

# Forrest Medical Centre

## Quality Report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

## Ratings

Overall rating for this service		Good	
Are services safe?		Good	
Are services effective?		Good	
Are services caring?		Good	
Are services responsive to people's needs?		Good	
Are services well-led?		Good	

# Summary of findings

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## Overall summary

### Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Forrest Medical Centre on 17 August 2016. Overall the practice is rated as good.

- There was an effective system in place for reporting and recording significant events, which were discussed and analysed at monthly practice meetings.
- Risks to patients were assessed and well managed through discussion at practice meetings and multidisciplinary team meetings.
- Patients' needs were assessed and the practice planned and delivered care in line with best practice guidance.
- Staff had the skills, knowledge and experience to deliver effective care and treatment to patients.
- Patients said they were treated with kindness, dignity and respect and that they were involved in their care and decisions about their treatment.
- The practice achieved 100% in the Quality and Outcomes Framework (QOF) targets for 2014/15. Unpublished data for 2015/16 showed that this high standard had been maintained.
- Data from the National GP Patient Survey published in July 2016 evidenced that the practice team consistently scored higher than the Coventry and Rugby Clinical Commissioning Group (CCG) or national averages.
- Information about services and how to complain was available in the reception areas and on the practice website. Improvements were made to the quality of care as a result of complaints and concerns.
- Patients told us that 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.
- In exceptional circumstances, we heard that the practice would arrange for a taxi to collect a patient who needed to be seen urgently but who was unable to get transport, thus enabling them to be seen in a more appropriate clinical environment.
- Repeat prescription requests were processed on the day that they were ordered and paper prescriptions could be collected on Saturday mornings.
- Patients could request repeat prescriptions by phone.
- Patients could book appointments for blood tests with a practice nurse at 7.30am on three days of the week.

# Summary of findings

Early appointments with a GP were also available throughout the week, starting from 7.30am every day except Thursday, when GP appointments started at 8am.

- The practice was located in purpose built premises and had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff commented on the supportive attitude of the management team. The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of and complied with the requirements of the duty of candour.

The areas where the provider should make improvement are:

- Amend the Disclosure and Barring Service (DBS) policy to include the need to undertake a formal risk assessment before accepting a previously issued DBS check for a new employee.
- Maintain records for assessing competency levels for non-clinical staff.
- Maintain an audit trail of patient safety alerts, including from the Medicines and Healthcare products Regulatory Agency.
- Establish a system for checking uncollected prescriptions before destruction.

**Professor Steve Field (CBE FRCP FFPH FRCGP)**

Chief Inspector of General Practice

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

### Are services safe?

The practice is rated as good for providing safe services.

Good



- There was an effective system in place for reporting and recording significant events. We saw that 57 incidents had been recorded between August 2015 and June 2016.
- A significant event week was held every year in which staff were encouraged to record all incidents. The aim was to focus staff attention on the rationale for reporting incidents and learning from them.
- Lessons were shared across the practice team to make sure action was taken to improve safety in the practice.
- When things went wrong patients received support, information, and a written apology. They were told about any actions to improve processes to prevent a recurrence.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- Risks to patients were assessed and well managed through discussion at practice meetings and multidisciplinary meetings.

### Are services effective?

The practice is rated as good for providing effective services.

Good



- Data from the Quality and Outcomes Framework (QOF) showed that the practice was performing highly when compared to practices nationally. The practice scored 100% achievement for 2014/15 and unpublished data showed that this achievement had been maintained in 2015/16.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of annual appraisals and personal development plans for all clinical staff, but the formal appraisals for non-clinical staff had been discontinued in recent years in favour of a more informal approach to review competency levels, set objectives and determine training needs. This more informal approach still enabled staff to access training, raise concerns and get support.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

# Summary of findings

## Are services caring?

The practice is rated as good for providing caring services.

Good



- Data from the National GP Patient Survey published in July 2016 showed that patients rated the practice higher than others for most aspects of care. For example, 96% of patients said that the last GP they saw or spoke to was good at treating them with care and concern, which was higher than the CCG and national average of 85%.
- Patients said that they were treated with kindness, dignity and respect and that clinical staff involved them in decisions about their care and treatment.
- Views from the managers of three local care homes we spoke with aligned with these findings. We were told that the practice provided a first class service and support to patients and their relatives.
- Information for patients about the services available was easy to understand and accessible.
- During our inspection, we observed that staff treated patients with kindness and respect, and maintained patient and information confidentiality.

## Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

Good



- Practice staff 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. For example, Forrest Medical Centre was the pilot practice in the area for trialling the Electronic Palliative Care Communications System (EPaCCS). The EPaCCS was a software programme which would enable multidisciplinary teams to access and input data into patient records.
- Patients said that they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- Patients could book appointments for blood tests with a practice nurse at 7.30am on three days of the week, which provided access for patients who could not attend during normal surgery hours. Early appointments could be booked with a GP, starting at 7.30am apart from Thursdays, when the first GP appointment was at 8am.
- The practice had good facilities and was well equipped to treat patients and meet their needs. This included easy access for patients who used mobility scooters or wheelchairs.

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- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the Patient Reference Group.

## Are services well-led?

The practice is rated as good for being well-led.

**Good**



- The practice had a clear vision and strategy to deliver high quality care and promote best possible outcomes for patients. Staff understood the ethos of the practice, which was headlined in the practice logo: 'Compassionate. Community. Care' and worked to deliver that.
- There was a clear leadership structure and staff said that they were supported by the management team. The practice had a broad range of policies and procedures to govern activity and held regular meetings.
- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken.
- The practice proactively sought feedback from staff and patients, which it acted on. The Patient Reference Group was active.
- Although clinical staff had an annual appraisal, we noted that the annual appraisal system for non-clinical staff had lapsed in recent years, and there was not a formal performance review process in place for these staff. However, staff told us that they preferred this less formal approach and would not hesitate to raise concerns or requests for training with the management team and that they were encouraged to develop their skill base. For example, a member of staff had requested and received additional training on the clinical computer system.
- There was a strong focus on continuous learning and improvement at all levels. We heard that the practice went out

# Summary of findings

of their way to provide time off for study days with colleagues volunteering to work extra days in order to provide clinical cover. Teaching sessions for clinical and non-clinical staff were arranged on a regular basis.

# Summary of findings

## The six population groups and what we found

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

### Older people

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

Good



- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- Home visits and urgent appointments were provided for those with enhanced needs.
- The practice had responsibility for three local nursing homes, two of which cared for patients with dementia. Each home had a designated GP, who carried out weekly visits, thus ensuring continuity of care.
- All patients over 75 years who were prescribed more than eight medicines had their medicines reviewed as part of the polypharmacy programme.
- Monthly palliative care meetings were held with multidisciplinary teams, such as the district nurses, community matron and Macmillan nurse.
- Forrest Medical Centre was the lead practice in Coventry for developing the Electronic Palliative Care Communications System (EPaCCS).
- A weekly drop-in advice service was provided by the local Carers' Trust. The support worker had delivered training to practice staff.

### People with long term conditions

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

Good



- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- The percentage of patients with diabetes on the register, in whom the last diabetic reading was at an appropriate level in the preceding 12 months was 85%, which was 8% higher than both the Clinical Commissioning Group and national averages.
- Longer appointments and home visits were available when needed.
- Medication reviews for housebound patients were done by their usual GP during home visits.



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- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

## Families, children and young people

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.
- Immunisation rates were high for all standard childhood immunisations. The immunisation clinic for children and young families was a drop-in service, although patients could book routine appointments for immunisations if the drop-in service was not convenient for them.
- 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.
- 75% of women attended cervical screening within 3.5 to 5.5 years which was comparable to the Clinical Commissioning Group (CCG) average of 73% and the national average of 74%.
- Appointments were available outside of school hours and the premises were suitable for children and babies. A play table and a play kitchen were provided for children.
- We saw positive examples of joint working with midwives, health visitors and school nurses.

Good



## Working age people (including those recently retired and students)

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

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- 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.
- Patients could book routine GP appointments online as well as request repeat prescriptions, submit questions and view their medical records at a time that was convenient for them.

Good



# Summary of findings

- Patients could book appointments with a practice nurse at 7.30am.
- Extended hours were offered on a Saturday morning, which provided extra flexibility for working age patients. Paper prescriptions could also be collected on Saturday mornings.
- NHS health checks were offered to patients aged between 40 and 75 years.

## People whose circumstances may make them vulnerable

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

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice offered longer appointments for patients with a learning disability.
- There were 61 patients on the learning disability register, 23 of whom had had reviews since April 2016. A member of the practice's medicines management team phoned the patient or carer two days before the appointment in order to try to reduce non-attendance.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- Clinical staff were flexible when vulnerable patients arrived late for appointments.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- The community drug team visited the practice once a week.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.
- The child safeguarding lead met monthly with the health visitor and midwife to discuss families of concern and to identify vulnerable families in need of additional support.

Good



## People experiencing poor mental health (including people with dementia)

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

Good



# Summary of findings

- 83% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months, which was comparable to the CCG and national averages of 82% and 84% respectively.
- 95% of patients with poor mental health had a comprehensive care plan documented in their record in the preceding 12 months, which was 11% above the CCG average and 7% above the national average.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice carried out advance care planning for patients with dementia.
- Counselling and Improving Access to Psychological Therapies (IAPT) services were provided once a week at the practice.
- The manager of a local residential home that cared for patients with dementia praised the high level of care provided by the practice. We heard how the GPs had a good understanding of dementia patients' needs and were very supportive.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia.

# Summary of findings

## What people who use the service say

The National GP Patient Survey results were published on 7 July 2016. The results showed the practice was performing higher than local and national averages in most cases. 272 survey forms were distributed and 113 were returned. This represented a 42% completion rate.

- 96% of patients found it easy to get through to this practice by phone compared to the national average of 73%.
- 83% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the national average of 85%.
- 94% of patients described the overall experience of this GP practice as good compared to the national average of 85%.
- 93% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the national average of 78%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 19 comment cards which were very complimentary about the standard of care received. Patients wrote that Forrest Medical Centre was an excellent practice, with a patient centred ethos.

We spoke with 16 patients during the inspection, one of whom was a member of the Patient Reference Group (PRG). A PRG is a group of patients registered with the practice who worked with the practice team to improve services and the quality of care. Patients appreciated not being rushed during consultations and said that the GPs always listened to them.

We viewed two comments which had been posted by patients on the NHS Choices webpage for the practice. Both were very positive. The staff were praised for being friendly and helpful and the GPs were considered to be exceptional.

## Areas for improvement

### Action the service **SHOULD** take to improve

The areas where the provider should make improvement are:

- Amend the Disclosure and Barring Service (DBS) policy to include the need to undertake a formal risk assessment before accepting a previously issued DBS check for a new employee.
- Maintain records for assessing competency levels for non-clinical staff.
- Maintain an audit trail of patient safety alerts, including from the Medicines and Healthcare products Regulatory Agency.
- Establish a system for checking uncollected prescriptions before destruction.

# Forrest Medical Centre

## Detailed findings

### Our inspection team

#### Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

## Background to Forrest Medical Centre

Forrest Medical Centre is situated on the outskirts of Coventry on the edge of an area of high social and economic deprivation. The practice is registered with the Care Quality Commission (CQC) as a partnership provider and delivers a full range of family medical services, as well as providing a minor surgery service.

The practice has a General Medical Services (GMS) contract with NHS England. The GMS contract is the contract between general practices and NHS England for delivering primary care services to the local communities. At the time of the inspection, Forrest Medical Centre was providing medical care to approximately 9,240 patients.

The practice moved into the current purpose-built premises in September 2015. It has good facilities and is suitable for patients with mobility problems and for those who use wheelchairs. The consulting rooms are arranged over two floors, which can be accessed by stairs or by a lift.

Air conditioning ensures the comfort of patients in hot weather. Play tables and a play kitchen are provided for children.

There are five GP partners (three male, two female) and one non-clinical partner (male), who is also the practice manager. In addition, there are four salaried GPs (one male, three female). The partners are supported by two practice nurses, one health care assistant and administrative and reception staff.

Forrest Medical Centre is an approved training practice for trainee GPs. A trainee GP is a qualified doctor who is training to become a GP through a period of working and training in a practice. There are four GP trainers and four trainee GPs. The practice is also a teaching practice for medical students at university. The practice teaches six students a year, in three sets of two.

A Statutory Notification was submitted to the CQC in May 2016 regarding a serious injury to a patient who fell in the reception area. The incident was dealt with appropriately.

The practice is open between 7.30am and 6pm on Mondays, Tuesdays, Thursdays and Fridays. On Wednesdays, the practice is open from 7.30am to 12.30pm and from 2pm to 6pm. Appointments are available during these hours. The practice also provides pre-bookable appointments with GPs on a Saturday morning from 8.30am to 11.30am. NHS 111 provides cover when the practice is closed.

## Why we carried out this inspection

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. The inspection was planned to check whether the provider is meeting the legal

# Detailed findings

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 our announced inspection of Forrest Medical Centre on 17 August 2016, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We also reviewed nationally published data from sources including Coventry and Rugby Clinical Commissioning Group (CCG), NHS England and the National GP Patient Survey published in July 2016

During our inspection we spoke with members of staff including GPs, a practice nurse and members of the reception team. We also spoke with managers of three local care homes and the carer support worker.

We spoke with 16 patients, one of whom was a member of the Patient Reference Group (PRG). A PRG is a group of patients registered with the practice who worked with the practice team to improve services and the quality of care.

We reviewed 19 comment cards where patients shared their views and experiences of the service.

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 were provided for specific groups of people and what good care looked 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).

# Are services safe?

## Our findings

### Safe track record and learning

- The practice had a robust system for reporting and recording significant events. We saw that significant events were recorded on a monthly basis on a summary sheet with details of actions taken and the meeting at which they were discussed. Staff told us that they would tell the practice manager about any incidents and that they knew how to access the recording form on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment.
- We saw evidence that when things went wrong with care and treatment, patients were informed about the incident, received reasonable support, information, a written apology and were told about any actions to improve processes to prevent a recurrence.
- We viewed the significant event monitoring protocol and saw that the discussion and analysis of significant events was a standing agenda item at the monthly practice meetings.

There was a system in place to act on patient safety alerts, for example, from the Medicines and Healthcare products Regulatory Agency (MHRA). Alerts were received by the practice manager, who forwarded them to a nominated GP. There was no formal system for recording that an alert had been actioned and cascaded. However, an alert regarding a medicine prescribed for malaria was tracked on the day of the inspection and found to have been actioned appropriately. A recent alert regarding the prescribing of a medicine for epilepsy or bipolar disorder for girls and women of childbearing age was also tracked and no patients in this category were found to be taking the medicine.

### Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements.

Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs 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 on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child protection or child safeguarding level three.

- All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. 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. One non-clinical member of staff had a DBS check from their previous employment. A formal risk assessment to determine whether a new DBS check should have been carried out in view of the change of role and employer had not been done. The practice did have a DBS check policy in place. The policy did not refer specifically to the need to risk assess DBS checks issued by previous employers; it stated that DBS checks should be carried out on all relevant staff members and that that initial employment was conditional upon the provision of a satisfactory DBS certificate of a level appropriate to the post held.
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be visibly clean and tidy. Five comment cards referred specifically to the cleanliness of the new premises. One of the practice nurses 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 a training update in August 2016. Annual infection control audits were undertaken; the last one was carried out in September 2015. We saw that action was taken to address improvements identified as a result. For example, new pedal bins had been bought to replace those with pedals which no longer worked and a liquid soap dispenser had been wall-mounted.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal).



## Are services safe?

Processes were in place for handling repeat prescriptions which included the review of high risk medicines. We viewed the protocols for prescription security, anticoagulant prescribing and lithium prescribing. The practice carried out regular medicines audits, with the support of the local CCG medicines management teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms were securely stored and there were systems in place to monitor their use. We noted that there was not a system in place for notifying GPs if patients did not collect prescriptions. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. The health care assistant was trained to administer vaccines and medicines against a patient specific prescription or direction from a prescriber.

- There was a needlestick injuries policy and staff knew what to do if they accidentally injured themselves with a sharp medical device like a needle. The practice recorded the Hepatitis B status of staff. All instruments were single use. There was a contract for the collection of clinical waste and we saw that the waste for collection was securely stored.
- We saw the recruitment policy which specified the procedures for recruitment. We reviewed five personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identity, references, qualifications, registration with the appropriate professional body and the appropriate DBS checks.

### Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety action plan available with a poster in the staff kitchen which identified local health and safety representatives. The practice had received a certificate from Peninsula in July 2016 for 'successful and proactive Health and Safety culture' in the workplace. The practice had up to date fire risk assessments and carried out regular fire drills. The most recent fire risk assessment was carried out in August 2016 and a fire drill was carried out in November 2015. Two members of staff

had attended fire marshal training in April 2016. All electrical equipment was checked to ensure the equipment was safe to use. The last check was carried out in May 2016. Regular checks were also carried out on clinical equipment to ensure that it was working properly. The last check was carried out in October 2015. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and Legionella. Legionella is a term for a particular bacterium which can contaminate water systems in buildings.

- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. Staff told us that they provided cover for each other during periods of sickness and annual leave.

### Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to 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 was a sufficient range of emergency medicines available in the treatment room to cover the services provided.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a comprehensive business continuity plan, dated January 2016, in place for major incidents such as IT problems, power failure or building damage. The plan included emergency contact numbers for utility companies. Key members of staff held staff contact numbers on their mobile phones. The practice manager held a copy of the plan offsite.



# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

The practice assessed needs and delivered care 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 keep all clinical staff up to date. Staff had access to guidelines from NICE on the practice's computer system and used this information to deliver care and treatment that met patients' needs. Updates were discussed at the practice clinical educational meetings.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

### Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. The QOF is a system intended to improve the quality of general practice and reward good practice. Data from 2014/15 showed:

- The practice achieved 100% of the total points available. This was 6% above the Clinical Commissioning Group (CCG) average and 5% above the national average. Unpublished results from 2015/16 showed that the practice had maintained this level of achievement.
- The overall exception rate was 10%, which was 2% above the CCG average and 1% above the national average. Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects.
- The percentage of patients with diabetes on the register, in whom the last diabetic reading was at an appropriate level in the preceding 12 months was 85%, which was 8% higher than both the Clinical Commissioning Group and national averages.
- 96% of patients with poor mental health had a comprehensive care plan review completed within the last 12 months. This was 11% higher than the CCG average and 7% above the national average.

Exception reporting for chronic kidney disease was 23%, which was 15% above the CCG average and 14% above the national average. We were told that this was due to elderly patients being exempted after making an informed choice, because they suffered marked side effects from taking high doses of medicine.

The practice participated in local audits, national benchmarking, accreditation, peer review and research. There was a system for undertaking regular clinical and non-clinical audits, which were used to improve patient care or gauge patients' opinions on a service.

- There had been 11 clinical audits completed in the last year, two of these were completed audits where the improvements made were implemented and monitored.
- For example, an audit was carried out on the prescribing for patients over 80 years of age to review the number of prescriptions issued per patient in a six month period. The average number of prescriptions issued reduced from 41 to 37, which evidenced the effect of the change in prescribing for elderly patients.
- Another audit was carried out on the prescribing of vitamin supplements to prevent fractures (with the exception of giving vitamin D to care home residents) as a result of research, which indicated that there was little evidence to prove any benefit to patients. The second audit showed a 22% reduction in the prescribing of vitamin supplements.
- We saw evidence of high quality prescribing outcomes in the CCG Medicines Metrics feedback. For example, the practice consistently achieved scores of at least nine out of 10 and 10 out of 10 every quarter within the CCG's prescribing quality performance reports and was rated one the best out of local practices for the low prescribing of 'high risk' antibiotics.
- We saw evidence from the CCG Lead Pharmacist that the practice had been at the forefront of promoting polypharmacy reviews across the CCG. For example, the practice was instrumental in developing the 'Minimising Polypharmacy and Adverse Drug Reactions in the Over 75s' document in conjunction with the Medicines Management Team at the CCG and had promoted rational prescribing in chronic disease management to local practices.

# Are services effective?

## (for example, treatment is effective)

### Effective staffing

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

- We viewed the induction checklist for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. All clinical staff had received an appraisal within the last 12 months, but the formal appraisal system for non-clinical staff had been discontinued in recent years in favour of a more informal method of assessing competency levels, setting objectives and determining training needs. For example, a member of staff had requested and received additional training on the clinical computer system. Another member of staff was trained to take on a lot of Medicines Management work for the GPs.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.
- Clinical staff had additional expertise in a variety of areas, such as mental health, chronic lung disease and asthma.
- A GP was the chair of the 'In Spires' locality, so the practice benefitted from his knowledge of local initiatives and strategy.

### Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Meetings took place with multidisciplinary teams on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

### Consent to care and treatment

Clinical staff we spoke with showed that they understood the importance of obtaining informed consent and had received training about the Mental Capacity Act (2005) (MCA). The MCA provides a legal framework for acting and making decisions on behalf of adults who lacked the capacity to make decisions for themselves.

Clinical staff were aware of the requirement to assess children and young people using Gillick competence and Fraser guidelines when providing care and treatment. Gillick competence was used to decide whether a child (16 years or younger) was able to consent to his or her own medical treatment, without the need for parental permission or knowledge. Fraser guidelines relate specifically to contraception and sexual health advice and treatment.

### Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were signposted to the relevant service.

The practice's uptake for the cervical screening programme was 75% which was comparable to the CCG average of 73% and the national average of 74%. There was a policy to

# Are services effective?

(for example, treatment is effective)

offer telephone reminders for patients who did not attend for their cervical screening test. The practice ensured a female sample taker was available. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. Uptake for bowel screening in the last 30 months was 59%, which was slightly higher than the CCG and national averages of 58%. Uptake for breast cancer screening in the last three years was 72%, which was comparable to the CCG and national averages of 71% and 72% respectively.

Childhood immunisation rates for the vaccinations given were comparable to CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 94% to 98% and five year olds from 91% to 100%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. The NHS health checks were also available on alternate Saturday mornings. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

# Are services caring?

## Our findings

### Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations. The practice had introduced a system for playing music or local radio programmes in reception in order to preserve patients' privacy when they were in the consulting rooms or at the reception desk.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

All of the 19 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered a wonderful service and staff were helpful, caring and treated them with dignity and respect.

We spoke with one member of the Patient Reference Group (PRG). 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 National GP Patient Survey 2016 showed that patients felt that they were treated with kindness, dignity and respect. The practice was above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 96% of patients said the GP was good at listening to them compared to the Clinical Commissioning Group (CCG) average of 89% and the national average of 89%.
- 96% of patients said the GP gave them enough time compared to the CCG average of 87% and the national average of 87%.
- 99% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 95% and the national average of 95%.

- 96% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 85% and the national average of 85%.
- 98% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 90% and the national average of 91%.
- 94% of patients said they found the receptionists at the practice helpful compared to the CCG average of 86% and the national average of 87%.

These high levels of satisfaction aligned with the comments made by patients on the day of the inspection and by the comment cards.

### Care planning and involvement in decisions about care and treatment

Patients told us 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 from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

Results from the National GP Patient Survey 2016 showed that patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were above local and national averages. For example:

- 94% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 85% and the national average of 86%.
- 93% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 81% and the national average of 82%.
- 93% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 85% and the national average of 85%.
- 100% of patients said that they had confidence and trust in the last nurse they saw or spoke to compared with the CCG average of 97% and the national average of 97%.

The practice provided facilities to help patients be involved in decisions about their care:

## Are services caring?

- 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.
- Information leaflets were available in the three reception areas and there were patient information screens giving details of local services.

### **Patient and carer support to cope emotionally with care and treatment**

Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations. Information about support groups was also available on the patient information screen and on the practice website.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 152 patients as

carers, which represented 1.6% of the practice list. A support worker from the local Carers' Trust held a drop-in advice session every Friday. The support worker had also delivered an 'Express Carer' training session to practice staff in March 2016. The health care assistant was the practice lead for carers. The health care assistant liaised with the support worker and attended local carers' meetings. Questions about whether a patient was cared for or a carer were included on the new patient questionnaire. There was a page on the practice website advising patients how to register as carers.

Staff told us that if families had suffered bereavement, their usual GP would contact them and offer appropriate support.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Coventry and Rugby Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.

- There were longer appointments available for patients with a learning disability.
- Patients were able to make an appointment to see a practice nurse from 7.30am on three days of the week, in order to have a blood test.
- Appointments with a GP could also be booked from 7.30am on Mondays, Tuesdays, Wednesdays and Fridays and from 8am on Thursdays.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that required same day consultation.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately/were referred to other clinics for vaccines available privately.
- There were disabled facilities, a hearing loop and translation services available. The practice had a mobile phone number available for hard of hearing patients. This number could be used to request an appointment or a repeat prescription.

### Access to the service

The practice was open between 7.30am and 6pm on Mondays, Tuesdays, Thursdays and Fridays. On Wednesdays, the practice was open between 7.30am and 12.30pm and from 2pm until 6pm. Appointments were available during these hours. Additional extended hours appointments were offered for pre-bookable GP appointments on Saturday mornings between 8.30am and 11.30am. In addition to pre-bookable appointments which could be booked up to five weeks in advance, urgent appointments were also available for patients who needed them. A telephone triage system operated for all contacts needed on the day and an appointment would be booked

with the patient's named GP wherever possible. An audit conducted by the practice showed that 96% of patients were called back by the on call GP within one hour of their initial call; 53% were called back within 20 minutes.

Results from the National GP Patient Survey 2016 showed that patient's satisfaction with how they could access care and treatment was higher than local and national averages.

- 92% of patients were satisfied with the practice's opening hours compared to the CCG average of 75% and the national average of 76%.
- 96% of patients said they could get through easily to the practice by phone compared to the CCG average of 73% and the national average of 73%.

People told us on the day of the inspection that they were able to get appointments when they needed them, although there was sometimes a wait if they wanted to see a particular GP. The partners told us that they would adjust the profile of available slots during the day to cope with peak periods. The number of appointments available on the day was monitored weekly, thus ensuring that capacity met demand.

Patients who wanted a home visit were asked to contact the practice before mid-day where possible, the GP requested by the patient would attend, but this could not be guaranteed. When requests for home visits were received after mid-day, the duty GP would attend if they considered that a home visit was appropriate. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, a message was sent to the on call GP and alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

### Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints, comments and compliments, both verbal and written. We viewed the log where these were recorded; out of 51 records, only one was a complaint.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- The practice manager was the designated responsible person who handled all complaints in the practice.

## Are services responsive to people's needs? (for example, to feedback?)

- We saw that information was available to help patients understand the complaints system in the reception area and on the practice website.

We looked at one complaint received in the last 12 months and found that it had been dealt with in an appropriate and timely manner.



# 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 strapline on the practice logo highlighted the practice's values of compassion, community and care, which all the staff understood. The logo was on notices in the reception areas and on the practice website.

The practice had a robust strategy and supporting business plans which reflected the vision and values and were regularly monitored.

### Governance arrangements

A broad range of policies and procedures had been uploaded to the practice intranet. Staff we spoke with on the day confirmed that they understood their roles and responsibilities.

The partners met once a month to discuss business aspects of the practice. Practice meetings took place once a month. Educational meetings were held twice a month and minuted. The local Continuing Medical Education group was led by one of the GPs. The clinical staff met every day at coffee break to share problems and concerns.

A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.

There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

### Leadership and culture

On the day of inspection the partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. It was clear that the ethos was very patient-centric with high priority given to providing safe, high quality and compassionate care. Staff told us that the partners were approachable and always willing to listen to all members of staff.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment. This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty.

When things went wrong with care and treatment the practice explained the sequence of events and gave a full apology. We saw the log that the practice kept with details of verbal interactions as well as written correspondence.

There was a clear leadership structure in place and staff said that both partners and colleagues were very supportive. Staff told us there was an open, no blame culture within the practice and that they could raise any issues at team meetings and felt confident in doing so. Staff morale was high and staff knew that their contribution to the practice was valued. Staff told us that they appreciated the functions, such as quiz nights and cabaret nights, which provided opportunities to socialise outside of work.

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

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- The practice had gathered feedback from patients through the Patient Reference Group (PRG) and through surveys and complaints received. The PRG met regularly, helped to carry out patient surveys and submitted proposals for improvements to the practice management team. For example, additional chairs had been bought for the reception areas following feedback from the PRG. The PRG had planted flowers in the border outside the main entrance and they maintained the flowerbed.
- Local students had submitted designs for the practice's new logo. Examples were displayed in the main reception area.
- The practice conducted surveys in order to gauge patients' thoughts on services provided. For example, a baby clinic survey was carried out in February 2016 in order to check whether the drop-in system was still the most convenient. 83% of patients who responded said that they found the time convenient and 69% said that they preferred the drop-in system to either a pre-booked or a mixture of both pre-booked and drop-in. As a result, no changes were made, but patients were given the option of booking their children in for immunisations and baby checks at alternative times.
- Staff were encouraged to give feedback at staff meetings, and through discussion with colleagues and the management team.



# Are services well-led?

Good 

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

## Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. GPs commented on the open and informal atmosphere in the practice which assisted the constant review of individual and collective performance. We were told that there was a palpable desire to produce the best level of care for patients and to develop professionally.

The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. For example, Forrest Medical Centre was the lead practice in Coventry for developing the Electronic Palliative Care Communications System (EPaCCS). EPaCCS was a software programme which would enable multidisciplinary teams to access and input data into patient records.

The comments on the display boards from the trainees bore testimony to the high standards within the practice. One trainee wrote that the practice was a wonderful place

to work and that it provided the most supportive learning environment of all the practices in which they had worked. A salaried GP who had been a trainee with the practice wrote that they were lucky to be on the receiving end of all that the practice had to offer in terms of learning and development. All GPs at the practice, regardless of their role, were encouraged to attend the twice weekly educational sessions. Another GP told how they had been encouraged and supported to undertake an Advanced Diploma in Primary Care Mental Health.

The practice had been part of the Primary Care Clinical Research Network for two months and was actively involved in studies on gout and insomnia. We read an article in the Summer 2016 edition of PARTICIPATE (a primary care research journal) in which the practice was congratulated for taking a whole-team approach to embracing research and for their interest in promoting wider educational sessions for clinicians.