. The nurse took the lead on developing care plans for those patients over 75 years of age. For vulnerable patients at risk of unplanned hospital admissions, care plans had been developed and these were reviewed every three months. Staff told us relatives, carers or advocates were involved in helping patients who required support with making decisions about their care.

We noted that where required, patients could book extended appointments. For example, reviews of patients with learning disabilities or multiple conditions to help ensure staff had the time to help patients be involved in decisions.

Patient/carer support to cope emotionally with care and treatment

All staff we spoke with were articulate in expressing the importance of good patient care, and having an understanding of the emotional needs as well as physical needs of patients and relatives.

Results from the National GP Patient Survey 2013 showed 83% of respondents stated the last GP they saw was good at giving them enough time which was in line with the local CCG average of 84% and 76% stated the last GP they saw or spoke to was good at treating them with care and concern, which was in line with the local CCG average of 78%.

Good

Are services caring?

The practice had identified within their patient population many families who cared for an elderly relative within the home and were proactive in identifying carers. They had established a carer's register and provided identified carers with a support pack.

Patients who were receiving care at the end of life were identified and there were joint arrangements as part of a multi-disciplinary approach with the palliative care team. Bereaved families were visited by a GP and provided with support.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was responsive to patients' needs and had systems 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.

The practice worked with patients and families and in a joined up way with other providers to deliver palliative care and ensured patient's wishes were recorded and shared, with consent, with out of hours providers at the end of life. The practice made reasonable adjustments to meet patients' needs. Staff and patients we spoke with provided a range of examples of how this worked, such as providing home visits and booking extended appointments. Where patients required referrals to another service these took place in a timely manner.

A repeat prescription service was available to patients, via the telephone, website, and a box at reception or through requesting repeat prescriptions with staff at the reception desk.

The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the patient participation group (PPG). For example, a television was installed in the waiting room showing health information and advice.

Tackling inequity and promoting equality

The practice was located on the ground floor of a building. The practice was easily accessible by patients using wheelchairs and patients with prams. Accessible toilet facilities were available for all patients attending the practice, including baby changing facilities.

The practice had access to translation services for patients whose first language was not English.

Access to the service

Appointments were available from 8.30am to 6.30pm Monday to Friday with a half day on Thursdays from 8.30am to 12.30pm. Patients needing to see a GP Thursday afternoons could attend the branch surgery. Patients were able to make appointments in advance, one the day, online and in person at reception or over the telephone. On the day emergency appointments were available by telephoning the practice or booking online. When all appointments were filled, reception staff took patients details which were followed up by the GPs and where required same day appointments or telephone consultations were offered.

For vulnerable patients there was an alert system in the electronic records to help ensure whatever time of day they phoned, if required a same day appointment was provided. All children under five were seen on the day. Older patients who walked into the practice for an appointment, wherever possible were seen by a GP the same day.

The practice opening hours as well as details of how patients could access services outside of these times were available for patients to take away from the practice in written form. For example, in a practice leaflet. Practice opening hours were also available on the practice's website and were displayed on the front of the building.

Longer appointments were available for patients who needed them such as those with long-term conditions or patients with learning disabilities. This included appointments with the GPs or nurses. The majority of patients we spoke with were satisfied with the appointment system. Five patient comment cards indicated that patients found it difficult getting through to the practice on the telephone. The practice was monitoring access and had increased the number of GP sessions. This was being analysed to see if the increase was sufficient or deficient. The National GP Patient Survey 2013 results showed that 73% of respondents were able to get an appointment to see or speak to someone the last time they tried and 96% said the last appointment they got was convenient. Results from the practice survey carried out throughout 2014 showed that patients were generally happy with the appointments system.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. We looked at three complaints received over the last twelve months. Staff were able to describe how they responded to any

Good

Are services responsive to people's needs?

(for example, to feedback?)

complaint made and how they followed their complaints policy and records we viewed confirmed this. The practice could demonstrate that they had learned from complaints they had received.

Complaints information was available in the practice leaflet in the waiting area. Patients we spoke with told us they knew how to make a complaint if they felt the need to do so.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote beneficial outcomes for patients. Details of the vision and practice values were part of the practice's aims, objectives and statement of purpose. These values were clearly displayed on the practice website. The practice vision and values included providing personalised, effective and high quality general practice services.

The practice demonstrated a commitment to compassion, dignity, respect and equality. This was demonstrated in the way staff interacted with patients and spoke of the professional relationship developed with patients over a number of years.

We spoke with six members of staff who all expressed their understanding of the core values and there was evidence that the latest guidance and best practice was being used to deliver care and treatment.

Governance arrangements

The practice had policies and procedures to govern activity and these were available to staff within the practice. We looked at twelve of these documents and saw they were up to date and reflected current guidance and legislation.

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

The practice made use of data provided from a range of sources including the clinical commissioning group (CCG) and the national patient survey to monitor quality and outcomes for patients such as services for avoiding unplanned admissions. The practice used the range of data available to them to improve outcomes for patients. The practice also used the Quality and Outcomes Framework (QOF) data to measure their performance.

The QOF data for this practice showed it was performing in line with national standards. The practice manger and GPs met on a regular basis to discuss practice issues, significant events and complaints. Where required multi–disciplinary meetings with external health and social care professionals were arranged. All staff told us of an open culture among colleagues in which they talked daily and sought each other's advice.

The practice had an on-going programme of clinical audits which it used to monitor quality as well as systems to identify where action should be taken. For example, an audit regarding diabetic patients and how well they were managing their condition. The results of the audit compared to the previous year were: improved recall of patients at determined intervals for follow ups and one referral to secondary care for a patient who required further support.

The practice held monthly staff meetings and governance meetings. Minutes from the last three meetings demonstrated that performance, quality and risks had been discussed. The practice had arrangements for identifying, recording and managing risks. There were records demonstrating that maintenance and equipment checks had been carried out over the past twelve months. These helped ensure equipment was safe to use and maintained in line with manufactures' guidelines. Risk assessments had been carried out and where risks were identified action plans had been produced and implemented to mitigate risks.

Team meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice, they had the opportunity to raise issues at team meetings and there was always someone to speak with to seek support, advice or guidance.

The practice had human resources documents that guided staff such as a recruitment policy and an induction programme. Other documents were available to guide staff that included information on health and safety, equality, leave entitlements, sickness, as well as prevention of bullying and harassment. Staff we spoke with knew where to find these documents if required.

Leadership, openness and transparency

Staff felt able to speak out regarding concerns and make comments about the practice. They said they would interrupt a consultation if they had an urgent concern and GPs supported this. Staff had job descriptions that clearly defined their roles and tasks at the practice. All staff we

Are services well-led?

Good

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

spoke with said they felt valued by the practice and able to contribute to the systems that delivered patient care. All the staff had responsibility for different activities such as checking on QOF performance.

Practice seeks and acts on feedback from its patients, the public and staff

The practice had gathered feedback from patients through the national patient survey, the NHS friends and family test, patient surveys, suggestions, compliments and complaints.

The practice had an active patient participation group (PPG) who were arranging a health promotion event at the practice. The PPG had made suggestions with regard to access and appointments and the practice had made changes as a result.

Staff told us they were able to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistle blowing policy which was available to all staff in the staff policies file.

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Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at six staff files and saw that regular appraisals took place which included a personal development plan.