Paradise 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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of Paradise Medical Centre on 28 January 2015. We found Paradise Medical Centre provided a good service to patients in all of the five key areas we looked at. This applied to patients across all age ranges and to patients with varied needs due to their health or social circumstances.

Our key findings were as follows:

- The practice had comprehensive systems for monitoring and maintaining the safety of the practice and the care and treatment they provided to their patients.
- The practice was proactive in helping people with long term conditions to manage their health and had arrangements in place to make sure their health was monitored regularly.
- The practice was clean and hygienic and had arrangements for reducing the risks from healthcare associated infections.
- Patients felt that they were treated with dignity and respect. They felt that their GP listened to them and treated them as individuals.
- The practice had a well-established and well trained team and had expertise and experience in a wide range of health conditions.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. The practice provided opportunities for the staff team to learn from significant events and was committed to providing a safe service. Information about safety was recorded, monitored, appropriately reviewed and addressed. The practice assessed risks to patients and managed these well. There were enough staff to keep people 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. Patients' care and treatment took account of guidelines issued by the National Institute for Care and Health Excellence (NICE). Patients' needs were assessed and care was planned and delivered in line with current legislation. The practice was proactive in the care and treatment provided for patients with long term conditions and regularly audited areas of clinical practice. At the time of our inspection, the practice did not have a plan in place for the completion of clinical audit cycles. We saw cycles were completed regularly and were repeated at future dates to measure the effectiveness of any improvements made, but there was no formal plan of when these should be undertaken. The practice implemented immediately following our inspection. The practice also sent us evidence of further clinical audit cycles that they had carried out. There was evidence that the practice worked in partnership with other health professionals. Staff received training appropriate to their roles and the practice supported and encouraged their continued learning and development.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients told us they were treated with compassion, dignity and respect and they were involved in their care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We saw that staff treated patients with kindness and respect and were aware of the importance of confidentiality. The practice provided advice, support and information to patients, particularly those with long term conditions and to families following bereavement.

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice was aware of the needs of their local population and engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice and said that urgent appointments were available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. There was a clear complaints system with evidence demonstrating that the practice responded quickly to issues raised. The practice had a positive approach to using complaints and concerns to improve the quality of the service. The practice was regularly involved with trials of new medicines to improve outcomes for patients.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had a clear vision with quality and safety as its top priority, but at the time of our inspection this was not clearly documented. This was carried out and implemented immediately after our inspection. We were sent appropriate evidence that staff had been briefed and it would be regularly discussed and reviewed with staff. High standards were promoted and owned by all practice staff and teams worked together across all roles. Governance and performance management arrangements had been introduced and dates set for them to be reviewed. They took account of current models of best practice. The practice had also documented succession planning, to replace GP partners when they retired following our inspection. Staff had received inductions, regular performance reviews and attended staff meetings and events. Minutes of staff meetings needed to consistently record decisions taken and identify staff responsible for completing actions. The practice proactively sought feedback from patients and had an active patient participation group (PPG).

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

This practice is rated as good for the care of older patients. Patients over the age of 75 had a named GP and were included on the practice's avoiding unplanned admissions list to alert the team to patients who may be more vulnerable. The practice had a policy of not turning away an older person who needed an appointment and would endeavour to see anyone within this age group who walked in. The GPs carried out visits to patients' homes if they were unable to travel to the practice for appointments. At the time of our inspection, the practice had just completed delivering its flu vaccination programme. The practice nurse had arranged to do these at patients' homes if their health prevented them from attending the clinics at the practice.

People with long term conditions

Good

This practice is rated as good for the care of patients with long term conditions, for example asthma, arthritis and diabetes. The practice had effective arrangements for making sure that patients with long term conditions were invited to the practice for annual reviews of their health. Clinics were held for a range of long term conditions, including diabetes, arthritis and chronic obstructive pulmonary disease (COPD). Members of the GP and nursing team at the practice ran these clinics. Patients whose health prevented them from being able to attend the surgery received the same service from one of the practice nurses as home visits were arranged. Patients told us they were seen regularly to help them manage their health. At the time of our inspection, the practice had just completed offering flu vaccinations to people with long term conditions. One of the practice nurses was an asthma specialist and had recently completed a diploma funded by the practice.

Families, children and young people

Good

This practice is rated as good for the care of families, children and young people. The practice held weekly childhood vaccination clinics and its rates of immunisation for children was above average for the Coventry and Rugby Clinical Commissioning Group (CCG). Weekly antenatal and baby and children's clinics were held. The practice provided cervical screening and a family planning service.

Working age people (including those recently retired and students)

Good

This practice is rated as good for the care of working age patients, recently retired people and students. The practice provided

Summary of findings

extended opening hours until 6.00pm and on Saturday mornings for patients unable to visit the practice during the day. Patients who worked were given priority for Saturday morning appointments. NHS health checks were carried out for patients aged 40-75. The practice referred patients to the smoking cessation support provided by University Hospital in Coventry.

People whose circumstances may make them vulnerable

Good

This practice is rated as good for the care of patients living in vulnerable circumstances. Regular reviews were carried out in conjunction with community nurses and matrons. One of the GPs was the lead for learning disability (LD) care at the practice and the practice had an LD register. All patients with learning disabilities were invited to attend for an annual health check. Staff were aware of safeguarding procedures and GPs told us how alerts were placed on the records of potentially vulnerable patients. The practice carried out reviews to ensure children were immunised and referred patients to other organisations for support, for example, Coventry Foodbank.

People experiencing poor mental health (including people with dementia)

Good

This practice is rated as good for the care of patients experiencing poor mental health (including people with dementia). The practice had a register of patients at the practice with mental health support and care needs and invited them for annual health checks. Staff described close working relationships with the community mental health team, consultant psychiatrists and social services staff. These teams worked with the practice to identify patients' needs and to provide patients with counselling, support and information. The practice carries out dementia screening.

Summary of findings

What people who use the service say

We gathered the views of patients from the practice by looking at 35 CQC comment cards patients had filled in and by speaking in person with ten patients. During our inspection, we spoke by telephone with a patient who was involved with the Patient Participation Group (PPG). The PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care.

We also received a letter from a PPG member who told us how a GP had supported their family through difficult times and had always acted with professionalism, care and compassion. The letter also mentioned how practice staff had been seen to suffer verbal abuse from some patients and had always acted professionally.

All patients we spoke with were highly complimentary about Paradise Medical Centre. Patients said GPs and practice nurses gave them the time they felt they needed and were professional and courteous at all times. Patients said practice staff were always friendly and helpful. Six patients made positive comments about one GP in particular and said he was a respected member of the local community. Six patients commented on the high standard of cleanliness within the practice. Some patients we spoke with mentioned concerns about difficulty with car parking as the practice lost the use of its car park last year.

Some patients who gave us their views had been patients at the practice for many years and their comments reflected this long term experience. Data available from practice patient survey showed that the practice scored at or below average within the Coventry and Rugby Clinical Commissioning Group (CCG) for satisfaction with the practice.

Most patients also said they were usually able to obtain appointments with ease and could usually get through to the practice on the telephone without difficulty. However, five patients commented on how it could be difficult to get appointments at times, but it was clear this centred upon appointments with a particular GP who was very popular. Some patients told us they would happily recommend the practice to friends and family members.

Paradise Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector. The inspection team also included a GP specialist advisor, a practice manager specialist advisor and an expert by experience (a person who has experience of using this particular type of service, or caring for somebody who has).

Background to Paradise Medical Centre

Paradise Medical Centre is located approximately a mile to the north of Coventry city centre. The practice has been at its current location since 1975 and currently has 7106 patients registered.

The practice is in an area with a high ethnic population and a large percentage of patients do not speak English as their first language. Patients' health needs reflect those within the local ethnic community. As a result, the practice has a higher than average proportion of patients with long term medical conditions. For example, there are high rates of diabetes and coronary heart disease. The practice showed us statistics that demonstrated 10% (766) of patients smoked and one third of those (238), had chronic obstructive pulmonary disease (COPD), a lung condition.

Many patients at the practice are living in deprived circumstances and needed additional support as a result. Locally, there is a high rate of unemployment.

Paradise Medical Centre offers a range of NHS services including an antenatal clinic run by a community midwife from University Hospital Coventry and Warwickshire; a well woman clinic and minor surgery. The practice also offers a family planning service and smoking cessation support. It is also a training practice and regularly hosts trainee GPs from university.

The practice has four male GP partners, a trainee female GP medical student and three practice nurses. The clinical team are supported by a practice manager, and a team of administrative and reception staff.

The practice has a General Medical Services (GMS) contract with NHS England.

Paradise Medical Centre currently does not have a car park. The building is owned by a third party and following a re-organisation of local healthcare last year, the car park was let to another NHS organisation.. Some patients have been unhappy with this. Practice GPs have discussed possible alternative solutions with the Coventry and Rugby Clinical Commissioning Group (CCG), however, a solution has not yet been found.

This was the first time the Care Quality Commission (CQC) had inspected the practice. Based on information we gathered as part of our monitoring systems we had no specific concerns about the practice. Data we reviewed showed that the practice was achieving results that were average or in some areas slightly below average with the England or Clinical Commissioning Group in most areas.

The practice does not provide out of hours services to their own patients. Patients are provided with information about local out of hours services provided by Virgin Care Coventry which they can access by using the NHS 111 phone number.

Detailed findings

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. This provider had not been inspected before and that was why we included them.

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

Before this inspection, we reviewed a range of information we held about Paradise Medical Centre and asked other organisations to share what they knew. These organisations included Coventry and Rugby Clinical Commissioning Group (CCG), NHS England area team and Healthwatch. We carried out an announced inspection on 28 January 2015. During the inspection we spoke with a range of staff (GPs, nurses, practice manager, reception and administrative staff). We spoke with ten patients who used the service and contacted a further patient, a member of the Patient Participation Group (PPG) by telephone after our visit.

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
- Families, children and young people
- Working age people (including those recently retired and students)
- People living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

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. Staff we spoke with were aware of their responsibilities to raise concerns, and discussed how to report incidents and near misses. Staff told us about some clinical incidents which had occurred and we were satisfied that these had been properly investigated and patients contacted as necessary.

We reviewed safety records, incident reports and minutes of meetings where these had been discussed, for the last three years. This showed the practice had managed these consistently over time and could show evidence of a safe track record over the longer term. We were shown records that demonstrated information gained from clinical audits and health and safety audits was assessed with patient safety in mind. For example, in January 2015, a clinical audit was carried out to determine whether new guidelines for diagnosing type 2 diabetes had been followed. The practice identified five patients who required further follow up, but had previously failed to respond to telephone calls from the practice. GPs demonstrated that despite further letters and telephone calls to the patients, four had failed to respond. We were told appropriate notes were placed on their patient records. At the same time, the practice ensured all patients with diabetes had appropriate notes on their records and had been included in the register of diabetic patients. The practice planned to repeat this audit later in 2015.

Learning and improvement from safety incidents

The practice had 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 three years and we were able to review these. Significant events were discussed at practice meetings and complaints were reviewed. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff knew how to raise an issue for consideration at the meetings.

After our inspection, the practice supplied us with details of their latest clinical audit, carried out in February 2015. This examined patients with combined diabetes and kidney failure. This followed revised guidelines issued by the National Institute for Health and Care Excellence (NICE) – the organisation responsible for promoting clinical excellence and cost-effectiveness and producing and issuing clinical guidelines to ensure that every NHS patient gets fair access to quality treatment. The practice identified twelve patients who needed a medication review. Three of those patients had their medication changed to an alternative and nine were safely able to have their medication reduced. The practice planned to repeat this audit in May 2015.

We were shown the system used to manage and monitor incidents. We tracked four incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken when a patient who rarely attended the practice and had an undiagnosed long term medical condition became acutely ill. As a result, the practice introduced extra checks and alerts on the records of non-frequent attenders. When patients had been affected by something that had gone wrong, they were given an apology and informed of the actions taken, in line with practice policy.

National patient safety alerts were discussed in staff meetings with practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. For example, changes to the diagnosis of type 2 diabetes. Staff also told us alerts were discussed during meetings held for clinical staff to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

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. We asked members of medical, nursing and administrative staff about their training. 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 for relevant agencies were easily available to staff. The practice had carried out a safeguarding audit in January 2015 to ensure procedures and contact details

were up to date. Safeguarding concerns were discussed at the monthly multi-disciplinary team meetings and GPs told us safeguarding alerts were placed on the records of vulnerable patients.

The practice had appointed a dedicated GP as lead in safeguarding vulnerable adults and children with a deputy appointed to act in their absence. They had received appropriate training. All staff we spoke with were aware who the lead was and who to speak to in the practice if they had a safeguarding concern. The lead safeguarding GP was aware of vulnerable children and adults who were registered at the practice and records demonstrated good liaison with partner agencies such as the local authority.

There was a chaperone policy in place, which was visible on the waiting room noticeboard and in consulting rooms. We saw records that demonstrated nursing staff had been trained to be a chaperone and understood the requirements.

Systems were in place to identify potential areas of concern. For example, for clinical staff to identify children and young people with a high number of accident and emergency attendances and follow up of children who failed to attend appointments such as childhood immunisations.

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. We saw that practice staff followed this 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.

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example, changes to diabetes medication guidelines.

We saw there were Patient Group Directions (PGD) in place to support the nursing staff in the administration of vaccines. A PGD is a written instruction from a qualified and registered prescriber, such as a doctor, for a nurse or appropriately trained person to administer a medicine to groups of patients without individual prescriptions. We saw the PGDs had been signed by all the nurses who administered the vaccines and authorised by a manager. This meant that staff and managers were informed of any changes to the PGD. There was also a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. No stocks of controlled drugs were held.

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. The practice had also signed up to the electronic prescription service. Within the last twelve month the practice had made improvements to its repeat prescription system with advice from the medicines management department of the Coventry and Rugby Clinical Commissioning Group (CCG).

Cleanliness and infection control

We observed the premises to be visibly clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. The practice used a contract cleaner. Six patients we spoke with told us they always found the practice to be clean and had no concerns about cleanliness.

The practice had a lead for infection control who had undertaken further training to enable them 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 and received regular updates; the latest was in November 2014. We saw evidence that the lead had carried out an infection control audit during October 2014 and approximately annually in previous years. Any improvements identified for action were completed on time. Minutes of practice meetings showed that the findings of the audits were discussed. In the infection control audit carried out previously, in January 2013, the practice decided that curtains in the examination rooms should be replaced as they were made of a washable fabric. During our inspection we noted that all such curtains were now disposable and were regularly changed. No concerns had been identified during the most recent infection control audit. We looked at areas where minor surgery was carried out and found no areas of concern

Good

Are services safe?

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. They included the safe use and disposal of sharps; use of personal protective equipment (PPE); spills of blood and bodily fluid amongst others.

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.

The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). We saw records that confirmed the practice carried out annual checks in line with this policy to reduce the risk of infection to staff and patients. The latest legionella risk assessment had been carried out in January 2015.

There were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades. We saw evidence that their disposal was arranged through a suitable company.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date, January 2014. A schedule of testing was in place.

Staffing & Recruitment

We were shown how the practice ensured there were sufficient numbers of suitably qualified, skilled and experienced staff on duty each day. There was a staff rota throughout the week and always a member of clinical staff on duty. Some administrative staff were part time and able to work additional hours to provide staff cover if a staff member was unexpectedly absent.

We saw how the practice had monitored their workforce and reviewed their workforce requirements to ensure sufficient staff were available to meet the needs of the population they served. Management confirmed they had sufficient staff on duty throughout the week. At the time of our inspection, the practice had started to plan the succession of a GP partner who was likely to retire within the next four to five years and the practice manager who wished to reduce their hours in a similar time frame. The practice had also started the process to recruit a salaried female GP.

We looked to see what guidance was in place for staff about expected and unexpected changing circumstances in respect of staffing. We saw a selection of policies and procedures in place, for example, staff sickness, and planned absences.

We were shown the business continuity plan which had been adopted by the practice which advised what to do should there be an shortage of GPs and practice staff due to sickness for example. This included arrangements for using locum GPs. This would help to ensure sufficient availability of GPs to continue the primary care service provision to patients.

The practice had a comprehensive and up-to-date recruitment policy in place. The policy detailed all the pre-employment checks to be undertaken on a successful applicant before that person could start work in the service. This included identification, references and a criminal record check with the Disclosure and Barring Service (DBS). These are 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. When DBS checks were not required, for example, for administrative staff who did not work alone with patients, a risk assessment had been carried out to confirm this. We looked at a sample of recruitment files for GPs, administrative staff and nurses. They demonstrated that the recruitment procedure had been followed.

Additionally, the practice was also a training practice for doctors and regularly hosted trainee GPs from university. We saw how they were given appropriate training and supervision with the practice.

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 regular checks of the building, 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 who had received appropriate training for the role.

The practice had been due to be redecorated at the end of 2014, as some areas were in need of redecoration, but the contractor had to pull out at the last minute. We saw evidence the practice was looking for a suitable alternative contractor to enable this work to be carried out as a priority.

Identified risks were included on a risk log. Each risk was assessed and rated and actions recorded to reduce and manage the risk. We saw that any risks were discussed during staff meetings. For example, procedures for outgoing post were changed in December 2014 and a separate post tray was introduced for mail that needed to be sent securely, for example by registered post. This followed an incident when confidential information had been sent by ordinary mail.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. GPs explained how patients with long term medical conditions were monitored and appropriate alerts were placed on patients' medical records.

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 basic life support. This was last carried out in November 2014. Emergency equipment was available including oxygen and an automated external defibrillator (AED). This is a portable electronic device that analysed life threatening irregularities of the heart including ventricular fibrillation and was able to deliver an electrical shock to attempt to restore a normal heart rhythm. 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 and anaphylaxis (an allergic reaction). Processes were also 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.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Management confirmed copies of this were kept at the homes of GPs and practice management. Risks identified included power failure, adverse weather including flooding and access to the building. The practice had carried out a fire risk assessment in January 2015 and all staff received regular fire safety training. If the practice building was unavailable, we saw arrangements were in place for the use of a local health centre and an emergency control room would be set up in the home of one of the GPs.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care & treatment in line with standards

Patients' needs were assessed and care and treatment was planned and delivered in line with their individual needs and preferences. All patients we spoke with were happy with the care they received and any follow-up needed once they obtained an appointment and said GPs and practice staff provided high quality care.

Clinical staff managed the care and treatment of patients with long term conditions, such as diabetes, asthma and chronic obstructive pulmonary disease (COPD- the name for a collection of lung diseases including chronic bronchitis and emphysema).. We found there were appropriate systems in place to ensure patients with long term conditions were seen on a regular basis. Systems for diagnosing patients with diabetes had also been recently changed following the introduction of new medical guidelines issued by the National Institute for Health and Care Excellence (NICE) – the organisation responsible for promoting clinical excellence and cost-effectiveness and producing and issuing clinical guidelines to ensure that every NHS patient gets fair access to quality treatment.

Patients who required palliative care (palliative care is a holistic approach to care for patients with incurable illnesses and their families) were regularly reviewed. Their details were passed to the out of hours practice each weekend to ensure care would continue when the practice was closed.

Staff showed us how they used the National Institute for Health and Care Excellence (NICE) templates for processes involving diagnosis and treatments of illnesses. NICE guidance supported the surgery to ensure the care they provided was based on latest evidence and of the best possible quality. Patients received up to date tests and treatments for their disorders. We saw records of meetings that demonstrated revised guidelines were identified (for example with the treatment of diabetes) and staff were trained appropriately.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. Examples of completed clinical audits included procedures after the death of a patient and minor surgery procedures. Dates had been set to repeat audits to continue to determine their effectiveness. We found other monitoring the practice had carried out included patients with chronic conditions, for example diabetes. Some of this monitoring was carried out as part of 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, for example. diabetes and implementing preventative measures. The results are published annually. The practice's performance was average or above average in some areas for the Coventry and Rugby Clinical Commissioning Group (CCG) for QOF.

The practice was able to identify and take appropriate action on areas of concern. For example, when patients were identified who needed follow up treatment for diabetes, they were invited to the practice.

We also saw evidence that the practice attended training events hosted by other local practices to identify and discuss best practice.

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 courses such as annual basic life support and safeguarding. 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 had annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. As the practice was a training practice, the trainee doctor based at the practice had access to a senior GP for support when needed.

Practice nurses had clearly defined duties which were outlined in their job description and were able to

Good

Are services effective?

(for example, treatment is effective)

demonstrate that they were trained to fulfil these duties. For example, in the administration of vaccines. We were shown certificates to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. It received blood test results, x-ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles.

The practice held integrated team meetings every month to discuss concerns, for example, to meet the complex needs of some patients, those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses as appropriate and decisions about care planning were documented.

Clinical staff and the GP partners met regularly outside practice opening times. We saw evidence that clinical updates, difficult cases, significant events and emergency admissions to hospital were discussed and actions identified.

We saw records that confirmed the practice worked closely with the community midwife service, based at University Hospital in Coventry, health visitors, the community mental health team and community drug teams. Clinics were held for blood testing, hypertension (high blood pressure), diabetes and minor surgery amongst others, to which patients were referred when appropriate.

There was a large range of information leaflets about local services in the waiting room. Most of this information was available in other languages. Relevant information was also displayed on a screen within the patient waiting room.

Information sharing

The practice used several 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 shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made most of its referrals through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to the Accident and Emergency (A&E) department.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patient care. All staff were fully trained on the system.

Consent to care and treatment

There were processes to seek, record and review consent decisions. We saw there were consent forms for patients to sign agreeing to minor surgery procedures. We saw that the need for the surgery and the risks involved had been clearly explained to patients. We also saw evidence that audits of minor surgery were carried out.

We saw the process in place to obtain signed consent forms for children who had received immunisations. The practice nurse was aware of the need for parental consent and what action to follow if a parent was unavailable. There was information available for parents informing them of potential side effects of the immunisations. The GPs and nurses that we spoke with demonstrated a clear understanding of the importance of determining if a child was Gillick competent especially when providing contraceptive advice and treatment. A Gillick competent child is a child under 16 who has the legal capacity to consent to care and treatment. They are capable of understanding the implications of the proposed treatment, including the risks and alternative options.

Staff we spoke with had an understanding of the Mental Capacity Act 2005 and demonstrated knowledge regarding best interest decisions for patients who lacked capacity. Mental capacity is the ability to make an informed decision based on understanding a given situation, the options available and the consequences of the decision. People may lose the capacity to make some decisions through illness or disability.

Good

Are services effective?

(for example, treatment is effective)

The practice used its own staff to interpret to ensure patients understood procedures if their first language was not English. All GP partners and most staff employed at the practice spoke a range of languages that were represented within the local community.

Health Promotion & Prevention

We saw all new patients were offered a consultation with the practice nurse when they first registered with the practice. If any medical concerns were found, the patient was referred to the GP or another healthcare professional if more appropriate. The practice also offered NHS health checks to all its patients aged 40-75. The practice's performance for cervical smear uptake was above average compared to others in the Clinical Commissioning Group (CCG) area. The practice's performance for cervical smears had improved last year following a clinical audit carried out. This identified patients who had not previously attended. It was intended to repeat this audit at regular intervals.

We were shown work the practice had carried out to identify and promote particular health needs within the area. For example, smoking cessation support and well woman clinics.

Due to the high prevalence of diabetes within the local community, the practice has undertaken a large amount of appropriate research into effective diagnosis, treatment and management of the condition. We saw evidence of this within completed clinical audits.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

All patients we spoke with and patient comment cards we received were complimentary about the care given by the practice and any follow-up needed once patients had obtained an appointment. All patients felt they were always treated with respect and dignity by all members of staff. Patients commented on how professional, friendly and helpful GPs and staff were.

During our inspection we observed within the reception area how staff and patients interacted with each other, in person and over the telephone. Staff were helpful, polite and understanding towards patients. Staff we spoke with told us excellent patient care was crucial and their behaviours displayed this at all times. We saw evidence that staff had received customer service training to assist with the way they handled patients.

In February 2014, 189 patients completed a patient survey issued by the practice. Of those patients who responded 91% said they felt the practice was very good or good overall. This was above the national average measured by NHS England. The sample represented 2.6% of the patient list. It was planned to repeat this survey later in 2015.

We saw curtains could be drawn around treatment couches in consultation rooms. This would ensure patients' privacy and dignity in the event of anyone else entering the room during treatment.

Care planning and involvement in decisions about care and treatment

We looked at patient choice and involvement. GPs explained how patients were informed before their treatment started and how they determined what support was required for patients' individual needs. Clinical staff told us they discussed any proposed changes to a patients' treatment or medication with them. Some patient we spoke with confirmed this. GPs described treating patients with consideration and respect and said they kept patients fully informed during their consultations and subsequent investigations. Patients we spoke with confirmed this and told us decisions were clearly explained and options discussed when available. Patients had the information and support available to them to enable them to make an informed decision about their care and treatment needs.

Clinical and administrative staff were able to speak a variety of languages and patients told us they felt GPs understood their needs. Patients told us that their GP listened to them and gave us examples of advice, care and treatment they had received. Some patients we spoke with had long term conditions and they told us they were seen regularly.

Patient/carer support to cope emotionally with care and treatment

We did not speak with or receive any comment cards from patients who were also carers. However the GP and staff described the support they provide for carers and links to refer patients to appropriate organisations, including a counselling service for professional support. A counsellor was available for appointments at the practice. Information was provided about organisations specialising in providing bereavement support. Coventry Carers ran sessions in the practice two or three times every month to provide support for carers

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had appropriate systems in place to maintain the level of service provided. The needs of the practice population were understood, particularly within the context of the local area and systems were in place to address identified needs in the way services were delivered. For example, the practice had a register of patients with diabetes as 10% of the patients registered at the practice had the condition. They were regularly reviewed and subjected to clinical audits.

We were shown how the practice had good links with the Coventry and Warwickshire based Recovery Partnership who offered a variety of services, including counselling and support for patients with alcohol misuse. The practice enabled homeless people and people who resided in Coventry's Salvation Army hostel to register as patients to enable them to access NHS services. Staff were aware of additional needs of patients as many lived in a deprived area, for example, the practice carried out reviews to ensure children were immunised and referred patients to other organisations for support, for example, Coventry Foodbank.

The practice planned its services carefully to meet the demand of the local population. We saw minutes of meetings that demonstrated regular meetings were held to discuss capacity and demand. As a result of this, changes were made to staffing and clinic times when required. GPs provided examples of how the practice responded to the needs of the local community. For example, a Saturday morning surgery had been introduced following the patient survey carried out in February 2014. Of the 189 patients surveyed, 29% requested a Saturday morning surgery to provide access to patients at work during week days. Practice services were also reviewed in the wider context of the local health community. Review meetings were held with the Clinical Commissioning Group (CCG) and a GP attended these.

There was an established Patient Participation Group (PPG) in place at the practice. This was a group of patients registered with a practice who work with the practice to improve services and the quality of care.

This ensured that patients' views were included in the design and delivery of the service. We saw how the PPG played an active role and was a key part of the organisation. Regular meetings were held. We saw how the PPG had been involved with discussions to improve patient care, analyse and discuss action following the patient survey and possible solution to the car parking problem.

Tackling inequity and promoting equality

A large proportion of patients who used Paradise Medical Centre spoke English as their second language. All GPs and most administrative staff were multi-lingual, so could converse with ease with patients. We noted that information leaflets in the practice were available in a variety of languages, as was the information displayed on the visual display unit in the waiting area.

The practice had an induction loop to assist people who used hearing aids and staff could also take patients into a quieter private room to aid the discussion if required. The practice was fully wheelchair accessible.

Access to the service

The practice opened from 8.30am to 12pm and from 2pm to 6pm every weekday. There was no afternoon surgery on Thursday afternoons. In addition, the practice held a surgery every Saturday from 8.30am to 12pm primarily aimed at patients who worked during the week. Those patients were prioritised over others for these Saturday morning appointments. The practice had a policy not to turn away elderly patients who walked in and wanted an appointment. They were always seen as soon as they could be slotted in, if they were happy to wait, otherwise a timed appointment was offered. In addition, a telephone triage system was operated for patients who could not be immediately offered same day appointments. When the GP called the patient back, if they decided the patient needed to be seen the same day they would be called into the practice. Outside of these times and during the weekend, an out of hours service was provided by another organisation and patients were advised to call the NHS 111 service. This ensured patients had access to medical advice outside the practice's opening hours. Additionally, the practice was within walking distance or a frequent direct bus journey to the local walk in centre. Despite this, unlike other practices in the immediate area, Paradise Medical Centre did not have a higher than average number of patients who attended the walk in centre.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Appointments could be booked for the same day, within two weeks or further ahead. Patients could make appointments and order repeat prescriptions through an on-line service. Home visits were available for patients who were unable to go to the practice. The practice offered 710 GP appointments per week, compared with the CCG guideline figure of 420. This represented 69% more than the required number.

In February 2014, 189 patients completed a patient survey issued by the practice. This represented 2.6% of the patient list. Of the patients surveyed, 63% were able to get an appointment the same day or within the next two working days. This was an improvement from 57% from the 2013 patient satisfaction survey. Following the 2013 survey, the practice introduced a system called 'Paradise 111' where appointments of five minute lengths were offered to patients who requested same day appointments for a single problem. This enabled more patient appointments to be offered despite an increased demand for appointments. GPs told us demand for patient appointments had increased due to an increase in the patient list size, an increase in the number of patients in the older age group category, more patients have developed long term conditions and an increase in NHS work carried out at primary care level.

GP partners and practice staff had examined ways of increasing practice opening times. Saturday morning surgeries were the first part of this process, but the practice had plans to consider further evening and weekend availability. This work was being carried out in conjunction with the PPG.

The information from CQC comment cards and patients we spoke with indicated that the service was easily accessible and that patients were usually able to get an appointment on the same day they phoned if this was needed.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. The complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. We were shown how patients' concerns were listened to and acted upon. There was information about how to complain displayed in the waiting area. All of the patients we spoke with said they had never had to raise a formal complaint. The complaints procedure identified how complaints would be dealt with. It also identified the timescales for responding to and dealing with complaints. The practice had a complaints summary which summarised the complaints for each year. This was used to identify any trends.

We looked to see whether the practice adhered to its complaints policy. Between 1 October 2013 and 30 September 2014, five formal complaints had been received by the practice. None had been received since. An annual complaints summary was produced. Out of the five complaints we examined, three concerned general administration, one regarding staff attitude and communication and one was connected with appointment availability. None related to safety incidents. We found that the complaints had been dealt with appropriately and within the timescales set out in the practice's complaints policy. Patients were given an explanation and when appropriate, an apology. The complaints policy also gave patients the opportunity to contact Healthwatch Coventry about any concerns and staff also confirmed this was the case. No patients had chosen to take up this option.

It was also clear that verbal complaints were dealt with in the same way as written complaints. If a patient telephoned the practice to complain, the practice manager would immediately take the call if available. The practice had a policy to give every patient who wished to speak with the practice manager the opportunity to do so.

Are services well-led?

Good

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

Our findings

Vision and Strategy

The practice aimed to provide quality care within the practice and to provide clinical governance, leadership and advice for patients. We were shown how the practice kept up to date with research and governance recommendations and communicated these accordingly. We spoke with three GPs and three members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these.

In discussion with staff, it was evident that the team at the practice shared a desire to provide patients with a safe and caring service where people were treated with dignity and respect. The practice vision and values included a desire to understand the potential vulnerability of patients. Staff told us the working environment was comfortable and supportive with a good team spirit.

The GP partners held regular partners' meetings outside of surgery opening times, to discuss important issues such as forward planning, succession planning, practice objectives and future direction and vision. The practice regularly reviewed these objectives at staff meetings.

The practice had developed a five year plan. GPs told us during this time, the patient list was expected to grow by about 500 additional patients. To handle this increased demand, the practice recognised they would need to adopt new innovations and guidelines through continual staff development using personal development planning and appraisal. It was planned that the practice took up opportunities provided by NHS changes. These included providing services through the Coventry GP Alliance, a group of Coventry based GPs who had signed up to work together to improve services offered by NHS England. To enable this to be achieved, the practice intended to examine staffing levels, premises and IT system development and funding. The practice had discussed expanding into an adjoining health centre if spare capacity was confirmed has and had also considered alternative sites. The practice told us they would continue with GP training.

Governance Arrangements

The GP partners all had lead roles and specific areas of interest and expertise. This included governance with clearly defined lead management roles and responsibilities. During the inspection we found that all members of the team we spoke with understood these roles and responsibilities, however at the time of our inspection there were no formal written policies in place to cover these areas. This was provided immediately after our inspection with information on how this would be kept under review.

Paradise Medical Centre displayed an atmosphere of teamwork, support and open communication. The practice held a regular meeting of clinical staff which included discussions about any significant event analyses (SEAs) that had been done. All of the clinical staff attended these meetings and where relevant, other staff also took part in the discussions about SEAs. This helped to make sure that learning was shared with appropriate members of the team. GPs also met regularly to discuss clinical and governance issues. Succession planning was in place for GP partners, although the first was not expected to retire for another four to five years. Succession planning had also started for the practice manager who had also expressed a wish to reduce their working hours in four to five years' time.

The practice used information from a range of sources including their Quality and Outcomes Framework (QOF) results and the Clinical Commissioning Group (CCG) to help them assess and monitor their performance. 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's performance was average or above average in some areas for the Coventry and Rugby Clinical Commissioning Group (CCG) for QOF. We saw examples of completed clinical audit cycles, such as cervical smears. This demonstrated the practice reviewed and evaluated the care and treatment patients received.

Leadership, openness and transparency

The practice had a team of partners, some of whom had worked together over a number of years to provide stable leadership. They were supported by a practice manager who was described by clinical and other staff as playing a crucial role in the management of the practice. The practice had started the recruitment process for a salaried female GP as they currently only had a female trainee GP medical student attached to the practice. Staff told us they

Are services well-led?

Good

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

were well supported by GPs and the practice manager and they were always open and approachable. The staff we spoke with told us that Paradise Medical Centre was an excellent place to work where staff felt supported, appreciated and cared for.

Practice seeks and acts on feedback from users, public and staff

The practice had an established Patient Participation Group (PPG) in place. This was a group of patients registered with the practice who work with the practice to improve services and the quality of care.

This ensured patient views were included in the design and delivery of the service. We saw minutes of previous PPG meetings and saw how the PPG has been fully involved in initiatives such as promoting on line patient services and the patient satisfaction surveys.

All staff were fully involved in the running of the practice. We saw there were documented regular staff meetings. This included meetings for clinical staff and meetings that included all staff. This ensured staff were given opportunities to discuss practice issues with each other.

The practice asked patients who used the service for their views on their care and treatment and they were acted on. This included the use of surveys to gather views of patients who used the service. We saw that there were systems in place for the practice to analyse the results of the survey so that any issues identified were addressed and discussed with all staff members. In advance of the NHS Friends and Family Test launched in December 2014, the practice carried out its own preliminary friends and family test survey in August 2014. The practice issued 100 questionnaires and received responses from 73 patients, this represented 0.7% of the patient list. Of the total number of responses received, 89% of those patients said they would be extremely likely or likely to recommend the practice to friends and family if they needed similar care or treatment.

An action plan had been produced for the patient satisfaction survey that had been carried out in February 2014. This included examining extending evening and weekend appointments and improving the practice environment with the advice of an interior designer.

We saw records of discussions within the minutes of staff meetings. All the patients we spoke with on the day of our inspection told us they received a high quality service from the practice. It was clear patients experienced the quality of service that met their needs.

Management lead through learning & improvement

We saw evidence that the practice was focussed on quality, improvement and learning. There was a staff development programme for all staff within the practice, whatever their role. As an example of staff learning and development, the practice had paid for a practice nurse to study for an asthma care diploma which was completed in 2014. The practice was also supporting and encouraging a receptionist who aimed to attend medical school.

The whole practice team had sessions each year for 'protected learning'. This was used for training and to give staff the opportunity to spend time together. Topics such as advances in diabetes diagnosis and treatment had been covered.

The results of significant event analyses and clinical audit cycles were used to monitor performance and contribute to staff learning.