

Beacon View 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 a planned comprehensive inspection of Beacon View Medical Centre

on 06 January 2015.

Overall, we rated the practice as good. We found the practice to be good for providing safe, effective, caring, responsive and well-led services. Our key findings were as follows:

- The services had been designed to meet the needs of the local population.
- Feedback from patients was positive; they told us staff treated them with respect and kindness.
- Staff reported feeling supported and able to voice any concerns or make suggestions for improvement.

- The practice was visibly clean and tidy.
- The practice learned from incidents and took action to prevent any recurrence.

We saw the following area of outstanding practice:

- The practice participated in the FLORENCE project. The project enabled certain patients with chronic obstructive pulmonary disease (COPD) to be monitored remotely and self-administer medication from tailored rescue packs when necessary. The project has shown an overall reduction of 70% in the hospital admissions rate of patients involved in the project.

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?

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. 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 people safe.

Good



Are services effective?

The practice is rated as good for providing effective services. Care and treatment was being delivered in line with current published best practice. They used the data from the Quality Outcomes Framework (QOF) to assess how the practice was performing. 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 implementing preventative measures. The results are published annually. For 2014 the practice achieved an overall QOF score of 99.8% which was above the England average by 6.3%.

Patients' needs were being met and referrals to other services were made in a timely manner. The practice regularly undertook clinical audits.

Staff had received training appropriate to their roles. The practice worked with other healthcare professionals to share information.

Good



Are services caring?

The practice is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. The results of the National GP Patient Survey showed patients felt the GPs and nurses involved them in decisions about their care. We saw that 88% of patients said they had confidence and trust in their GP, compared to the national average 93% and 81% said their GP was good at treating them with care and concern, compared to the national average 83%. We also saw that 87% of patients said they had confidence and trust in their nurse, compared to the national average of 86% and 83% said their nurse was good at treating them with care and concern, compared to the national average 79%.

Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Good



Summary of findings

Are services responsive to people's needs?

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS 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 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. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. We saw that lessons were learnt from complaints and shared with staff.

Patients experiencing poor mental health had their needs reviewed. For example, data showed that 100% of patients on the dementia register had their needs reviewed within the preceding 12 months. This was 16.2% higher than the national average.

Good



Are services well-led?

The practice was rated as good for well-led. The practice had a clear vision and strategy which had quality and safety as its top priority. There was also a strategy in place to implement this vision.

Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by the management team. The practice had a number of policies and procedures to govern activity and held regular governance meetings. 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 upon. There was an active patient participation group (PPG). Staff had received inductions, performance reviews and attended staff meetings and events. We found there was a high level of staff engagement and staff satisfaction.

Good



Summary of findings

The six population groups and what we found

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

Older people

The practice is rated as good for the care of older people.

Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older people. The practice offered personalised care to meet the needs of the older people in its population. The practice gave us an example of how reception staff had identified and escalated concerns they had about an older patient to the clinical team which they addressed.

The practice had written to patients over the age of 75 years to inform them who their named GP was. The practice was responsive to the needs of older people, including offering home visits.

Good



People with long term conditions

The practice is rated as good for the care of people with long-term conditions.

The practice had systems to ensure care was tailored to patients' individual needs and circumstances. We spoke with GPs and nurses who told us regular patient care reviews, for example for patients with chronic obstructive pulmonary disease (COPD - severe shortness of breath caused by chronic bronchitis, emphysema, or both) or asthmatic conditions, took place. These appointments included a review of the effectiveness of patients' medicines, as well as their general health and wellbeing. In addition, the practice participated in the FLORENCE project. The project enabled certain patients with COPD to be monitored remotely and self-administer medication from tailored rescue packs when necessary. The project had shown an overall reduction of 70% in the hospital admissions rate of patients involved in the project.

The practice ensured timely follow-up of patients with long-term conditions by adding them to the practice registers. Patients were then recalled as appropriate, in line with agreed recall intervals.

Good



Families, children and young people

The practice is rated as good for the care of families, children and young people.

Systems were in place for identifying and following-up children who were considered to be at-risk of harm or neglect.

Good



Summary of findings

Appointments were available outside of school hours and the premises were suitable for children and babies. Arrangements had been made for new babies to receive the immunisations they needed.

The practice held regular maternity and baby clinics.

Working age people (including those recently retired and students)

The practice is rated as good for the care of working age people (including those recently retired and students).

The needs of the working age population, those recently retired and students, had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, the practice provided us with evidence that they undertook regular reviews of a patient's health over the telephone to fit in with their frequent work trips abroad.

Good



People whose circumstances may make them vulnerable

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

Systems were in place to identify patients, families and children who were at risk or vulnerable. These patients were offered regular reviews. The practice worked in collaboration with other agencies, for example, health visitors and district nurses, to ensure vulnerable families and children and other patients were safe. Multidisciplinary meetings were also held regularly to monitor the care provided.

The practice worked with patients being treated for addictions and provided personalised support.

The practice sign-posted vulnerable patients to various support groups and other relevant organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children and were aware of their responsibilities to ensure they were safeguarded.

Good



People experiencing poor mental health (including people with dementia)

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia).

Patients experiencing poor mental health had received an annual physical health check. The practice worked closely with multidisciplinary teams in the case management of people experiencing poor mental health. For patients with dementia their care had been reviewed in a face-to-face appointment in the preceding 12 months.

Good



Summary of findings

The practice worked with patients experiencing poor mental health and provided personalised support. For example, the practice provided evidence that they appropriately reviewed the needs of patients experiencing substance misuse issues.

Summary of findings

What people who use the service say

We spoke with four patients during our inspection. They told us the staff who worked there were caring and understanding, and there were no problems getting appointments. They also told us they found the premises to be clean and tidy.

We reviewed seven CQC comment cards which had been completed by patients prior to our inspection. All were complimentary about the practice, staff who worked there and the quality of service and care provided.

The latest National GP Patient Survey completed in 2014 showed the large majority of patients were satisfied with the services the practice offered. There were 317 surveys sent out and 124 were returned.

This was a 39% completion rate. The results were:

- 85% of patients said they would recommend their GP surgery, compared to a national average of 79%;
- 77% of patients said they were 'fairly satisfied' or 'satisfied' with the opening hours, compared to the national average of 77%;
- 86% of patients said that it was 'very easy' or 'easy' to get through on the phone, compared to the national average of 73%;
- 84% of patients said that their experience of making an appointment was 'fairly good' or 'very good', compared to the national average of 75%;
- 89% of patients said their practice was 'fairly good' or 'very good', 89%, compared to the national average of 86%.

Outstanding practice

The practice participated in the FLORENCE project. The project enables certain patients with chronic obstructive pulmonary disease (COPD) to be monitored remotely and

self-administer medication from tailored rescue packs when necessary. The project has shown an overall reduction of 70% in the hospital admissions rate of patients involved in the project.

Beacon View Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team also included a GP.

Background to Beacon View Medical Centre

Beacon View Medical Centre provides services to around 4507 patients, from Beacon Lough Road, Gateshead, Tyne and Wear, NE9 6YS.

The practice area covers a five mile radius of the surgery. The practice provides their services under a NHS General Medical Services (GMS) contract.

The practice is located in a purpose built two storey building, all patient facilities are situated on the ground floor. It also offers on-site parking, a disabled WC, wheelchair and step-free access.

The practice has two GPs partners and one salaried GP, two practice nurses, two health care assistants, a practice manager, a deputy practice manager and four administration and support staff.

The opening hours for the practice are 8:00am to 6:00pm Monday, Tuesday, Thursday and Friday. On Wednesdays it is open from 8:30am to 8:00pm.

The practice has opted out of providing urgent medical attention out of hours to their own patients and this is provided by GatDoc and the NHS 111 service.

Why we carried out this inspection

We inspected this service as part of our 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 the 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?

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

Detailed findings

- 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. This included the local Clinical Commissioning Group (CCG). This information did not highlight any areas of risk across the five key question areas.

We carried out an announced visit on 06 January 2015. We spoke with four patients, two GP partners, two GP registrars, two nurses, two health care assistant, the practice manager and two of the administration team. We also spoke with two members of the patient participation group (PPG). We observed how staff received patients as they arrived at or telephoned the practice and how staff spoke with them. We reviewed seven CQC comment cards where patients and members of the public had shared their views and experiences of the service. We also looked at records the practice maintained in relation to the provision of services.

Are services safe?

Our findings

Safe track record

The practice had a good track record for maintaining patient safety.

Patients we spoke with said they felt safe when they came into the practice to attend their appointments. Comments from patients who completed CQC comment cards were complimentary about the service they had received and raised no concerns about their safety.

We saw that the practice used the Information from the Quality and Outcomes Framework (QOF) to monitor their patients. For 2014 the practice achieved an overall score of 99.8% which was above the England average by 6.3%. (The 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, e.g. diabetes and implementing preventative measures. The results are published annually).

The practice had a significant event audit (SEA) policy and procedures that staff followed. SEAs enable the practice to learn from patient safety incidents and 'near misses', and to highlight and learn from both strengths and weaknesses in the care they provide. The practice also maintained an annual list of safety incidents which helped in identifying any emerging patterns. We saw records for 2014 which listed five significant events. Some examples of SEA were given to us. We saw that one led to a change of method in the monitoring of patients receiving hormone replacement therapy. We found that it had been dealt with appropriately to avoid any recurrences and had been discussed with relevant staff.

Learning and improvement from safety incidents

The practice was open and transparent when there were 'near misses' or when things went wrong. There was a system in place for reporting, recording and monitoring significant events. In addition to their significant event records the practice used the Safeguarding Incident and Risk Management System (SIRMS). This is an on-line incident reporting system which enables information about incidents to be shared with CCG member practices. We saw an incident report schedule for April 2014 to September 2014. It had eight entries. The schedule included details of the incident and actions taken by the practice. The actions included advising staff of the incident, changing the ways

things were done and advising other health care providers who were involved what had occurred to reduce the likelihood of any recurrences. Staff told us that incidents were reviewed at regular practice meetings and changes were made as necessary. We saw evidence, for example, notes of a practice meeting in October 2014 that confirmed this.

We discussed the process for dealing with safety alerts with the practice manager. Safety alerts inform the practice of problems with equipment or medicines or give guidance on clinical practice. They told us alerts came into the practice from a number of sources, including the General Medical Council (GMC) and the clinical commissioning group (CCG.) All safety alerts were received by the practice manager who forwarded the email to all clinicians to action. All alerts were kept on computer and a hard copy was taken as a back-up. Any alerts relating to medication were also sent to the practice pharmacist to action.

Reliable safety systems and processes including safeguarding

We saw the practice had safeguarding policies in place for both children and vulnerable adults. We also saw the practice provided guidance on safeguarding for staff which included how to identify report and deal with suspected abuse. The practice displayed a contact list of other agencies that may need to be informed when concerns arise such as the local police and Social Services.

The practice had safeguarding leads for both children and adults with responsibilities for overseeing safeguarding within the practice. The safeguarding lead for children was trained to Level 3. The practice manager told us that all relevant staff had been trained and were up-to-date in safeguarding adults and children. We saw training records that confirmed this. The staff we spoke with had a good knowledge and understanding of the safeguarding procedures and what action should be taken if abuse was witnessed or suspected.

The practice had a process to highlight vulnerable patients on their computerised records system. This information would be flagged up on patient records when they attended any appointments so that staff were aware of any issues.

The practice had a chaperone policy. There were notices on display in the waiting area to inform patients of the availability of chaperones. Staff told us that the chaperones

Are services safe?

were trained. The staff we spoke with were clear about the requirements of their roles as chaperones. (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 the chaperones had been checked by the Disclosure and Barring Service (DBS). The DBS checks to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

Medicines management

We checked vaccines stored in the medicine refrigerators. We found they were stored securely and were only accessible to authorised staff. Maximum and minimum temperatures of the vaccine refrigerators were monitored daily by the nurses. Vaccines were administered by nurses using patient group directions (PGDs) and patient specific directions (PSDs). PGDs and PSDs are specific guidance on the administration of medicines authorising nurses and health care assistants to administer them.

The practice was supported by a pharmacist. Their role included working closely with GPs to undertake medication reviews with patients by telephone or face to face meetings. A medicines review includes an examination of a patient's medicines, reaching an agreement with the patient about treatment, optimising the impact of medicines and minimising the number of medication related problems.

The practice used a system to review all hospital discharge letters and checked to ensure that any changes to medication by the hospital were appropriate and recorded on the patients' record.

Cleanliness and infection control

The practice was clean, tidy and well maintained. The patients we spoke with about the cleanliness of the practice told us that it was always clean and tidy.

The practice had a lead for infection control and an infection control policy. All of the staff we spoke with about infection control said they knew how to access the practice's procedures for infection control and had received infection control training. We saw the last infection control audit took place in June 2014 which did not highlight any concerns.

The risk of the spread of infection was reduced as all instruments used to examine or treat patients were

single-use, and personal protective equipment (PPE), such as aprons and gloves, were available for staff to use. Hand washing instructions were also displayed by hand basins and there was a supply of liquid soap and paper hand towels. We saw training records that showed all staff had received training in October 2014 in the use of PPE, handling samples and hand washing.

The practice employed a cleaning contractor. The practice had daily, weekly and monthly schedules to indicate which areas required cleaning. We saw the practice manager had kept a record of the 'spot checks' they had undertaken to ensure the practice was clean. The record covered the period February 2014 to December 2014. At the time of the inspection the practice was clean and tidy.

We saw there were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades.

We saw that a legionella (legionella is a bacterium that can grow in contaminated water and can be fatal) risk assessment took place in October 2013 no concerns were identified.

Equipment

The practice had processes in place to make sure that equipment was regularly checked to ensure that it was safe and effective to meet patients' needs. The fire extinguishers were checked in January 2014. We saw that all the medical equipment had been checked or calibrated in December 2014. We saw that the defibrillator was checked daily. We saw that a portable appliance test (PAT) had been undertaken in 2014. (Portable appliance testing (PAT) is the term used to describe the examination of electrical appliances and equipment to ensure they are safe to use.)

Staffing and recruitment

We saw that the practice had a recruitment policy. The practice manager told us they took up references. Staff we spoke with confirmed this. They also obtained photographic proof of identity and satisfactory documentary evidence of any relevant qualifications in accordance with regulations. The practice undertook an induction process for all new staff. A new member of staff we spoke with confirmed that they had undertaken a period of induction.

Are services safe?

We saw that the practice manager regularly checked online with the relevant authorising bodies to ensure that the GPs and nurses maintained their registration which allowed them to practice. For example, we saw that they checked the nurses' registration in December 2014.

All clinical staff that were in contact with patients had been subject to DBS checks. This demonstrated that the practice had taken reasonable steps to ensure that the staff they employed were suitable to work with vulnerable patients.

The practice manager told us that they employed sufficient numbers of suitably qualified, skilled and experienced staff. Staff told us that colleagues were very supportive and they were a really good team. The patients we spoke with and comments made on the CQC comment cards did not raise any concerns about access to appointments. The practice had a procedure for managing staff absences.

Appropriate staffing levels and skill-mix were provided by the practice during the hours the service was open. Staff we spoke with were flexible in the tasks they carried out and they also told us that they worked well as a team and covered for each other when necessary to ensure their patients received good care.

Monitoring safety and responding to risk

The practice had a well-established system in place to manage and monitor health and safety. Their health and safety policy, which was reviewed in July 2013, reminded staff of their individual responsibility for the health and safety of themselves and other people who may be affected by the practice's activities. Staff received health and safety training at induction and regular refresher training such as manual handling.

We saw records showing that the fire alarms were tested weekly and the fire extinguishers tested annually. They were last tested in January 2014. The practice had undertaken a full evacuation fire drill in July 2014. The training records showed that most staff had completed a fire safety training course in 2014.

Arrangements to deal with emergencies and major incidents

The practice had detailed plans in place to ensure business continuity in the event of any foreseeable emergency, for example, a fire or flood. The practice manager told us that copies of the plan were kept off-site so this could be accessed if practice staff were unable to gain entry to the practice. The plans included essential contact numbers such as electricity suppliers and the water authority.

The practice had resuscitation equipment and medication available for emergencies. Arrangements were in place to check emergency medicines were within their expiry date and suitable for use. All of the staff we spoke with told us they had either attended CPR (resuscitation) training or refresher training had been scheduled. We looked at records which confirmed this. Clear guidance was available for staff on how to deal with a medical emergency, including when they needed to seek help from emergency services such as paramedics or ambulance staff. This ensured staff had sufficient support and knew what to do in emergency situations. Therefore staff knew to call an ambulance in a medical emergency.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Care and treatment was considered in line with recognised best practice standards and guidelines.

GPs and nurses demonstrated an up-to-date knowledge of clinical guidelines for caring for patients. There was an emphasis on keeping up-to-date with clinical guidelines, including guidance published by professional and expert bodies such as the National Institute for Health and Care Excellence (NICE) and from local health commissioners Gateshead Clinical Commissioning Group (CCG).

The practice had processes in place to ensure current guidance was being followed. They used the data from the Quality Outcomes Framework (QOF) to assess how the practice was performing following the current guidance. The practice was aware of their achievements in comparison to other local practices and nationally. For example, we saw that they achieved the second best score out of 32 practices locally for addressing substance misuse. This showed that there were fewer patients, in comparison to similar practices locally that were being prescribed hypnotic medication. This followed action by the practice to reduce the number of patients who were dependent on this type medication.

The practice coded patient records using specific READ Codes. These are codes which provide the standard vocabulary by which clinicians can record patient findings and procedures in health and social care IT systems. This enabled them to easily identify patients with long-term conditions and those with complex needs. We found from our discussions with the GPs and the nurses that staff completed, in accordance with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate. For example, the practice had planned for, and made arrangements to deliver, care and treatment to meet the needs of patients with long-term conditions. There were regular clinics where patients were booked in for an initial review of their condition; they were then scheduled for recall appointments. This ensured patients had routine tests, such as blood or spirometry tests to monitor their condition (A spirometer measures the volume and speed of air that can be exhaled and is a method of assessing lung function).

We saw evidence that the practice were appropriately reviewing the healthcare needs of people with long term conditions. For example, patients with asthma the QOF data showed that 90.2% had an asthma review within the previous 12 months, which was 14.7% above the national average.

The practice manager told us that all new patients were offered new patient health checks which included a comprehensive assessment of their health needs by nurses or HCAs. Any patients identified with health care needs were referred to a GP to follow up.

Staff told us that all patients over the age of 75 had a named GP who was responsible for their care. Patients could request a different GP if that was their preference. This helped to ensure continuity of care.

The practice kept a register of patients with learning disabilities which enabled them to monitor their care effectively. Staff told us that they undertook home visits for patients with learning difficulties. They also liaised with a local home for patients with learning difficulties which helped ensure coordinated care for these patients.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles, which led to improvements in clinical care. We saw records of five audits that had been undertaken in the last 12 months two of which had completed a full two year audit cycle. We saw an example of an audit of patients with heart problems. The patients had been reviewed annually to ensure that they had been prescribed the most effective medication for their condition.

The practice used the information from QOF to monitor the practice's progress against their QOF targets to ensure that patients were invited for routine regular monitoring tests such as blood pressure checks. The practice told us that they monitored all patients with long term conditions every four months.

We reviewed a range of data available to us prior to the inspection relating to health outcomes for patients. We saw that under the clinical heading the overall achievement for QOF 2013/14 was 99.8%, which was 6.3 percentage points above the England average.

The practice had systems to ensure care was tailored to patients' individual needs and circumstances. The practice

Are services effective?

(for example, treatment is effective)

held registers of various patients, such as those with learning difficulties aged 18 and over, patients suffering from Chronic Obstructive Pulmonary Disease (COPD) – severe shortness of breath caused by chronic bronchitis, emphysema or both. These enabled the practice to monitor those patients and the care offered. We saw evidence that patients with complex needs had their care planned. For example QOF data showed that 97.7% of patients with mental health issues had a comprehensive care plan documented in the record, in the preceding 12 months; this was 11.8% higher than the national average. The practice achieved 100% in the ‘Palliative care’ category, which was 3.3 percentage points above the England average. The practice also achieved 100% in the ‘Cancer’ category, which was 4.5 percentage points above the England average. In addition the practice achieved 100% in the ‘Heart Failure’ category, which was 2.9 percentage points above the England average.

The practice participated in the FLORENCE project. The project enables certain patients with COPD (COPD is a severe shortness of breath caused by bronchitis, emphysema, or both.) to be monitored remotely and self-administer medication from tailored rescue packs when necessary. The project has shown an overall reduction of 70% in the hospital admissions rate of patients involved in the project.

Effective staffing

Practice staffing included administrative, clinical and managerial staff. We reviewed staff training records and saw that the practice had a method of recordings training undertaken and when the training needed updating. Clinical staff maintained their individual continuing professional development (CPD) records. Good medical practice requires doctors and nurses to keep their knowledge and skills up to date throughout their working life and to maintain and improve their performance. CPD is a key way for them to meet their professional standards.

We saw from the staff training records that staff had attended courses which included safeguarding for children and vulnerable adults, and fire safety. All staff were up-to-date with mandatory courses such as basic life support. Staff undertook ‘Time in and Time out’ training courses which gave the staff an opportunity to undertake undisturbed formal and informal training.

All GPs were up to date with their yearly continuing professional development requirements and all either had

been revalidated, or had a date for revalidation (every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the NHS England). We saw that both partners had completed their revalidation in 2014.

All staff had received an annual appraisal. We saw records that confirmed this. During the appraisals, training needs were identified and personal development plans put into place. The practice had an ‘open door’ policy whereby all staff were encouraged to freely raise any issues or concerns in meetings or privately with the practice manager, and GPs. All staff we spoke with confirmed this and told us they would have no problems in raising any issues and also said they felt well supported by the practice.

Nursing staff told us that they worked well as a team and were mutually supportive. The nurses also mentored the health care assistants (HCA) and undertook clinical supervisions with them. The nurses had their appraisals with the lead GP.

The practice manager told us that all staff had had appraisals. Staff we spoke with confirmed this and told us action plans were completed to address relevant issues, such as training. We saw a copy of the annual appraisal for a receptionist which took place in April 2014 which confirmed this.

We looked at the training records for the practice and saw that they offered staff training that covered safeguarding, fire safety and Cardiopulmonary resuscitation (CPR), along with other courses appropriate to their work.

The patients we spoke with were complimentary about the staff. There were no negative comments, and five positive comments, about staff in the seven CQC comment cards we reviewed.

Working with colleagues and other services

The practice worked closely with other health and social care providers, to co-ordinate care and meet their patients’ needs. For example, they worked with the community matron and secondary care teams, such as heart failure nurses, and respiratory nurses. The practice also worked with the community nursing team to provide care to patients in their own homes.

Are services effective?

(for example, treatment is effective)

Multidisciplinary meetings which included practice nurses, GPs, if available district nurses, health visitors and other health care professionals were held regularly. We saw from the notes of practice meeting in October 2014 that a community matron had also attended. The notes of a quarterly palliative care meeting showed that a district nurse and palliative care nurses had attended.

Correspondence from external health care and service providers, such as letters from hospital including discharge summaries, blood tests, information from out-of-hours providers and the 111 service, were received both electronically and by post and distributed to relevant staff to action.

Information sharing

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. These records generated alerts which included prompts to staff that a patient needed medical reviews such as blood tests.

Staff told us that they shared patient information with the out of hour's service which helped ensure that their patients received appropriate care.

Regular meetings were held throughout the practice. These included staff, clinical and multidisciplinary team meetings. Information about risks and significant events were shared openly at meetings. Patient specific issues were also discussed with appropriate staff and other health care professionals to enable continuity of care. We saw notes of a practice meeting held in October 2014. Topics discussed included discussing incident reports and changes to the practice protocols for monitoring patients receiving hormone replacement therapy

Consent to care and treatment

Staff we spoke with were able to give examples of how they obtained implied, verbal and written consent.

We found that staff were aware of the Mental Capacity Act (MCA) 2005 and their responsibility in respect of consent prior to giving care and treatment. They described the

procedures they would follow where patients lacked capacity to make an informed decision about their treatment. The practice told us about an anonymized case study of a patient with memory problems and how they assessed the patient's capacity. The practice involved the patient, liaised with the patient's family and support agencies to implement measures which enabled the patient to live safely in the community in accordance with their wishes.

The clinicians we spoke with showed they were knowledgeable about how and when to carry out Gillick competency assessments of children and young people. Gillick competence is a term used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

Health promotion and prevention

A range of health promotion information was available to patients in the reception and waiting area of the practices. This included information about lifestyle management such as smoking cessation.

The practice proactively identified patients who needed ongoing support. In particular, they identified carers and placed a flag on their records so that clinicians were made aware of this before these patients attended appointments. The practice undertook annual reviews for patients with long term conditions or more frequently when needed.

The practice identified patients who would benefit from treatment and regular monitoring, for example, they offered flu vaccinations and immunisations for children in line with current national guidance. Data showed that 93.3% of children received the second dose of the MMR vaccination, compared to the CCG average of 91.5%.

The practice told us that they were proactive and opportunistic when offering NHS health checks to patients. The practice undertook various health checks which included health checks for patients between 40 and 70 years old.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We spoke with four patients during our inspection. They were complimentary about the services they received. Comments left by patients on the seven CQC comment cards we received also reflected this. Words used to describe the approach of staff included helpful, friendly and cannot fault.

We looked at data from the National GP Patient Survey, published in July 2014. They issued 317 questionnaires and 124 were returned. This showed that patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, 89% of patients in this survey said they thought their overall experience was good, compared to the national average 86%. For the helpfulness of reception staff the practice achieved 92%, compared to the national average 87%. We saw that 88% of patients said they had confidence and trust in their GP, compared to the national average 93% and 81% said their GP was good at treating them with care and concern, compared to the national average 83%. We also saw that 87% of patients said they had confidence and trust in their nurse, compared to the national average of 86% and 83% said their nurse was good at treating them with care and concern, compared to the national average 79%.

Staff we spoke with told us how they would protect patient's dignity. Consultations took place in purposely designed consultation rooms with an appropriate couch for examinations and curtains to maintain privacy and dignity. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in those rooms could not be overheard.

We saw the reception staff dealt with patients pleasantly and warmly. The reception staff were aware of the need for confidentiality. They ensured conversations were conducted in a confidential manner. For example, a radio was playing in the background to obscure their conversation and staff also spoke quietly so their conversations could not be overheard.

Care planning and involvement in decisions about care and treatment

Staff told us that they used a 'one stop' appointment process where clinical staff would consider and address all the patients issues at a single appointment rather than call a patient back for a number of appointments.

Patients told us they felt they had been involved in decisions about their care and treatment. They told us that the clinical staff took their time with them and always involved them in decisions. The results of the National GP Patient Survey from July 2014 showed patients felt the GPs and nurses involved them in decisions about their care. Seventy nine per cent of patients surveyed rated GPs good at involving them in decisions, compared to the national average 75%. For nurses this was 76% compared to the national average 67%. In addition 83% of patients surveyed rated GPs good at explaining the need for any test or treatments, compared to the national average 82%. For nurses this was 76% compared to the national average 67%. This demonstrated that most patients who responded were satisfied with the way they were treated.

For example, patients told us they felt 'fully involved' and 'well cared for'. The practice gave us an example of how they involved patients, family members and support agencies with their care.

We saw that access to interpreting services was available to patients, should they require it.

Patient/carer support to cope emotionally with care and treatment

Staff told us that in addition to pre-bookable appointments the practice offered urgent appointments on the same day. These services gave patients assurance that their needs would be met on the day they contacted the practice. The practice also undertook home visits for those patients not well enough to attend the practice.

The practice offered support to patients receiving end of life care at home. Such as having a care plan which included a record of patient's wishes in the event of cardiac or respiratory arrest. Staff told us that bereaved relatives and carers would be contacted by the practice to offer them support. The practice also used a non-clinical room specifically for counselling patients.

Are services caring?

We saw there was a variety of patient information on display throughout the practice. This included information on health conditions, health promotion and various support groups and services.

The practice worked with patients experiencing poor mental health and provided personalised support. For example, with the patients consent a GP reviewed the patient's needs with members of their family present and where appropriate agreed to issue weekly prescriptions for the patient's safety. They also offered the patient regular reviews and liaised with secondary care for additional support for them.

The practice also held regular multidisciplinary team meetings where they planned care for patients, such as those experiencing mental health problems, who would benefit from coordinated support from other health care providers in conjunction with the care provided by the practice. For example, a patient was supported by the practice to access the practice substance misuse practitioner in house. This was agreed as an alternative to referring to another service, which they were reluctant to attend. The structured programme of support led to a successful recovery.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Staff told us that patients suffering from some long term conditions such as diabetes were given longer appointment times if necessary.

The practice gave an example where they met a patient's specific need. The patient was unable to tolerate florescent lighting. The practice ensured that when the patient attended their appointment the florescent lighting was switched off.

Patients we spoke with told us they felt they had sufficient time during their appointment. Results of the National GP Patient Survey from 2014 confirmed this with 87% of patients stating the doctor gave them enough time and 84% stating they had sufficient time with the nurse. These results were well above the national averages (86% and 81% respectively).

The practice used electronic notes and alerts which were attached to medical records to advise staff that patients had additional needs such as, for example, a learning disability or that they were a carer.

The practice offered personalised care to meet the needs of the older patients in its population. The practice had written to patients over the age of 75 years to inform them who their named GP was.

There was information available to patients in the waiting room and reception area about support groups, various clinics such as the flu clinics, and health and wellbeing advice.

Tackling inequity and promoting equality

The practice had recognised the needs of the different groups in the planning of its services.

Nationally reported data showed the practice had achieved good outcomes in relation to meeting the needs of patients whose circumstances may make them vulnerable. Registers were maintained, which identified which patients fell into these groups. The practice used this information to ensure patients received an annual healthcare review and access to other relevant checks and tests. Patients experiencing poor mental health had their needs reviewed. For example, 100% of patients on the dementia register had their needs reviewed within the preceding 12 months. This was 16.2% higher than the national average.

The practice registered patients from out of area who were in vulnerable circumstances as temporary patients to ensure they had access to primary care. The practice registered those patients initially on a provisional basis which ensured that they were offered the care and treatment required in the short-term. Staff told us that most of these patients were happy with the services they received and stayed with the practice. The practice scheduled appointments for these patients which took into account their specific circumstances.

Staff told us that the practice offered extended appointments for patients who needed them.

There was parking available in a car park directly outside the practice. The practice buildings had step free access for patients with mobility difficulties. The consulting and treatment rooms were accessible for all patients. There were disabled toilet facilities available at the practice.

The practice had arrangements in place to access interpretation services for patients whose first language was not English.

Access to the service

Opening times for the practice were 8:30am to 6:00pm Monday, Tuesday, Thursday and Friday. On Wednesdays it was open from 8:30am to 8:00pm. Baby clinics were held on Thursdays between 1:30pm to 3:00pm for routine immunisations of babies and children.

Staff told us that if patients telephoned the practice at 8:30am they would usually get an appointment with any GP that day. Feedback from patients we spoke with, and those who completed CQC comment cards, did not raise any concerns about getting an appointment with a clinician on the day if their need was urgent.

Patients were able to book appointments either by calling into the practice, on the telephone or online. Home visits were available for patients who needed them. The practice also undertook patient reviews over the telephone. For example, they undertook regular reviews of a patient's health over the telephone to fit in with their frequent work trips abroad.

The practice had implemented safe procedures to ensure those patients who had a history of violent behaviour towards staff could still receive healthcare from the practice, with safeguards put in place to manage known

Are services responsive to people's needs?

(for example, to feedback?)

risks. For example undertaking telephone consultations and scheduling patient face to face appointments at the end of sessions when there likely to be fewer patients around.

Most of the patients we spoke with commented on the appointments system. They said they were satisfied with the appointment systems operated by the practice. Some patients commented that it was easy to get an appointment. This was reflected in the results of the most recent National GP Patient Survey (2014). This showed 84% of respondents described their experience of making an appointment as 'very good' or 'fairly good', in comparison to the national average 75% and 96% said that the last appointment they got was 'convenient for them', in comparison to the national average 92%.

The practice had an up-to-date practice leaflet which provided information about the services available, contact details and repeat prescriptions. The practice also had a clear, easy to navigate website which contained detailed information to support patients.

Listening and learning from concerns and complaints

The practice had a system in place 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.

There was information displayed in the waiting room and within the practice leaflet, informing patients of the practice complaints process. The practice leaflet explained that the practice manager would be happy to deal with any concerns patients had about the services they provided.

None of the four patients we spoke with on the day of the inspection said they had felt the need to complain or raise concerns with the practice. In addition, none of the seven CQC comment cards completed by patients indicated they had felt the need to make a complaint.

Staff we spoke with were aware of the complaints policy and the action they needed to take if they received a complaint which included informing the practice manager of any complaints made to them.

We saw that the practice had recorded their complaints in an annual register. We saw that they had received two complaints in 2013/14. A summary of the complaint, details of the steps taken to address the complainant were recorded. Any learning from the complaints was recorded and shared with staff at staff meetings.

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 mission statement which was, 'The practice team are committed to providing high quality care to all users of our services. To be responsive to the needs of our patients and treat each patient as an individual.'

The staff we spoke with all knew and understood the vision and values and what their responsibilities were in relation to these. Staff also told us that the practice was patient centred.

The practice manager told us that the practice had an open culture where staff were encouraged to discuss issues with colleagues and GPs when the need arose. Staff we spoke with confirmed this and told us that the practice was very supportive and they had no concerns about raising any matters with colleagues, GPs or the practice manager.

Governance arrangements

We saw that the practice had developed a clear leadership structure showing lines of accountability for all aspects of patient care and treatment. This included details of nominated individuals who were responsible for various clinical and non-clinical areas.

The practice had a number of policies and procedures in place which governed their day-to-day activities. Staff were able to access these electronically. Staff told us that they worked in accordance with their policies and procedures, for example, they told us they followed patient group directions (PGDs) and patient specific directions (PSDs). These are specific guidance on the administration of medicines including authorisation for nurses and healthcare assistants to administer them. The policies and procedures that were in place, and feedback from staff, showed us that effective governance structures were in place.

Staff told us that they interacted with their colleagues throughout the day, supporting each other to provide their services to patients. We saw that the practice held various regular team meetings such as weekly team meetings, monthly clinical meetings with GPs, registrars, nurses and health care assistants, monthly safeguarding meetings with health visitors, safeguarding nurse, GPs and registrars, and quarterly palliative care meetings with district nurses, Macmillan nurses, community matron, GPs and registrars.

Leadership, openness and transparency

The practice had a clear corporate structure designed to support transparency and openness. There was a well-established management team with clear allocation of responsibilities. Staff undertook lead roles in such areas as infection control and monitoring QOF data and practice performance. Management had a good understanding of, and were sensitive to, the issues which affected patients and staff.

Staff told us they worked in a supportive team and there was an open culture in the practice and felt they could report any incidents or concerns they might have. This environment helped to promote honesty and transparency at all levels within the practice.

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

The practice gathered feedback from staff through staff meetings, appraisals and informal discussions in their day-to-day activities. Staff we spoke with told us these meetings provided them with the opportunity to discuss the service being delivered, feedback from patients and raise any concerns they had. They said they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff also told us that the practice was open to suggestions and acted upon them. We saw the practice also used the various meetings to share information about clinical and administration issues.

We saw that the practice had undertaken a patient survey in January 2014 and received 78 responses. The responses were analysed and in collaboration with their patient participation group (PPG) an action plan was formulated. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. Action was taken by the practice to address the issues highlighted. For example, the survey showed that 63% of the patients were unaware that they could book appointments online. The practice put up posters advertising this facility; coupled with the introduction of a new computer system the practice had seen an increase in patients booking their appointments online.

We spoke with two members of the PPG. They told us that they were not handpicked by the practice; they had volunteered and were willing to raise any issues with the practice. They said they had been involved in discussions about the format of the 2014 patient survey and the results

Are services well-led?

Good 

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

of the survey. The members told us that their relationship with the practice was collaborative and constructive; they felt listened to and their opinions were valued, which encouraged open debate.

There was a suggestions box in reception which patients used to comment about the practice. We saw that two comments were received in October 2014, both of which were complimentary about the practice.

Management lead through learning and improvement

The practice had management systems in place which enabled learning and improved performance.

Staff told us that the practice was supportive of training. They said they had received the training they needed or it had been scheduled, both to carry out their roles and responsibilities and to maintain their clinical and professional development. They also said that requests for training have never been refused. The practice undertook regular training workshops within the practice. Staff also attended Time Out workshops run by the CCG. The workshops they offered included training in areas such as palliative care guidelines, Mental Capacity Act and antibiotic prescribing. Staff told us that they had appraisals which included agreeing future training courses to increase staff skills.

The practice was a training practice. The practice provided training placements to fully qualified doctors (called 'Registrars') to undertake supervised specialist training as part of their GP training. Staff told us that they also learnt from the registrars. This demonstrated that the practice staff shared their skills and experience with colleagues for the benefit of patients.

The practice had an effective approach to incident reporting in that it encouraged reporting and the review of all incidents. Team meetings were held to discuss any significant incidents that had occurred. The practice had completed reviews of significant events and other incidents and shared these with staff and other relevant health care providers.

The practice was a Research Quality Plus practice. This accreditation enabled the practice to participate, with the support and consent of patients when necessary in research into various medical issues. The practice gave us a list of eleven research projects they had been involved in which included a study to determine if exercise improves a fatty liver. This demonstrated that the practice was engaged with the wider health community in finding ways to improve the care and treatment of patients.