The Surgery Rugby Road

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 an announced comprehensive inspection at The Surgery Rugby Road on 19 August 2015. Overall the practice is rated as good.

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

• Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed. Lessons learned were regularly discussed at team meetings.

• Risks to patients were assessed and well managed.

• Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles.

• Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.

• Information about services and how to complain was available and easy to understand.

• Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. Patient reviews were routinely carried out and some of the patients lived in care homes in the local area.

• The practice had good facilities and was well equipped to treat patients and meet their needs.

• There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

However there were areas of practice where the provider needs to make improvements.

Importantly the provider should:

- Ensure that an accurate record is kept of meetings relating to significant events and complaints to facilitate the sharing of learning and analysis of patterns and trends

Summary of findings

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Each week the lead GP and one of the long term locums had a meeting to discuss all significant events and referrals. The discussions were fed back verbally to the other locum GP at the practice. Both doctors were able to share learning from these weekly meetings during the inspection. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance including National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice had systems in place to ensure all clinical staff were kept up to date. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. This included safeguarding, fire procedures, and basic life support and information governance awareness. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams including health visitors, district nurses, midwives and Macmillan nurses.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they felt the practice offered a helpful service and staff were knowledgeable, caring and professional and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality. We spoke with the managers of two local care homes where many of the practice's patients lived. They told us that the lead GP took their time to sit and speak with patients when they visited and that the care delivered by the GP was second to none.

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and the Coventry and Rugby Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. As the practice had been operating for over 20 years they were in the process of modernising the building. This including the fitting of automatic doors and a re-decoration. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. There was an open culture at the practice. 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 on. There was an active PPG which met on a regular basis, carried out patient surveys and submitted proposals for improvements to the practice management team. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older patients. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services. High risk patients were discussed at the unplanned admission avoidance meeting every two months. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs and personalised care plans were given to patients. Patients over the age of 75 were offered health checks and dementia screening.

People with long term conditions

Good

The practice is rated as good for the care of patients with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of unplanned hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. Annual osteoporosis audits were carried out and medication was changed in accordance with guidelines. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. Patients with uncontrolled diabetes were referred to the long term GP with a specialist interest in diabetes.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. Baby and postnatal checks were usually done together within normal surgery time to provide extra flexibility for families. We saw good examples of joint working with midwives, health visitors and school nurses. Well woman clinics were run by the nurses. The lead GP and one of the long term locums were able to fit and remove coils for patients.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age patients (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. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. This meant that appointments could be booked over the telephone 24 hours a day without the need to speak with a receptionist. The practice offered extended hour services on a Monday from 6.30pm to 8.15pm excluding the third Monday in the month. The practice also offered extended hours services the third Saturday of every month from 9am to 10.30am.

People whose circumstances may make them vulnerable

Good

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

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people such as the Recovery Partnership. This is an integrated and recovery-focused treatment service for residents across Coventry and Warwickshire with a drug or alcohol problem. One of the long term locums had a special interest in substance and alcohol misuse. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children.

Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of patients experiencing poor mental health. A total of 89% of patients who experienced poor mental health had received a health check in the last 12 months. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

Summary of findings

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. The practice worked closely with Improving Access to Psychological Therapies (IAPT) workers for patients who experienced poor mental health. The practice also worked closely with the community psychiatry nurse (CPN) and secondary care. The practice liaised with the crisis resolution team for patients who needed immediate help. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results published in January 2015 showed the practice was performing in line with local and national averages. There were 114 responses and a response rate of 31%.

•83% found it easy to get through to this surgery by phone compared with a CCG average of 66% and a national average of 73%.

•97% found the receptionists at this surgery helpful compared with a CCG average of 85% and a national average of 87%.

•63% with a preferred GP usually got to see or speak to that GP compared with a CCG average of 63% and a national average of 60%.

•85% were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 86% and a national average of 85%.

•95% say the last appointment they got was convenient compared with a CCG average and a national average of 92%.

•79% described their experience of making an appointment as good compared with a CCG average of 71% and a national average of 73%.

•85% usually waited 15 minutes or less after their appointment time to be seen compared with a CCG average of 67% and a national average of 65%.

•76% feel they did not normally have to wait too long to be seen compared with a CCG average of 61% and a national average of 58%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 42 comment cards which were positive about the standard of care received. Patients we spoke with on the day described staff as knowledgeable, caring and professional.

Areas for improvement

Action the service SHOULD take to improve

Ensure that an accurate record is kept of meetings relating to significant events and complaints to facilitate the sharing of learning and analysis of patterns and trends.

The Surgery Rugby Road

Detailed findings

Our inspection team

Our inspection team was led by:

A Care Quality Commission (CQC) inspector and included a GP specialist advisor, a practice manager specialist advisor and an expert by experience who spoke with patients on the day.

Background to The Surgery Rugby Road

The Surgery Rugby Road opened in June 1991. It is situated in the rapidly growing village of Bulkington surrounded by other villages like Barnacle and Shilton and part of Wolvey. The surgery also caters for Bedworth, Whitestone and a small number of patients in Withybrook. The practice has 3,400 patients.

There is a parking space reserved for disabled persons at the practice. The main entrance, reception, all downstairs consulting rooms and disabled toilets are designed to allow easy wheelchair access.

There is a branch surgery based at the Health Centre in Bedworth and its practice area extends to Exhall, Ash Green and part of Longford in Coventry. We had no specific information about the branch surgery to lead us to visit there and the inspection therefore focussed on the main site. The Surgery has managed this since September 1993, with the present building being completed in 1996.

The practice has one lead GP and two regular long term locum GPs, one female and one male, providing patients with a choice. The practice has 2 part time practice nurses. The clinical team are supported by a practice manager and a team of five reception and administrative staff.

The practice provides a range of minor surgical procedures to patients.

The practice has a patient participation group (PPG), a group of patients registered with a practice who work with the practice team to improve services and the quality of care.

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

Data we reviewed showed that the practice was achieving results that were higher than or in line with national or Clinical Commissioning Group (CCG) averages in respect of most conditions and interventions.

The practice does not provide out of hours service for their own patients but provided information about the telephone numbers to use for out of hours GP arrangements (NHS 111).

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme 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 references to the Quality and Outcomes Framework data in this report relate to the most recent information available to the CQC at the time of the inspection.

Detailed findings

How we carried out this inspection

Before this inspection, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. These organisations included Warwickshire North Clinical Commissioning Group (CCG), NHS England Area Team and Healthwatch. We carried out an announced visit on 19 August 2015. We sent CQC comment cards to the practice before the visit and received 42 completed cards giving us information about those patients' views of the practice.

During the inspection we spoke with 12 patients and a total of 5 staff including the practice manager, GPs and the practice nurse**.** We spoke with three members of the Patient Participation Group (PPG).

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 whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Good

Are services safe?

Our findings

Safe track record and learning

The practice had a strong system in place for reporting, recording and monitoring significant events. People affected by significant events were contacted by the practice and given a full apology. They were also told about actions taken to improve care. Staff told us they would inform the practice manager of any incidents and there was also a recording form available on the practice's computer system. All complaints received by the practice were entered onto the system and automatically treated as a significant event. The practice carried out an analysis of the significant events and the learning was evident. Each Monday the lead GP and one of the long term locums had a meeting to discuss all significant events and referrals. The discussions were fed back verbally to the other locum GP. Both doctors were able to share learning from these weekly meetings but they not documented.

We saw an example where the practice had learned from a significant event following a prescribing error which was picked up by the pharmacist. It was agreed that all administration staff would check date of births and addresses whilst booking appointments to prevent errors occurring.

Safety was monitored using information from a range of sources, including National Institute for Health and Care Excellence (NICE) guidance. This is 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. This enabled staff to understand risks and gave a clear, accurate and current picture of safety.

Overview of safety systems and processes

The practice had clear systems, processes and practices in place to keep people safe, which included:

• Systems were in place to manage and review risks to children and vulnerable adults from abuse that reflected relevant legislation and local requirements. Policies were accessible to all staff. Information was available on the noticeboards and the computer system. The policies clearly outlined whom to contact for further guidance if staff had concerns about a patient's welfare. The lead GP attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training relevant to their role. Staff alerted the GP if a child was distressed and needed to be seen sooner. Any children that did not attend appointments were reviewed by the health visitor. The practice had a sign on the back of the toilet door for patients needing to seek advice about domestic violence.

• A chaperone policy which all staff were aware of was displayed for patients to see and they knew who to contact if required. All staff who acted as chaperones were trained for the role and had received a disclosure and barring check (DBS). DBS checks 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. Staff told us that they regularly acted as chaperones when intimate procedures were carried out such as smear tests and breast examinations.

• There were 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 and the environment.

• Appropriate standards of cleanliness and hygiene were followed. We observed the premises to be visibly clean and tidy. The practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result. For example at the last audit in February 2015 the practice identified the need for soap dispensers in all the rooms, which has now been implemented.

• The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). Regular medication audits were carried out to ensure the practice was prescribing in line with best practice guidelines for safe prescribing. The practice manager was regularly sent updates with NICE and local guidelines. Every Tuesday the lead GP updated changes to medications and coded these in line with NICE guidance. Prescription pads were securely stored and there were systems in place to monitor their use.

Good

Are services safe?

• The files we reviewed showed that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service. The practice manager was the lead for this.

• Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. The staff covered for each other when they were on annual leave and supported each other.

Arrangements to deal with emergencies and major incidents

There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. All staff received annual basic life support training and there were emergency medicines available in the treatment room. The practice had a

defibrillator available on the premises and oxygen with adult and children's masks. There was also a first aid kit and accident book available. Emergency medicines were easily accessible to staff. All the medicines we checked were in date and fit for use.

The practice had a business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff. We felt that this was adequate as there was a branch surgery which could be used in an emergency situation.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The clinical staff carried out assessments and treatment in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice had systems in place to ensure all clinical staff were kept up to date. The practice had access to guidelines from NICE and used this information to develop how care and treatment was delivered to meet needs. The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

The practice took part in an enhanced service for learning disabilities. The lead GP specialised in this area. The lead GP ensured patients with learning disabilities received annual medical reviews. This included consideration of the carers and their needs in line with the enhanced service protocol.

Patients over the age of 75 were offered health checks and dementia screening. Frailty Screening had also been offered to patients over the age of 75.

The practice participated in the unplanned admissions avoidance enhanced service for patients with complex needs. These patients were reviewed regularly to ensure multi-disciplinary care plans were documented in their records and that their needs were being met. A designated member of the administration team maintained the unplanned admissions register. They ensured patients were followed up at appropriate intervals for example after unplanned or emergency admissions to hospital. The practice telephoned patients after discharge to see if they were alright and managing their medicines. If required the practice would book them an appointment with a nurse or GP.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF). This is a system intended to improve the quality of general practice and reward good practice. The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. Current results were 99% of the total number of points available, with 4.9% exception reporting. This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2013/2014 showed;

• Performance for diabetes-related indicators was 98.6% which was better than the CCG average by 5.8% and national average by 8.5% The checks were carried out to help manage diabetes and identify conditions associated with diabetes such as heart and kidney disease.

• Performance for mental health related and hypertension indicators was 90.9% which was 5.4% below the CCG average and the same as the national average. The checks were carried out to ensure that appropriate monitoring was undertaken for patients with mental health conditions.

• The dementia diagnosis rate was 89% which was above the CCG average by 4.1% and national average by 5.1%

The practice were planning to use a new screening tool for patients with dementia.

Clinical audits were carried out to demonstrate quality improvement and all relevant staff were involved to improve care and treatment and people's outcomes. There had been two clinical audits completed in the last two years. Both of these were completed audits where the improvements made were implemented and monitored. The practice participated in applicable local audits, national benchmarking, accreditation, peer review and research. Findings were used by the practice to improve services. For example, recent action taken as a result of the

atrial fibrillation audit led to more patients being offered anticoagulation therapy (medicine to thin blood and reduce the risks of blood clots and stroke). As a result of the bisphosphonate audit some patients who were taking the drug for more than five years were called for a face to face review and medication was stopped if appropriate.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

• The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. The lead person for training was the practice manager. Staff had access to appropriate training to meet these learning needs and to cover the scope of their work. This included ongoing support during sessions,

Good

Are services effective?

(for example, treatment is effective)

one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and facilitation and support for the revalidation of doctors. All staff had had an appraisal within the last 12 months. After staff attended training sessions they debriefed to the practice manager but there was no written documentation here. New members of staff were given training specific to their roles.

• Staff received training that included: safeguarding, fire procedures, basic life support and information governance awareness. Staff had access to and made use of e-learning training modules and in-house training. Staff also attended training sessions arranged by the clinical commissioning group.

Coordinating patient care and information sharing

The practice had systems to provide staff with information they needed. This included care and risk assessments, care plans, medical records and test results. Information such as NHS patient information leaflets were also available. All relevant information was shared with other services in a timely way, for example when people were referred to other services. Staff worked together and with other health and social care services to understand and meet the range and complexity of people's needs and to assess and plan ongoing care and treatment. This included when people moved between services, including when they were referred to, or after they were discharged from hospital. We saw evidence that multi-disciplinary team meetings took place on a monthly basis and that care plans were routinely reviewed and updated. Health visitors, district nurses, midwives and Macmillan nurses attended the multi-disciplinary team meetings.

The practice had a register of patients with various long term conditions such as diabetes, chronic obstructive pulmonary disease COPD, asthma, heart disease, hypertension, thyroid disease, cancer, rheumatoid arthritis, stroke and peripheral vascular disease. All of these patients were invited for an annual examination carried out by GPs and nurses. Care plans were created for patients with a high risk of hospital admission e.g. COPD. This is the name given for a collection of lung diseases, including chronic bronchitis and emphysema. Typical symptoms are increasing shortness of breath, persistent cough and frequent chest infections.

Consent to care and treatment

Patients' consent to care and treatment was always sought in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, assessments of capacity to consent were also carried out in line with relevant guidance. Where a patient's mental capacity to consent to care or treatment was unclear the GP or nurse assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment. The process for seeking consent was monitored through records audits to ensure it met the practice's responsibilities within legislation and followed relevant national guidance.

Health promotion and prevention

Information about numerous health conditions and self-care was available in the waiting area of the practice. Patients who may be in need of extra support were identified by the practice. These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Rescue packs were available for patients with COPD with instructions for when to use them.

The practice had a comprehensive screening programme. The practice's uptake for the cervical screening programme was 79% which was comparable to the national average of 81%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

Childhood immunisation rates for the vaccinations given were comparable to national averages. For example,

- Childhood immunisation rates for the vaccinations given to under two year olds ranged from 93% to 100% and five year olds from 90% to 100% compared with the national average which ranged from 92% to 100%.

Baby and postnatal checks were usually done together within normal surgery time to provide extra flexibility for families.

- Flu vaccination rates for the over 65s was 79% which was above the national average of 73%

Good

Are services effective?

(for example, treatment is effective)

- Flu vaccination rates for the at risk groups was 60% which was above the national average of 52%

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people aged 40–74. Appropriate follow-ups on the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified. Diabetic reviews were carried out by the long term locum GP who carried out insulin initiation.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Throughout the inspection we observed that members of staff were courteous and very helpful to patients both attending at the reception desk and on the telephone and that people were treated with dignity and respect. Curtains were provided in the doctors' consulting rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. There was no curtain in the practice nurse's room but the room was locked with the patient's consent. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

Forty one out of the 42 patient CQC comment cards we received were positive about the service experienced. Patients said they felt the practice offered a helpful service and staff were knowledgeable, caring and professional. Some patients we spoke with gave particularly positive accounts of the care and treatment they and their families received. They described being involved in their care and never feeling rushed. We received one negative comment about obtaining appointments. We also spoke with three members of the patient participation group (PPG) on the day of our inspection. They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the 2015 national GP patient survey showed patients were happy with how they were treated and confirmed this was with compassion, dignity and respect. The practice was in line with CCG and national averages for its satisfaction scores on consultations with doctors and nurses. For example:

• 80% said the GP was good at listening to them compared to the CCG average of 89% and national average of 89%.

• 82% said the GP gave them enough time compared to the CCG average of 87% and national average of 87%.

• 91% said they had confidence and trust in the last GP they saw compared to the CCG average of 95% and national average of 95%

• 75% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 86% and national average of 85%.

• 93% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 92% and national average of 92%.

• 95% patients said they found the receptionists at the practice helpful compared to the CCG average of 85% and national average of 87%.

We spoke with the managers of two local care homes where some of the practice's patients lived. They told us that the lead GP took their time to sit and speak to patients when they visited and that the care delivered by the GP was second to none.

Care planning and involvement in decisions about care and treatment

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

Results from the national GP patient survey we reviewed showed patients responded quite positively to questions about their involvement in planning and making decisions about their care and treatment and results were slightly below local and national averages. For example:

• 80% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 88% and national average of 86%.

• 67% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 82% and national average of 81%

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.

Good

Are services caring?

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations, for example smoking cessation and information about the phlebotomy service.

The practice's computer system alerted GPs if a patient was also a carer. There was a practice register of all people who were carers and 1% of the practice list had been identified as carers and were being supported, for example, by offering health checks and referral for social services support. Written information was available for carers to ensure they understood the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP contacted them and gave them advice as to how they could get support.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice worked with the local Clinical Commissioning Group (CCG) to plan services and to improve outcomes for patients in the area. The Clinical Commissioning Group is a group of general practices that work together to plan and design local health services in England. They do this by commissioning or buying health and care services. For example;

- The practice worked closely with Improving Access to Psychological Therapies (IAPT) workers for patients who experienced poor mental health.
- The practice worked very closely with the community psychiatry nurse (CPN) and secondary care. The practice also liaised with the crisis resolution team for patients who needed immediate help.
- One of the long term locums had a special interest in substance and alcohol misuse and they worked closely with the Recovery Partnership. This is an integrated and recovery-focused treatment service for residents across Coventry and Warwickshire with a drug or alcohol problem.
- The lead GP carried out procedures such as joint injections, coil fittings and coil removals

Services were planned and delivered to take into account the needs of different patient groups and to help provide flexibility, choice and continuity of care. For example;

• The practice offered extended hours on a Monday evening (excluding the third Monday in a month) until 8.15pm and every third Saturday 9am to 10.30am for the working population group.

• There were longer appointments available for people with a learning disability.

• Home visits were available for older patients and housebound patients. Follow up appointments for house bound patients were booked with the same GP.

• Urgent access appointments were available for children and those with serious medical conditions.

• There were disabled facilities, hearing loop and translation services available.

- As the practice had been there for over 20 years they were in the process of modernising the building. This including the fitting of automatic doors and a re-decoration.

Access to the service

The practice was open between 8.30am and 6.30pm Monday to Friday. Appointments were available from 8.30am to 11am and from 3pm to 6pm daily. Extended hours surgeries were offered on Mondays until 8.15pm (except on the third Monday of each month) and the 3rd Saturday of every month from 9am to 10.30am.

Results from the 2015 national GP patient survey showed that patients' satisfaction with how they could access care and treatment was comparable to local and national averages and people we spoke to on the day were able to get appointments when they needed them. For example:

• 75% of patients were satisfied with the practice's opening hours compared to the CCG average of 75% and national average of 75%.

• 86% patients said they could get through easily to the surgery by phone compared to the CCG average of 73% and national average of 76%.

• 79% patients described their experience of making an appointment as good compared to the CCG average of 71% and national average of 73%.

• 85% patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 67% and national average of 65%.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England and the practice manager held the lead responsibility for complaints handling.

Information was available in the reception area to help patients understand the complaints system. There were clear posters on the noticeboards explaining the complaints procedure. There were also complaints and compliments leaflets available. The leaflets provided

Good

Are services responsive to people's needs?

(for example, to feedback?)

patients with the names and contact details of the practice manager and informed patients that if they did not wish to contact the practice directly they could complain to the Health Service Ombudsman.

We looked at three complaints and noted that the practice had handled these well. Following one complaint where the practice reviewed its procedure related to a patient not being seen due to arriving late to the appointment. This resulted in changes to the system and if a patient was less than 15 minutes late the practice accommodated them.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to adhere professionally and responsively to patient needs and provide an excellent standard of quality of care in a safe and appropriate environment. The practice manager had discussions with all members of staff at the practice so that they were all involved with the practice vision and strategy.. It was evident in discussions with staff during the day that this vision was shared throughout the practice

The practice sent us a copy of their statement of purpose prior to the inspection of the service. This told us that the aims of the practice was to provide high quality services available to all irrespective of gender, race, disability, sexual orientation, religion or belief.

Governance arrangements

The practice had appropriate governance arrangements in place for example:

- The practice used the Quality and Outcomes Framework (QOF) to measure its performance. QOF is a national performance measurement tool. The QOF data for this practice showed that in all relevant services it was performing above or in line with national standards. We saw that QOF data was regularly discussed at weekly meetings and action taken to maintain or improve outcomes. There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff.
- The practice had meetings to share information, to look at what was working well and where improvements needed to be made. Staff we spoke with confirmed that complaints and significant events were discussed with them. The meeting minutes were not documented but staff were able to describe issues discussed at meetings.
- Staff had a comprehensive understanding of the performance of the practice.
- There was a programme of continuous clinical and internal audit in place which was used to monitor quality and to make improvements. Staff we spoke with were able to discuss the audits thoroughly but the paper records did not reflect this.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

Leadership, openness and transparency

The lead GP and two long term locum GPs in the practice had the experience, capacity and capability to run the practice and ensure high quality care. They prioritise safe, high quality and compassionate care. The lead GP was visible in the practice and staff told us that they were approachable and always take the time to listen to all members of staff. Staff told us that the lead GP encouraged a culture of openness and honesty. All staff were clear about their own roles and responsibilities. They told us they felt valued and well supported and by the practice and the lead GP. Staff were enthusiastic and told us they enjoyed working at the practice.

In the long term the lead GP hoped for a partner to join. If the lead GP was absent the two long term locums would provide cover for the lead GP.

Staff told us that regular team meetings were held. All staff was involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice. One member of staff was finding it difficult to see the screens clearly. They raised this with the lead GP and the practice manager. As a result, new screens were being fitted.

There was a very caring approach towards all staff working at the practice. Staff told us they spent time together outside practice hours to help them build their relationships as a team. Staff gave examples of when they had been in difficult situations in their personal lives and the lead GP and the practice manager had been very understanding.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients, proactively gaining patients' feedback and engaging patients in the delivery of the service. It had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. The PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. There was an

Are services well-led?

Good

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

active PPG which met on a regular basis, carried out patient surveys and submitted proposals for improvements to the practice management team. For example, as a result of a recommendation from the PPG the patient survey was made into a concise single page document which more patients completed.

The practice had also gathered feedback from staff through appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. For example one member of staff wanted more support with an area of their work and as a result was given protected time to attend study days which were run by the Clinical Commissioning Group (CCG). Staff told us they felt involved and engaged to improve how the practice was run.