Beddington Medical Centre

Quality Report

172 Croydon Road
Beddington. CR0 4PG
Tel: 020 8688 8486
Website: www.beddingtonmedicalcentre.nhs.uk

Date of inspection visit: 15 January 2015
Date of publication: 28/05/2015

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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Beddington Medical Centre on 15 January 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well-led services. It was also good for providing services for the six population groups we report on.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed, including those relating to recruitment, medicines management and infection control.
- 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 said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

However there was an area of practice where the provider needs to make improvements.

Importantly, the provider must :

Summary of findings

- clarify its policies in relation to Disclosure and Baring Service (DBS) checks, and include these in its recruitment policy.
- ensure DBS checks are undertaken for all staff who undertake chaperone duties at the practice.

In addition, the provider should

- Ensure an automated external defibrillator (AED) is available, or have on record a risk assessment if a decision is made to not have an AED on-site.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

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 facilities and was well equipped to treat patients and meet their

Summary of findings

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

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. There was a patient participation group (PPG) in the practice, and the management team was actively recruiting to expand its membership. Staff had received inductions, regular performance reviews and attended staff meetings and events.

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.

All patients over the age of 75 had a named GP.

Regular medicines reviews were completed with all patients. Letters inviting patients to these reviews were sent out with the repeat prescriptions.

Patients with mobility needs could be seen in a consultation room on the ground level of the practice premises.

All patients over the age of 65 were offered a flu vaccination in line with government recommendations. At the time of our inspection the practice had vaccinated 73.3% of its patients in this group, which was similar to the national average. The practice also offered shingles vaccines and pneumococcal vaccines.

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.

There were weekly asthma and chronic obstructive pulmonary disease (COPD) clinics in the practice, run by a practice nurse.

One of the principal GP was able to provide minor surgical procedures, the form of joint injections. We saw that appropriate records were completed for these procedures, and suitable entries made on the patients' notes.

Longer appointments and home visits were available when needed.

Summary of findings

Government guidelines recommend that flu vaccinations are offered to certain at risk groups so that they are protected from the illness and developing serious complications. Patients with long term conditions were offered seasonal flu vaccinations in response to these recommendations.

All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. We saw evidence that care plans were appropriately completed with patients with particular needs. We also saw that when there were changes to patients' circumstances, these care plans were reviewed and amended as required, for example following a hospital admission. Alerts were put on patients' notes if they had a care plan in place. This alerted the reception staff when the patient called for appointments, so they may be prioritised for appointments.

For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. Multidisciplinary meetings were held to discuss the patients' needs and these were well documented.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances, or who did not attend fore recommended appointments such as childhood vaccinations.

Pregnant women were offered health information booklets and referred on to appropriate community based healthcare services.

The practice GPs carried out eight week post natal check for new mothers, and 6 week baby checks in line with government guidelines.

Immunisation rates were relatively high for all standard childhood immunisations.

Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors.

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).

Summary of findings

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.

The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability. It had carried out annual health checks and offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

The practice GPs carried out the health checks, as required under the directed enhanced service (DES) that was in addition to their contract, for patients with learning disabilities. All the residents (eight in total) in a local care home for people with learning disabilities were registered patients at the practice. The practice manager gave us an example of how they had worked with local providers, in this case the phlebotomy service at the local hospital, to provide them with recommended tests.

The practice reception team organised transport for vulnerable patients who made the request, such as those with mobility needs.

Home visits were available for housebound patients.

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). For the 2013 / 14 year, the QOF data showed that 95.8% of patients with schizophrenia, bipolar affective disorder and other psychoses had had a comprehensive care plan documented in their record, in the preceding 12 months, agreed between the individuals concerned, their family and/or carers as appropriate.

Summary of findings

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.

The practice GPs were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in the practice.

Patients with poor mental health had their records coded accordingly. This meant that this information was flagged up to reception staff when they called for appointments, and prompted them to offer these patients additional support such as longer appointments.

Summary of findings

What people who use the service say

We received 25 comment cards from patients, which were completed in the two weeks leading up to the inspection and on the inspection day itself. All the patients' comments were positive about the treatment they had received and the caring, attentive and helpful nature of the staff team. Patients described many examples of how they and their family members who were also patients had been treated with respect and concern, and said that they had been involved in their care and treatment decisions. Patients told us they were able to get appointments when they needed them. We spoke with eight patients during our inspection, and their feedback was also consistently positive and aligned with these views.

The practice had run a patient survey online through its website, and by paper forms completed in the practice, between November 2013 and February 2014. The results from this patient survey showed that over 80% of patients said their consultations with the GP were very good or good, and 86% of patients would describe their experience of the surgery as excellent, very good or good. In addition, 88% of patients found the receptionists very helpful or fairly helpful.

Data from the national GP patient survey showed that 76% of respondents describe their overall experience of this surgery as good; the local and national results for this question were 86%. In addition, 62% would recommend the surgery to someone new to the area; the local and national results were 80% and 78% respectively. Data from this source therefore suggested that the practice was performing somewhat below the local and national averages in terms of people's overall experiences.

In response to questions about their consultations with doctors and nurses in the national GP patient survey, 88% of practice respondents said the GP was good at listening to them, a result the same as the local and national average; and 82% said the GP gave them enough time which was similar to the local and national averages of 86%. Seventy three percent of practice respondents said the nurse was good at listening to them, which was similar to the local and national averages of 76% and 79% respectively. Furthermore, 76% said the nurse gave them enough time, which was the same as the local average and slightly below the national average of 81%.

Areas for improvement

Action the service MUST take to improve

- clarify its policies in relation to Disclosure and Baring Service (DBS) checks, and include these in its recruitment policy.
- ensure Disclosure and Barring service (DBS) checks are undertaken for all staff who undertake chaperone duties at the practice.

Action the service SHOULD take to improve

Ensure an automated external defibrillator (AED) is available, or have on record a risk assessment if a decision is made to not have an AED on-site.

Beddington Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

a **CQC Lead Inspector.** The other member of the team was a GP specialist advisor.

Specialist advisors who take part in inspections are granted the same authority to enter registered persons' premises as the CQC inspectors.

Background to Beddington Medical Centre

Beddington Medical Centre is located in Sutton, Surrey. It operates from converted premises which consist of a ground floor comprising the reception and waiting areas, treatment and consultation rooms. The upper floor of the premises has further consultation rooms and designated staff offices.

At the time of our inspection, there were 3682 registered patients in the practice.

The practice had a personal medical services (PMS) contract for the provision of its general practice services.

The practice staff team were two GPs, both male, one female practice nurse and regular locum practice nurse, a practice manager, an IT administrator and a team of four reception staff.

Beddington Medical Centre is registered with the Care Quality Commission (CQC) to carry on the regulated activities of Diagnostic and Screening procedures, Family planning services, Maternity and midwifery services, Treatment of disease, disorder or injury to everyone in the population.

The practice had opted out of providing out-of-hours services to their patients. Patients were directed to contact the national free-to-call medical helpline, 111, when the practice was closed.

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.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

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?

Detailed findings

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People 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 15 January 2015.

During our visit we spoke with a range of staff (GPs, practice manager, reception and administrative staff) and spoke with patients who used the service. We observed how people were being cared for and 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 used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last 12 months. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The Practice has a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last 12 months and we were able to review these. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms and sent completed forms to the practice manager. She showed us the system used to manage and monitor incidents. One incident had been recorded in the 12 months preceding our inspection. We saw that it was documented in a comprehensive and timely manner, and that actions and lessons learnt were also recorded.

The practice GPs were signed up to receive national patient safety alerts directly. They told us they discussed relevant alerts and decided how they would respond to them. They told us that where appropriate they shared them with other practice staff.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

One of the GPs was the lead in safeguarding children and the other GP for vulnerable adults. They had been trained, including in adult safeguarding and to level three in child protection, and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who the lead was and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. The practice also raised alerts under a centralised local system, the multi-agency safeguarding hub (MASH).

The practice clinical team provided reports to child protection conferences or attended them in person if possible.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, acted as chaperones.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

Processes were in place 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.

Good

Are services safe?

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of directions and evidence that nurses had received appropriate training to administer vaccines.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. Appropriate action was taken based on the results.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

One of the practice GPs was a member of the new drugs committee for a local clinical commissioning group. The committee decided on the formulary of new drugs to be used in the area. We saw minutes of meetings, updates and communications shared about the committee's work and evidence of the GP's involvement in the decision making process.

The practice GPs referenced prescribing guidelines issued by their local clinical commissioning group (CCG) as well as national guidelines. They worked closely and had good communications with the local pharmacists to ensure safe prescribing.

Cleanliness and infection control

Patients we spoke with and those who provided us with feedback through our comments cards told us they felt the environment in the practice was clean and well maintained. We observed the premises to be clean and tidy.

The reception team told us they had received an infection prevention and control (IPC) overview session from the nurse. They told us they rarely handled samples from patients, but if they needed to, they followed protocols which included using gloves and sample bags.

We saw there were cleaning schedules in place and cleaning records were kept.

The practice had a lead for infection control, who was the practice nurse. She had undertaken further training to enable her to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy, for example when they handled samples from patients. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

We saw evidence that the practice had received an IPC audit in September 2014 led by infection control team at NHS England. The practice had responded and made changes as a result of the audit findings, including replacing shelving in the consulting rooms with cupboards to minimise dust, ensuring occupational health contact details were made available to the staff team, and carrying out Legionella testing.

We saw records that confirmed the practice had arranged for legionella testing to be carried out by an external contractor in November 2014.

Equipment

There was equipment available to enable staff to carry out diagnostic examinations, assessments and treatments. We found that the equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed they were tested on 20 November 2014.

All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to

Good

Are services safe?

employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and evidence of criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

We found that the practice needed to clarify its policies in relation to DBS checks, as this was not mentioned in the recruitment policy. We found that the practice accepted DBS checks that had been carried out by an employee's previous employer, and did not complete a new one when an employee joined them. In addition, DBS checks were not completed for all staff that had chaperoning duties.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also 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 practice mitigated against risks to patients. For example, they had a policy whereby a GP should be in the practice whenever immunisation clinics were running. This was in order to support the response to any anaphylactic reactions to immunisations.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in first aid and basic life support in January 2013 (the training was valid for three years). Emergency equipment was available including access to oxygen. An automated external defibrillator (used to attempt to restart a person's heart in an emergency) was not available in the practice. When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia Processes were in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs 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. They provided us with examples of recent guidelines and clinical pathways they were following which included those relating to hypertension, transient ischaemic attack (TIA) or "mini stroke", and chronic kidney disease. The guidelines were stored on the practice shared computer drive and could be referenced by the clinical team when required.

We found from our discussions with the GPs that they completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease, musculoskeletal disorders and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions.

We were shown data from the local CCG of the practice's performance for antibiotic prescribing, which was comparable to similar practices. The practice had also completed a review of case notes for patients with high blood pressure which showed all were receiving appropriate treatment and regular review. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital, which required patients to be contacted by the practice for offer of additional support within two days of their hospital discharge.

The practice GPs held weekly referral meetings where regular reviews of elective and urgent referrals were made, and that improvements to practice were shared with all clinical staff. National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. The GPs we spoke with used national standards for the referral of patients with suspected cancers referred and seen within two weeks.

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

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management.

One of the GPs was able to provide minor surgical procedures, in the form of joint injections. We saw that appropriate records were completed for these procedures, and suitable entries made on the patients' notes.

The practice showed us three clinical audits that had been undertaken in the last two years, which were for anticoagulants, cervical cytology, and hypnotics prescribing. One of the audits we reviewed was of a hypnotics prescribing. The audit had been initiated to highlight inappropriate prescribing of hypnotics and promote the use of hypnotics in line with NICE and BNF guidance. The audit reviewed all patient prescribed hypnotics between 01 April 2011 and 31 March 2012. During the first cycle of the audit completed in September 2012, the auditor found some areas where they were not meeting the guidance: the practice had prescribed 10% of the patients hypnotics as non-acute items, 18% were prescribed hypnotics for more than three weeks and were provided more than three weeks' supply. A plan of action was put in place to address these areas where improvements were required, which included carrying out reviews with the patients where their treatment plan was discussed and alternative treatments explored. The practice also ensured hypnotics drugs were issued as acute items only, so could not be made available as a repeat prescription item, and that the items were prescribed for a maximum of three weeks at a time. A second cycle of the audit was completed in January 2015. They found improvements had been made. 3% of patients were now prescribed hypnotics for more than three weeks and were provided more than three weeks' supply. However the practice had not yet achieved full compliance in ensuring hypnotics were only prescribed as an acute item.

Good

Are services effective?

(for example, treatment is effective)

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

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The practice performed above the local and national averages for all clinical standards reported under the QOF, with the exception of osteoporosis and palliative care where they did not until recently have patients in those categories. For example, 83.9% of patients with asthma had had an asthma review in the preceding 12 months that includes an assessment of asthma control; the local and national averages were 9.5% and 8.4% respectively below this value. This practice was not an outlier for any QOF (or other national) clinical targets.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area.

The reception staff completed handover notes at the end of their shifts. They told us this allowed them to make sure any issues were followed up by the team taking over, and required actions taken. There were also notes of pharmacy prescriptions issued and when they were collected so that they could be traced.

There was a message book in use, for when patients called and requested to speak to a GP. The GPs told us that they responded to these requests after their morning and afternoon surgeries. We saw records that confirmed that the patients were called back, and there was appropriate documentation of these discussions in their notes, as well as of failed attempts to make contact with the patient if they had made a request.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in sourcing and allowing time for staff to attend training courses relevant to their role.

The practice recognised where they had staffing needs. They had had two practice nurses leave their employment in September 2014. At the time of our inspection they told us they were seeking to increase the nursing sessions, by offering an additional session.

The practice staff team received training relevant to their roles. For example the reception staff had attended training sessions in medical terminology, customer service, health and safety, and safeguarding adults and child protection.

One of the practice GPs had a specialist interest in diabetes mellitus, and was involved in providing leadership in its management to other GPs locally and nationally. We saw evidence of the programme of lectures that GP had been involved in.

Good

Are services effective?

(for example, treatment is effective)

Working with colleagues and other services

The practice GPs attended regular clinical meetings at the local hospital, where they discussed referral pathways, services available, and met with consultants to discuss the care of particular patients. They

The practice held monthly multidisciplinary meetings with their local district nurse and an end of life nurse specialist. They recently also started having separate end of life care meetings, working closely with a local hospice and their care team.

Information sharing

The practice used electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be received in a secure and timely manner. Electronic systems were also in place for making referrals through 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).

The practice used the electronic Summary Care Records system, which provided faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record system to coordinate, document and manage patients' care. All staff were fully trained on the system, and they were able to demonstrate to us how they used it to ensure records were kept up to date and appropriate actions were taken in response to correspondence received about patients. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff, for example with making do not attempt resuscitation orders. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions.

When interviewed, clinical staff gave examples of how a patient's best interests were taken into account if a patient 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 was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

Health promotion and prevention

It was practice policy to offer a health check with the health care assistant to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers.

The practice had found that their uptake of chlamydia screening had been low. They had installed special containers near the entrance to the practice, so patients could discreetly collect a test kit, without having to make a request at reception.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years.

The practice's performance for cervical smear uptake was 85.7%, which was better than the national average (81.9%). There was a policy to offer telephone reminders for

Good

Are services effective?

(for example, treatment is effective)

patients who did not attend for cervical smears and the practice audited patients who do not attend. There was also a named nurse responsible for following up patients who did not attend screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The 2013 /14 year's performance for all childhood immunisations was above the average for the local area, and again there was a clear policy for following up non-attenders by the named practice nurse.

The TV screen in the waiting area played health promotion notices and information for patients.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey (published in January 2015) and a practice patient survey. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, the results of the practice survey showed that over 80% of patients said their consultations with the GP were very good or good, and 86% of patients would describe their experience of the surgery as excellent, very good or good. In addition, 88% of our patients found the receptionists very helpful or fairly helpful.

We received 25 comment cards from patients, which were completed in the two weeks leading up to the inspection and on the inspection day itself. All the patients' comments were positive about the treatment they had received and the caring, attentive and helpful nature of the staff team. Patients described many examples of how they and their family members who were also patients had treated with respect, concern and that they had been involved in their care and treatment decisions. Patients told us they were able to get appointments when they needed them. We spoke with eight patients during our inspection, and their feedback was also consistently positive and aligned with these views.

Data from the national GP patient survey showed that 76% of respondents describe their overall experience of this surgery as good; the local and national results for this question were 86%. In addition, 62% would recommend the surgery to someone new to the area; the local and national results were 80% and 78% respectively. Data from this source therefore suggested that the practice was performing somewhat below the local and national averages in terms of people's overall experiences.

In response to questions about their consultations with doctors and nurses in the national GP patient survey, 88% of practice respondents said the GP was good at listening to them, a result the same as the local and national average; and 82% said the GP gave them enough time which was similar to the local and national averages of 86%. Seventy three percent of practice respondents said the nurse was good at listening to them, which was similar to the local and national averages of 76% and 79% respectively. Furthermore, 76% said the nurse gave them enough time, which was the same as the local average and slightly below the national average of 81%.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The staff told us they used patients' electronic record numbers to maintain confidentiality rather than their names or other personal information. There was a notice in the waiting area letting patients know that a private room was available if they needed to have a conversation with the staff without being overheard.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their GP involving them in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national GP patient survey showed 80% of practice respondents said the GP involved them in care decisions and 81% felt the GP was good at treating them with care and concern. Both these results were similar to the national averages of 82% and 85% respectively. However the data showed the practice respondents rated the nurse lower than the

Good

Are services caring?

national averages in these areas; 66% of practice respondents said the nurse involved them in care decisions and 72% felt the nurse was good at treating them with care and concern. The national averages to these questions were 85% and 90.5% respectively.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language.

Patient/carer support to cope emotionally with care and treatment

Patients were offered help and support during a time of bereavement. Notes were placed on patients' records alerting staff, so that they could be offered additional support if they called the practice. The GPs told us that they called the bereaved patient to offer their condolence and ask if there was any further support they needed. We saw records of this were written up in patients' notes.

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had a patient participation group (PPG) which had been active since July 2013. They had received input from their local Healthwatch into the development of the PPG. The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the PPG.

In response to patient feedback from their practice survey, the practice was planning to introduce a text reminders service.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example they had recently targeted patients who were carers in their seasonal flu campaign. This had led to a 71% increase in flu vaccination among this group from the previous year.

The practice had a population that included non-English speaking patients. It could cater for other different languages through translation services. The practice had access to in person and telephone translation services.

The practice accessed equality and diversity training through the training programme offered by their local CCG.

The premises and services had been adapted to meet the needs of patient with disabilities. There was a ramp access with hand grab rails to the automatic entrance door, which aided those with mobility needs in accessing the premises.

The practice actively supported patients who have been on long-term sick leave get the support they needed and to return to work. They provided sickness certificates and statements of fitness for work for patients who had been unable to work due to illness, and to help patients' employers understand the impact of their illness on them and their ability to work.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Access to the service

All consultations in the practice were by appointment only; the practice did not offer a walk-in service.

The practice clinic times were 09:00am to 12:00pm on Monday to Friday mornings, and 3:30pm to 6pm on Mondays to Thursday afternoons. The practice was closed on Friday afternoons. The reception opening hours were Reception hours are 09:00am to 1pm, then 3pm to 6.30pm on Mondays to Thursdays, and 09:00am to 1pm on Fridays. The practice did not offer extended opening hours. A doctor was available to speak to and see from 8am until 6.30pm Monday to Friday, and could be contacted even during Friday afternoon when the surgery was closed.

The practice informed us that from 01 April 2015, the reception hours would be from 8am to 6.30pm on Mondays to Fridays. The practice clinic times would be 09:00am to 12:00pm, and 3:00pm to 6pm on Mondays to Fridays. The practice would offer extended hours on a Tuesday evening between 6pm and 7.30pm.

Routine appointments could be booked up to a month in advance. Emergency appointments were available on the same day, through a telephone triage system where patients could call to speak to a doctor between 9am and10am and 3pm and 4pm. As part of the discussion with the GP they would judge the urgency of the illness or condition and offered an appointment accordingly. This GP telephone triage system had been introduced to help improve access to appointments following patient feedback.

A limited amount of appointments were available to be booked within 48 hours.

Comprehensive information was available to patients about the appointments system on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website.

The practice offered online services including appointments booking and ordering repeat prescriptions. These services were well publicised in the practice waiting area.

There was information about the arrangements to ensure patients received urgent medical assistance when the practice was closed, including the details of out of hours services and the local walk in centre.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse.

Patients were able to sign in on arrival for their appointment via an electronic terminal in the waiting area or directly with the reception staff. The appointments check in terminal provided them with information on the estimated wait time for their appointment which patients commented they found useful.

Patients we spoke with and those who provided us with feedback through our comments cards told us they were satisfied with the appointments system and were able to get appointments when they needed them. They confirmed that they could see a doctor on the same day if they had an urgent medical need. The practice manager reported that the triage system had helped to improve access, particularly for patients who were not able to attend the practice; and that other practices had asked them about the system with a view of considering whether it would be appropriate for their setting.

The responses from the national GP patient survey (published in January 2015) aligned with these views. The areas where the practice scored highest related to access to the service. Specifically, 75% of respondents said they usually waited 15 minutes or less after their appointment time to be seen; the national average was 66%. In addition, 79% of respondents found it easy to get through to this surgery by phone; whilst the local average was 74%. Finally 89% of respondents were able to get an appointment to see or speak to someone the last time they tried, when the local average was 86%.

Listening and learning from concerns and complaints

The practice has a system in place for handling complaints and concerns. Its complaints policy is in line with recognised guidance and contractual obligations for GPs in England and there is a designated responsible person who handles all complaints in the practice.

We saw that information was available to help patients understand the complaints system in the form of a complaints leaflet available from the practice reception and complaints information on their website. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at the seven complaints received in the12 months preceding our inspection. We found they were satisfactorily handled, dealt with in a timely way, and that there was openness and transparency with dealing with the complaints. We saw evidence that complaints were discussed at practice meetings and agreed action points hared with the staff team.

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

Beddington Medical Centre is a family run practice, which was started by the current principal GP's parents. The practice prides itself on being able to offer good continuity of care. Many of the practice's patients had been cared for by the principal GP's parents, who retired in 2014. The GP sessions were provided by two principal GPs, and a regular locum female GP who was available on Wednesdays.

The principal GPs told us the practice adopted and worked in line with local clinical commissioning group priorities.

Governance arrangements

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing better than the local and national averages. For the 2013 / 2014 year, the practice achieved an overall score of 97%, which was 5% above the local average and 3.5% above the national average. The practice had an IT administrator whose duties included monitoring the practice QOF performance, and implementing their recall system for patients who had not attended recommended appointments and reviews. The GPs also opportunistically used other appointments with patients to offer services such as flu vaccinations.

We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

Leadership, openness and transparency

Staff we spoke with told us the management team were caring and supportive, and that they found the practice to be a good working environment.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, including the recruitment policy, safeguarding policy and the whistleblowing policy. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

Staff meetings were held on the first Thursday of every month. Staff we spoke with told us these meetings were useful in sharing news of any upcoming events and programmes, and problems or issues all staff should know about.

Staff received annual appraisals, which were carried out for most of the staff team by the practice manager. Staff we spoke with told us between appraisals they felt able and supported to raise any issues with the practice manager.

Management lead through learning and improvement

Staff told us the practice supported them to develop in their roles, including those maintaining clinical professional development. The practice manager told us they made use of the CCG induction programme for new staff in GP practices which included a range of relevant topics such as customer care, dealing with difficult situations, equality and diversity, health and safety, medical terminology and chaperone training.

We looked at two staff files and saw that annual appraisals took place. The appraisals were a two way process where the appraiser and the staff member both contributed to the discussions and agreed on the performance achieved in the year as well as actions that needed to be taken to support the staff member concerned in the year ahead.

We saw evidence that the clinical team maintained their continuous professional development and attended relevant courses, seminars and meetings. The principal GP was also a tutor for medical students.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients.