Penketh Health Centre

Mission Statement

Our Mission:

"To deliver an excellent patient-centred service using innovative technology consistent with modern general practice"

Our Vision:

"To be the leading practice for patient experience and clinical outcomes"

Our values:

- **Quality**
- **Innovation**
- **Integrity**
- **Compassion**

CARING

We try to promote an atmosphere of dignity and respect. We always try to treat staff and patients with kindness, respect and compassion.

- We send condolence cards to bereaved patients.
- We take a very considered approach in our patient removal policy.
- We have policies for consent and chaperones to ensure we practice in a patient centred way.
- We invite community groups into our practice foyer such as Carers UK, Independent Age, KOOTH, Papyrus, Parkinson's UK, Cancer Research, Talking Matters, John Holt Foundation and Cancer Awareness – to help to provide extra support to our patients.
- If a patient is distressed they will be offered a side room for privacy and if a patient looks particularly unwell the receptionist will inform the clinician.
- We have a Carers list, we have very recently implemented a Carers Co-ordinator one of our HCAs who is going to try to contact carers on our list by telephone especially if they have been noted to be struggling when in the surgery. Working together with Carers UK and Independent age we are looking at putting together the most useful pack of information.

EFFECTIVE

We try to provide the highest quality health service to our patients.

- Our clinicians are constantly updating their knowledge and skills using up to date guidelines and attending update courses.

- We try to encourage staff development for example, our practice nurse becoming a prescriber, our receptionist upskilling to a HCA role. One of our receptionists is now Public Health Champion, publicising current campaigns and has done a brilliant job bringing outside agencies in the practice foyer such as Carers UK, Parkinson's society, Talking matters, KOOTH providing extra support to our patients and making links with the practice team. Our receptionist have had Care Navigator training.
- Our ANPs have regular meetings and mentoring sessions and attend appropriate training courses.
- We are a training practice, registrars have a weekly tutorial with a dedicated GP to ask for advice.
- We have a practice pharmacist, CCG pharmacist and a newly employed Pharmacy technician.
- The clinicians meet daily at 2pm to discuss complex patients and to share learning, together with practice nurses and pharmacist when free also, all are welcome.
- All staff have annual appraisals to aid our continued development; this includes 50 hours of learning activities for GPs.
- We run chronic disease clinics such as Diabetes, Cardiovascular, Asthma and COPD; all nurses running these clinics have the appropriate qualification and vast experience. We also run joint sessions alongside the Specialist Diabetes Nurse.
- We developed the role of Patient Care Co-ordinator, identifying a list of patients who may benefit from dedicated reviews, named nurse, named GP and named receptionist/ care co-ordinator.
- We complete clinical audits to try to further improve our clinical work. This year we are taking part in the National Cancer Audit, early results show patients are often diagnosed with cancer following a single consultation within our practice.
- Our website and patient information boards in the surgery provide advice on health promotion and self -care advice.
- We provide NHS Health Checks and have high uptake rates.
- We work very closely with our community services, for example the community matrons, district nurses, care home support team, cardiac and respiratory nurses.
- We have a Gold Standards Framework register and have regular GSF meetings to provide fair access to good quality end of life care. Our practice Care Home sessions provide time to spend having these difficult discussions with patients and their families.
- We provide care to six care and nursing homes in the area we try our best to manage well this higher workload using our designated care home sessions to provide better care for these patients.
- We are always looking at more innovative ways to provide effective care such as the Digital Hypertension Project and the AF Kiosk and Kardia devices.

RESPONSIVE

We are always trying to develop our services for the better.

- We have a named GP for all patients and actively try to manage our frail patients and patients with chronic disease to prevent hospital admissions.
- We offer telephone appointments and electronic prescribing to try to make the lives of our patients easier.
- We have added two extra telephone lines as getting through on the phone was another complaint, we are looking at ways to improve the phone system further.
- We listen to the patient feedback, and along with our PPG try our best to respond to this.
- Our main complaints have been around the appointment system, we are constantly changing the way we offer appointments to meet the needs of our patients. Following our latest survey we plan PPG meetings and focus groups to try to find a solution to the ongoing appointment issues to try to make things better.
- Like many practices we have found it impossible to recruit new doctors to the practice, we have therefore employed 3 ANPs with years of experience and qualifications, enabling to them to deal with a wide range of conditions, freeing up GPs for the more complex patients. The ANPs can consult with any GP at any time for further advice. They are a valued asset to our team.
- We have also employed a full time practice pharmacist to help us deal with the huge number of hospital letters and prescription queries and requests that we receive on a daily basis.
- We have employed an extra salaried GP last year who was one of our Registrar doctors in a bid to improve patient access.
- We have an emergency duty doctor every day and any emergency that can't wait will be seen such as chest pain, unwell babies and small children, priority cancer patients and severe mental health issues.
- We also provide four extended access sessions on Monday and Wednesday evenings from 6pm – 8.30pm offering both GP and practice nurse appointments, for those patients finding it difficult to attend during the day.

PLEASE CONTINUE TO GIVE US YOUR FEEDBACK AND ANY IDEAS OR SUGGESTIONS TO IMPROVE OUR SERVICE. WE CAN ONLY IMPROVE THINGS IN PARTNERSHIP WITH OUR PATIENTS.

SAFE

We will provide a safe place for your health and have systems in place to do our best to protect our more vulnerable patients.

- We take patient concerns seriously and have a comprehensive and easily accessible patient complaints system in place.
- To identify and protect vulnerable patients (such as children, the elderly and those being abused) all members of staff have undergone "Safe-guarding" training. Every member of staff is aware when to raise a concern. We have a named practice Safeguarding lead for children and adults.
- One of our GPs was the CCG Lead for Adult Safeguarding we have regular Child Safeguarding meetings with our health Visitors and School nurses.
- We follow strict policies including DBS checks on new members of staff where appropriate.
- We prescribe carefully according to guidance and our practice pharmacists help us with medication reviews and changes. Sometimes we will ask for you to attend a review or have bloods to continue your medication, this is to keep you safe from harm from medications.
- We have safe systems in place to monitor high risk drugs such as warfarin and methotrexate and have tried to make this process even safer using spreadsheet data and protocols. We have a DOAC recall monitoring system in place.
- We have systems to deal safely with test results and recently updated our management of urgent test results making this safer.
- We recognise that sometimes things can go wrong, we have regular significant event meetings where we discuss events with a "no blame culture" so we can all learn from the event and make our systems even safer.
- We also use the Datix reporting system to report events relating to outside services e.g. hospitals and pharmacies as well as our own events.
- We review unexpected deaths to see if anything could have been done better.
- Any external safety alerts such as MHRA alerts and CAS alerts are shared with the entire team and actioned as appropriate. All staff have annual BLS training and we have the skills and equipment to deal with medical emergencies.

WELL LED

Being well led ensures smooth running of the practice. We place great importance on training of staff.

- We have upskilled a receptionist to HCA role, supported our practice nurse to become a prescriber.
- We have diversified our team with the current GP recruitment difficulties to include 3 ANPS and a practice pharmacist and pharmacy technician.

- Our practice manager ensures policies and procedures are followed. We hold a daily 30 minute meeting as well as regular ANP, Practice nurse and admin team meetings.
- We have named doctor and nurse leads for different medical conditions.
- We have an active PPG who have regular meetings
- We are always striving for continuous learning and innovation, we have used an AF Kiosk and Kardia machines to try to increase our AF detection, our prevalence has increased greatly with the aim to try to prevent any AF related strokes in our patients, we worked with the Innovation Agency on this.
- We have also been a pilot practice for a Digital Hypertension project using a digital BP monitor and phone app to improve our BP detection and monitoring, working with Public Health.
- We have been involved with medical research studies e.g. COPD.
- We have just commenced work within our new Network of local practices to continue to improve health outcomes for patients and to develop our services.
- Any staff member can voice concerns or worries to the GP Partners or Practice manager and will be supported.

CARING FOR SPECIFIC PATIENT GROUPS

VULNERABLE PATIENTS

- We have both Adult and Child Safeguarding leads who co-ordinate a response to any safeguarding concerns raised.
- Child safeguarding meeting include health visitors and school nurses, and often named safeguarding nurse. We review children that DNA vaccinations and appointments and our child in need registers. For adults we have multidisciplinary best interests meetings.
- All staff have safeguarding training and have confidence to report concerns.
- We attend CCG Safeguarding leads meetings and feedback any learning points.
- If patients DNA – do not attend an appointment, clinicians will check they are not vulnerable or at risk needing a call.
- We action MARAC alerts and use the appropriate codes to highlight vulnerable patients.
- We have registers of patients with dementia, learning disabilities and who are terminally ill.
- We provide annual health checks for our patients with learning disabilities they are offered longer appointments with their carer, practice nurse and the GP.
- Patients on our GSF register are offered priority appointments and care. We hold regular GSF meetings to update on these patients.
- We developed the role of Patient Care Co-ordinator, identifying a list of patients who may benefit from dedicated reviews, named nurse, named GP and named receptionist/ care co-ordinator, particularly for those at risk of multiple hospital admissions.

- We add alerts to the notes of visually impaired patients who may need help getting into see the clinician, receptionist will assist patients to rooms.
- We use a LOOP system for those patients who are hard of hearing. There is a magnifying glass on the reception desk for use by anyone having difficulty with small print.
- We use an interpreter service, language line as required, with a " what is your language " sheet written in other languages for identification should an interpreter be required.
- If a patient becomes upset or distressed the reception staff will offer a side room and inform the GP.
- We have a Carers list, we have very recently implemented a Carers Co-ordinator one of our HCAs who is going to try to contact carers on our list by telephone especially if they have been noted to be struggling when in the surgery. Working together with Carers UK and Independent age we are looking at putting together the most useful pack of information and having a monthly Carers Café where carers can get together and chat.
- Urgent on the day appointments with the duty doctor are offered to patients with urgent mental health issues .Our Care Navigators can also signpost to appropriate services.
- We provide 7 day scripts for those at risk of medication abuse our practice pharmacist helps with these patients.

OLDER PATIENTS

- We provide care to older people in six care and nursing homes.
- We provide a designated Care home session to four of the Care homes every week. This allows time for GPs to provide more pro-active care and to spend time discussing difficult issues like End of Life Care with patients and their families. We work closely with our colleagues from Care home support team.
- We provide seasonal flu vaccine, end of life and dementia care.
- We offer home visits both GP and nurse to the elderly housebound, nurses do home visits for flu vaccinations.
- We work together with our community team members, district nurses, community matrons, cardiac failure nurses, community respiratory nurses etc.
- We provide daily ECGs and phlebotomy clinics in the surgery to improve access to diagnostics for our elderly patients .
- Our Adult Safeguarding lead was the CCG Adult Safeguarding Lead.
- We have a named GP for all over 75 year olds. 27% of the practice population is over 65 years.
- We developed the role of Patient Care Co-ordinator, identifying a list of patients who may benefit from dedicated reviews, named nurse, named GP and named receptionist/ care co-ordinator

PEOPLE WITH LONG TERM CONDITIONS

- Our QOF Data reflects our good chronic disease management; our 5 practice nurses provide regular health reviews for patients on our chronic disease registers e.g. asthma, COPD, diabetes. They have diplomas and training in diabetes, cardiovascular disease, diabetes and women's health etc. . One of our practice nurses has trained to be a prescriber so can issue scripts at these reviews.
- We have a process for COPD patients requiring rescue packs where all requests are sent to the Practice Nurse Lead for COPD/Asthma.
- Our involvement with the digital BP project tried to help patients to self-manage chronic conditions, encouraging lifestyle changes and medicine concordance.
- We provide regular drug monitoring for patients on high risk medication such as warfarin and methotrexate. We have recall systems in place for patients on clopidogrel and the newer DOAC medications to aid safer monitoring. We have updated our high risk drug monitoring policy.
- We have employed a full time practice pharmacist and also have a CCG employed pharmacist to help us with medication reviews and review of hospital discharges for patients with long term conditions. They also run regular clinics with patients for medication reviews.
- We have regular GSF multidisciplinary meeting s to improve care for our palliative patients.

FAMILIES, CHILDREN AND YOUNG PEOPLE

- We have a lead Safeguarding GP and nurse, who meet regularly to review the child DNA lists, looked after children, children on protection plans and any children where concerns have been raised within the practice. We have regular safeguarding meetings with our school nurse and health visitor to share concerns with a "safeguarding task group" set up to share concerns and feedback. We attend the Warrington Safeguarding Leads meetings. All our staff have safeguarding training.
- We provide weekly child health clinics with longer appointment times to discuss any concerns and run alongside the vaccination clinic. We have a high vaccination uptake and offer further discussions if parents are unsure.
- If any young children or babies are very unwell with high temperatures, rashes etc. or other symptoms suggesting possible infection or sepsis they are always booked in with the daily duty doctor to be seen that day. The GP is alerted if the child seems unwell or distressed in the waiting room and offered side rooms where appropriate e.g. if infectious diseases are being queried. We can also access the PART and CREST teams community nursing services for children.
- We provide breastfeeding and baby changing rooms. One of our GPs is a breastfeeding advisor.
- We offer on the day appointments with duty doctor for younger people struggling with their mental health and have had volunteers KOOTH and papyrus in our practice foyer to offer advice and information.

- We have young people's posters with QR code for those using smart phones.

WORKING AGE PEOPLE

- We provide family planning services, in-house coil and implant fitting and cytology screening.
- We provide emergency contraception scripts and offer practice nurse appointments on our extended hours evenings so working ladies can attend for smear and contraception appointments.
- We offer 2 extended hours sessions twice weekly until 8.30pm on Monday and Wednesday evenings for working age people.
- We offer travel advice and travel vaccinations.
- We offer well man and well woman clinics and actively encourage our patients to attend for over 40 years Health checks when eligible.
- We offer a range of online services online appointment booking, with SMS text messaging reminders, ordering of repeat prescriptions.
- We have above average uptake for our Electronic Prescribing System over 75%, reducing the need to attend the surgery. Prescription queries can often be dealt with over the phone by our practice pharmacists.
- We hold Saturday morning flu clinics.
- Our involvement in the Digital hypertension pilot uses digital BP monitors and phone app allowing patients to take control of their own BP reminders and prompts with lifestyle advice and link to services.
- We have increased the number of telephone appointments around lunch time and at the end of the day for working age people.

PEOPLE EXPERIENCING POOR MENTAL HEALTH (INCLUDING PEOPLE WITH DEMENTIA)

- We have care plans for patients with poor mental health and annual reviews for patients with dementia.
- We actively screen for dementia in at risk populations and refer to memory clinic as appropriate. We have mental health and dementia registers with a nurse to oversee.
- We have a carers register and carers are invited to the appointments.
- We offer on the day appointments with duty doctor for people struggling with their mental health and we have had volunteers from KOOTH, papyrus and Talking Matters in our practice foyer to offer advice and information.
- Patients have follow up appointments booked in for them or have pre-authorisation to book if antidepressant medication is started that requires follow up.
- We provide 7 day scripts for those at risk of medication abuse our practice pharmacist helps with these patients.
- We offer the use of the side room to avoid the often crowded waiting area.

- We promote Advanced Care Planning where appropriate e.g. with advance dementia and do lots of work on this with our Patients in the care and nursing homes on our care home sessions.
- We use dementia templates.
- Carers UK, Parkinson's society and Independent Age amongst other have been in our Practice Foyer offering advice, information and support.