The Forum Health Centre

Quality Report

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Date of inspection visit: 1 December 2016
Date of publication: 14/02/2017

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	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Outstanding ☆
Are services caring?	Good ●
Are services responsive to people's needs?	Good ●
Are services well-led?	Outstanding ☆

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 The Forum Health Centre on 1 December 2016. Overall the practice is rated as outstanding.

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

- There was an open and transparent approach to safety with an effective system for reporting and recording significant events which was summarised and demonstrated shared learning. The practice had also shared learning nationally by uploading learning via the National Reporting and Learning System (NRLS) website.
- Risks to patients were assessed and well managed and there were systems which enabled routine assessment of risk. Safeguarding procedures and documentation had been reviewed by the safeguarding lead who had brought together all areas to enable easy access and guidance for staff. There was also evidence of detailed sharing of information, review and summarisation of actions regarding safeguarding showing positive outcomes for children and their families as a result of structured multi-disciplinary team working.
- The practice showed a commitment to learning, specifically regarding safeguarding. They had engaged in a project which resulted in a review of their procedures and the introduction of detailed summaries showing involvement, planning, and outcomes of intervention of child protection cases.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment. GPs and nurses had areas of special interest which they had developed to improve services for patients, such as in sexual health and care of the elderly.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Patient feedback was consistently positive regarding the care

Summary of findings

offered by all staff at the practice. The practice had also addressed services for carers and had taken additional steps to ensure staff were trained regarding carers and implemented measures to increase the number of carers identified.

- Information about services and how to complain was available and easy to understand and improvements were made to the quality of care as a result of complaints and concerns.
- Patients said 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.
- The practice had purpose built facilities, providing disabled access, additional space to allow easy movement for patients with mobility aids, access to specific areas of the practice using electronic doors and had a lift facility. The building had been designed to allow for growth and development of services.
- The practice demonstrated strong leadership and evidence of long term strategic planning to develop and provide services in the community in corroboration with other stakeholders. Discussions took place with secondary care, the local authority, the local CCG and other community health care services and plans were regularly revisited to review and realise the vision for the practice.
- The practice was committed to driving changes in primary care and were involved in leading projects to improve services for patients. 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.

There were two areas where the practice should make improvements:

- Confirm in writing the outcome of complaints investigations following discussion with patients.
- Monitor the revised process for repeat prescriptions for high risk medicines to ensure it is operating effectively.

There were areas of outstanding practice:

The practice demonstrated a commitment to promoting health and uptake of screening and had achieved improved rates of cervical screening as a result of a proactive approach to patients who did not attend. The lead nurse had introduced a system which enabled them to contact all women who had not attended, to discuss the procedure and alleviate concerns which may have impacted on their reasons for non-attendance. As a result they had increased the number of women who attended after their initial response to decline. Cervical screening uptake rates were 86% which were significantly higher than the CCG and national average rates of 75% and 76% respectively.

The practice had a GP lead for women's health and family planning and another GP who had a Diploma of the Faculty of Family Planning and Reproductive Medicine and a special interest in this area of health. They offered long acting reversible contraception (LARC) which included implants and intrauterine contraceptive device fitting (IUCD). The practice increased the number of sessions available for this service in response to increasing teenage pregnancies. We noted as a result that the practice termination of pregnancy rates had reduced significantly since 2013. For example, in 2013/14 there had been 30 cases, 2014/15 there had been 21 cases and in 2015/16 this had reduced to 13 cases.

The practice had been involved in a local project for Integrated Neighbourhood Teams (INT), which had resulted in the introduction of INTs in the area. They also had a GP who had led a project to introduce Acute Frailty Pathways for older people to reduce the length of stay and need for hospital admission which had demonstrated a reduction in length of stay from 11 to four days for elderly frail patients. This was then introduced across the area.

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.

- There was an effective system for reporting and recording significant events. Staff were involved in the process and there was evidence of sharing learning outcomes with all staff. The practice issued weekly staff briefings which required confirmation they had been read.
- Lessons were shared to make sure action was taken to improve safety in the practice and the practice sharing learning nationally by utilising the National Reporting and Learning System (NRLS).
- When things went wrong patients received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices to keep patients safe and safeguarded from abuse. The practice had been proactive and involved in a local project to improve interagency working. As a result the safeguarding lead had reviewed and revised the practice documentation to centralise and make all information and guidance easily available to all staff. They practice reviewed all cases and demonstrated how working with the multi-disciplinary team, prompt response, and tailored support and care had achieved positive outcomes for children and families as a result.
- Risks to patients were assessed and well managed and the practice had effective systems that ensured this was maintained and that addressing areas of risk and safety remained a priority.

Are services effective?

Outstanding

The practice is rated as outstanding for providing effective services. This is because the population groups older people, those patients with long term conditions, and families, children and young people were outstanding in the effective domain.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to the national average. The overall achievement in clinical areas was 97% compared to the Clinical Commissioning Group (CCG) and national average of 95% and exception reporting was below

average. We saw the practice had specific allocated staff with responsibilities for operating effective systems for call and recall of patients with long term conditions and screening. They were proactive and responsive when patients did not attend, which resulted in improved uptake of screening and review, for example, 82% of eligible women had received cervical screening compared to the CCG and national averages of 75% and 76% respectively. The practice also had GPs and nurses with special interests in clinical areas which had led to the development of services for older patients, those with long term conditions and mental health problems following involvement in successful pilot projects, such as fitness programmes.

- The practice had been proactive in offering long acting reversible contraceptive implants (LARCS) which had resulted on a year on year reduction in termination of pregnancy over three years. For example, in 2013/14 there had been 30 cases, 2014/15 there had been 21 cases and in 2015/16 this had reduced to 13 cases.
- The practice had introduced an Integrated Neighbourhood Team (INT) following a successful pilot project in 2014. The aim of INTs is to bring together all professionals and care providers delivering care to older people and vulnerable patients to improve efficiency and deliver outcomes such as reduced admissions to hospital, providing better support in patients' homes and joint visiting with GPs, community nursing, therapists, social workers, mental health services and the voluntary sector.
- The practice had been involved in projects in frail elderly care which had demonstrated a reduction in length of stay in hospital as a result. For example, the average length of stay had reduced from 11 to four days for frail elderly vulnerable adults. They had also become involved in a social prescribing project which was to be introduced in January 2017. Staff had been trained in readiness for this. (Social prescribing is a means of enabling primary care services to refer patients with social, emotional or practical needs to a range of non-clinical services which are often provided by the voluntary sector).
- Staff assessed needs and delivered care in line with current evidence based guidance. Staff had access to and utilised resources which provided guidance on best practice.
- Clinical audits demonstrated quality improvement and we saw evidence of how improvements had been introduced as a result, such as changes made in the referral process for two week wait cancer waits.

Summary of findings

- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff. Staff told us they had opportunities to identify areas of training and development and could raise these at any time.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the National GP Patient Survey 2016 showed patients rated the practice higher than others for several aspects of care. For example:
- 89% of patients said their GP treated them with care and concern compared with the Clinical Commissioning Group (CCG) and national average of 85%.
- 95% of patients said their GP was good at listening compared to the CCG and national average of 89%.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment from all staff at the practice.
- The practice had adopted a proactive approach to carers and had held meetings with the Carers Trust and arranged training for staff to raise staff awareness of the need to identify carers. They had worked with the Carers Trust and held carers information sessions monthly to support and provide information for carers. They had acknowledged that more carers could be identified and incorporated opportunities for carers to identify themselves via the practice's own patient survey. As a result they had identified a further 81 carers. The total number of carers identified had was 356 which represented 2.25% of the practice population.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality. The practice premises also enabled the practice to accommodate call handlers in a different part of the building to prevent patients waiting whilst calls were taken at reception.
- Staff were able to demonstrate where their actions had resulted in positive outcomes for patients, for example, noticing patients experiencing difficulties and directing them to appropriate services who were able to provide additional support.

Are services responsive to people's needs?

Good

Summary of findings

The practice is rated as good for providing responsive services.

Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The practice had recognised that the population was increasing together with the number of older patients and had become involved in pilot projects to develop services in these areas.

- The practice had assessed and been responsive to the increasing needs of the practice population and worked collaboratively to develop services. The practice used specialised templates to identify patients at risk of admission to hospital and those who may benefit from input from the Integrated Neighbourhood Teams (INT). They also hosted the INT team in the building.
- The practice hosted the Age UK GP navigator based in the practice who conducted home assessments of frail elderly patients, and the dementia navigator service for support for carers and relatives of patients with dementia.
- There was significant evidence of involvement with other organisations, the local community and local council to work together to introduce services collaboratively such as increasing activity in patients with long term conditions by introducing exercise sessions which were due to commence in January 2017.
- The practice responded to the National GP Patient Survey results and had also carried out their own patient survey where they had achieved a larger response and had used this information to improve services in response to patient feedback.
- Patients said 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. The practice had worked to respond to concerns regarding getting through on the telephone and had carried out audits to determine busy times of day and allocated increased staff at those times.
- The practice was a purpose built new premises with modern facilities and was well equipped to treat patients and meet their needs. The premises had been planned and built with consideration to current needs as well as long term development of services and hosted services from a variety of disciplines, such as Improving Access to Psychological Therapies (IAPT), the Age UK care navigator, Carers Trust and community psychiatric nurses.

Summary of findings

- 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 had developed their own bespoke website providing information regarding a range of conditions and links to further information and support services. This was developed with input from the Patient Participation Group (PPG) to ensure the information reflected patient needs. The practice also utilised social media sites to give patients information about the practice, the latest health promotion topics and screening available.

Are services well-led?

Outstanding 

The practice is rated as good for being well-led. This is because the practice was outstanding in all population groups for the well led domain.

- The practice demonstrated an innovative approach and a clear strategy with supporting business plans to deliver high quality care and promote positive outcomes for patients and improve and increase services for patients, incorporating patients in the wider Clinical Commissioning Group (CCG) area. This impacted on all population groups.
- Staff were clear about the vision and their responsibilities in relation to it. Significant communication and collaboration had taken place to acquire purpose built premises to enable services to be developed in line with the business plans.
- There was evidence of significant collaborative working with other agencies such as community matrons, social workers, hospital care staff, and voluntary agencies to understand and meet the range and complexity of patients' needs and develop services to address these. Key staff had driven ideas for improved services and engaged the practice in pilot projects to demonstrate the benefits of these prior to upscaling at the practice and in other areas of the CCG. The practice had been proactive in involvement in pilot projects and introduction of new services to deliver care more effectively and reduce the need to attend hospital, for example, the introduction of Integrated Neighbourhood Teams, the acute frailty pathways for older people and social prescribing.
- There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular meetings which included governance.

Summary of findings

- Regular meetings took place with other agencies such as the local council, secondary care providers, the CCG and other stakeholders to continue to innovate and develop future strategy and address local health priorities.
- There was an overarching governance framework which supported the delivery of the strategy and 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 for responding to notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken.
- The practice had introduced Cardio Pulmonary Resuscitation (CPR) training sessions for patients and the general public and held monthly training sessions and had been taken up by eight people in the first session and six in the second and the sessions were ongoing.
- The practice proactively sought feedback from staff and patients, which it acted on. They had involved the CCG in the development of the new premises and kept them up to date with progress throughout. The Patient Participation Group (PPG) was active.
- There was a strong focus on continuous learning and improvement at all levels.

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

Outstanding ☆

The practice is rated as outstanding for the care of older people. This is because they were outstanding for being effective and well led for this population group.

- The practice offered proactive, personalised care to meet the needs of the older people in its population. The practice used specialised templates to identify patients at risk of admission to hospital and those who may benefit from input from the Integrated Neighbourhood Teams (INT). They also hosted the INT team in the building.
- The practice hosted the Age UK GP navigator based in the practice who conducted home assessments of frail elderly patients, and the dementia navigator service for support for carers and relatives of patients with dementia.
- The practice had been involved in projects in frail elderly care which had demonstrated a reduction in length of stay in hospital as a result. For example, the average length of stay had reduced from 11 to four days for frail elderly vulnerable adults. They had also become involved in a social prescribing project which was to be introduced in January 2017. Staff had been trained in readiness for this. (Social prescribing is a means of enabling primary care services to refer patients with social, emotional or practical needs to a range of non-clinical services which are often provided by the voluntary sector).
- The practice had a medicine review process for patients over 75 years of age.
- The practice was responsive to the needs of older people, offered home visits and urgent appointments for those with enhanced needs.
- The practice held multi-disciplinary team meetings which included the geriatrician, community matrons and consultants.
- The practice supported and advertised the local public health Live Well programmes which promoted health living and exercise such as walking programmes.

People with long term conditions

Outstanding ☆

The practice is rated as outstanding for the care of people with long-term conditions. This is because they were outstanding for being effective and well led for this population group.

Summary of findings

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- There was a delegated member of staff responsible for the recall of patients with long term conditions and staff demonstrated a commitment and vigilance in monitoring uptake, following up patients who did not attend where necessary. The practice Quality and Outcomes Framework (QOF) achievement reflected this and the overall achievement was above the CCG and national averages in all areas. For example:
- The overall practice achievement for patients with diabetes was 96% which was above the CCG and national averages of 90%.
- The overall practice achievement for patients with chronic obstructive pulmonary disease (COPD) was 99% which was above the CCG and national averages of 94% and 95% respectively.
- The practice carried out regular audits on patient with long term conditions to ensure monitoring and medication was optimum.
- Longer appointments and home visits were available when needed.
- Diabetes education sessions were hosted at the practice for which the practice encouraged patients to attend.
- The practice had engaged patients with diabetes onto the PPG. The input from these patients had alerted the practice to ensure that patients received their last blood test in advance of their annual review to allow them to consider questions they may have.
- 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.
- The practice had worked with Public Health (Fitter Futures) and Coventry Solihull and Warwickshire Sport, and Sport England and Coventry City council towards delivery of a fitness programme to promote active lifestyles. This was to commence in January 2017.

Families, children and young people

The practice is rated as outstanding for the care of families, children and young people. This is because they were outstanding for being effective and well led for this population group.

Outstanding ☆

Summary of findings

There were systems 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.

- 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.
- The practice allowed 20 minute appointments for childhood immunisation to provide time for parents to ask questions and give sufficient information regarding the vaccines and aftercare. Child immunisation rates were higher than the CCG and national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 98% to 99%. These were higher than the national rates of 73% and 93%.
- We saw positive examples of joint working with midwives and health visitors.
- The practice offered separate flu clinics for children with timed appointments to minimise wait and anxiety.
- The practice offered text messages and email to improve engagement of young people on the PPG.
- The practice promoted sexual health and made information readily available in the reception area for young people and encouraged chlamydia screening.
- 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. For example, NHS Health Checks, sexual health and contraception services including fitting of contraceptive devices and implants. They had been proactive in offering long acting reversible contraceptive implants (LARCS) which had resulted on a year on year reduction in termination of pregnancy over three years. For example, in 2013/14 there had been 30 cases, 2014/15 there had been 21 cases and in 2015/16 this had reduced to 13 cases.
- One of the nurse practitioners was the lead for nurse for the CCG in cytology and had a special interest in this area. They had worked with one of the administration team to identify patients who had not attended for their cervical smear after three attempts to encourage them to do so. They contacted patients personally to advise of the importance of this and offer

Summary of findings

additional appointments. This had resulted in higher than the average CCG and national uptake of screening. For example, the practice rate was 82% compared to the CCG and national average of 75% and 76% respectively.

Working age people (including those recently retired and students)

Good

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

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.

- Early appointments were available to allow patients who worked to attend. This included appointments for cervical screening.
- The practice sent out birthday cards to all patients on their 40th and 60th birthdays to invite them for health checks and vaccinations to promote knowledge and uptake of these services.
- The practice website provided a comprehensive self-help section which had been developed specifically to reflect the needs of patients and the practice to promote self-care. They had sought the views of the PPG when developing this and had created a 'My Health' resource area.

People whose circumstances may make them vulnerable

Good

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

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- Patients with learning disabilities were flagged on the clinical system to alert staff that longer appointments may be required.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice informed 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. The practice had been proactive and involved in a local project to improve interagency working. As a result the safeguarding lead had reviewed and revised the practice documentation to centralise and make all information and guidance easily available to all staff. They practice reviewed all

cases and demonstrated how working with the multi-disciplinary team, prompt response, and tailored support and care had achieved positive outcomes for children and families as a result. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

- The practice were engaged in a social prescribing service pilot project with Age UK to offer support to patients over 18 years who were suffering social isolation.
- The practice supported the Coventry City Council Live Well programme which promoted healthy living and exercise for patients with learning disabilities.
- Appointments for health checks for patients with a learning disability were booked by telephone to offer a convenient time for patients and carers.

The practice worked closely with the Coventry Carers Trust and hosted information sessions for patients to provide advice and support to carers. The practice had been proactive in increasing the number of carers and had incorporated information into their own patient survey to do this which resulted in identification of an additional 81 carers . The practice offered health checks and signposted carers to appropriate services.

People experiencing poor mental health (including people with dementia)

Good

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

Staff had an understanding of how to support patients with mental health needs and dementia.

- 94% of patients diagnosed with dementia had had their care reviewed in a face to face meeting in the last 12 months, which is above to the CCG and national averages of 81% and 84 respectively.
- 93% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive care plan documented in their record which was higher than the CCG and national average of 85% and 89% respectively.
- 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.

Summary of findings

- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system for following up patients who had attended A&E where they may have been experiencing poor mental health.
- The practice employed their own counsellor to provide support to patients with mental health problems and the Improving Access to Psychological Therapies (IAPT) counsellor attended the practice weekly.
- The practice had engaged with local stakeholders and had approval for a mental health practitioner to be based at the practice from April 2017 to support patients with mental health issues in the community.

Summary of findings

What people who use the service say

The National GP Patient Survey 2016 results were published in July 2016. The results showed the practice was performing in line with or above local and national averages in all areas except for waiting to see their GP when at the practice. There were 304 survey forms distributed and 113 returned which represented a 37% response rate and less than 1% of the practice's patient list. The practice had also carried out their own patient survey in August 2016 and had received 873 responses which represented approximately 5% of the practice population. These responses were also positive with patients reporting high levels of satisfaction.

- 81% of patients found it easy to get through to this practice by telephone compared to the CCG and 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 CCG average of 83% and the national average of 85%.
- 87% of patients described the overall experience of this GP practice as good compared to the CCG average of 84% and the national average of 85%.
- 86% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 75% and 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 21 comment cards which were all positive about the standard of care received. Patients consistently referred to caring and helpful staff and GPs who allowed time to listen and explain their care.

We spoke with six patients during the inspection. All six patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. They commented how getting appointments had become easier since moving to the new premises.

Areas for improvement

Action the service SHOULD take to improve

- Confirm in writing the outcome of complaints investigations following discussion with patients.
- Monitor the revised process for repeat prescriptions for high risk medicines to ensure it is operating effectively.

Outstanding practice

The practice demonstrated a commitment to promoting health and uptake of screening and had achieved improved rates of cervical screening as a result of a proactive approach to patients who did not attend. The lead nurse had introduced a system which enabled them to contact all women who had not attended, to discuss the procedure and alleviate concerns which may have impacted on their reasons for non-attendance. As a result they had increased the number of women who attended after their initial response to decline. Cervical screening uptake rates were 86% which were significantly higher than the CCG and national average rates of 75% and 76% respectively.

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Summary of findings

The practice had been involved in a local project for Integrated Neighbourhood Teams (INT), which had resulted in the introduction of INTs in the area. They also had a GP who had led a project to introduce Acute Frailty Pathways for older people to reduce the length of stay and need for hospital admission which had demonstrated a reduction in length of stay from 11 to four days for elderly frail patients. This was then introduced across the area.

The Forum Health 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 adviser and a practice manager specialist adviser.

Background to The Forum Health Centre

The Forum Health Centre is a long established GP group practice located in the Wyken area of Coventry. The practice provided general medical services to a population to approximately 16,000 patients who live in Wyken, Stoke, Binley and Walsgrave areas of Coventry. The practice recognised some time ago that the population of the area was developing and growing rapidly. In July 2016 the practice moved into purpose built premises following successful planning and funding bids and collaboration with NHS England and local stakeholders. The practice provides services under a General Medical Services (GMS) contract. A GMS contract is a nationally agreed contract between general practices and NHS England for delivering primary care services to local communities. The practice is part of a local GP federation known as the GP Alliance. A federation is formed of a group of practices who work together to share best practice and maximize opportunities to improve patient outcomes. They are also working collaboratively with two other practices and are part of a Multispecialty Community Provider (MCP) project which explores new models of primary care working to improve outcomes for patients and provide services closer to home.

The practice population is predominantly white British, with a significant number of patients from ethnic groups such as Asian, Indian, African and Eastern European. The practice population has a higher than average number of patients aged 0 to 20 years slightly higher than average aged 25 to 30 years and 40 to 50 years. The practice area is one which experiences moderate levels of deprivation.

The practice has five GP partners (four male and one female) and two salaried GPs (one male and one female). The practice also employs three nurse practitioners, two health care assistants, a practice manager and an office manager who are supported by a team of reception and administration staff. The practice is a teaching practice who were supporting three trainee GPs at the time of our inspection. A trainee GP is a qualified doctor who is carrying out additional training to become a GP.

The practice is open from 8am to 6.30pm Monday to Friday and appointments are available during these times. Extended hours appointments are available on Mondays to Friday from 7.30am to 8am and on Saturday mornings from 8.30am until 11.30am.

When the practice is closed, patients can access out of hours care by calling the practice where they would be directed to the out of hours service provider via NHS 111. This information is also available on the practice's website.

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 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.

Detailed findings

How we carried out this inspection

Before inspecting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced inspection on 1 December 2016. During our inspection we:

- Spoke with a range of staff including the GPs, the practice manager, nurses, the office manager and members of the administration and reception team. We also spoke with patients who used the service.
- Observed how staff assisted patients who attended the practice and how they dealt with patients on the telephone.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Reviewed staff records and a range of risk assessments, policies and protocols held by the practice.

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).

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.

Good

Are services safe?

Our findings

Safe track record and learning

The practice had an effective and comprehensive system for reporting incidents. They had recently introduced a new system as a result of one of the GPs undertaking additional training in 'Leading Improvements in Safety and Quality'. We saw evidence to demonstrate how clinical and non-clinical staff had been involved and notified of the system and the outcomes of recent incidents and learning points. Staff were encouraged to identify all incidents and issues which affected their work in the practice or patient care. There was a protocol available to staff which provided guidance on the levels of severity of incidents to ensure appropriate reporting. All staff we spoke with were aware of the incident reporting process. The practice discussed all incidents at a weekly meeting. Incidents which were more serious were escalated as significant events for more in depth investigation. 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 the practice had carried out a thorough analysis of all significant events and ensured communication with other agencies and staff where applicable. There was also evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, information, a written apology and were told about any actions to improve processes to prevent the same thing happening again. The practice demonstrated a commitment to sharing and learning from events and we also noted that the practice had reported significant events to the National Reporting and Learning System (NRLS). The NRLS is a national database of patient safety incident reports which analyses and identify commons risks to patients and opportunities to improve patient safety.

A reporting form was available to all staff on the practice computer system. We saw how these were clearly recorded and the investigation and outcomes summarised and shared. We noted that non-clinical staff were involved in this process and examples where they had identified significant issues resulting in actions which improved patient outcomes. For example, a member of the administration team had noted how a patient had been highlighted for a routine recall for screening when they met a criteria for more frequent monitoring. This was investigated and changes introduced to address this. We also saw examples of audits undertaken in response to outcomes of significant events.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. The practice also provided a weekly staff news bulletin which highlighted information for staff such as learning points from incidents, new guidance and other relevant information to make all staff aware of current issues. Staff were required to sign to confirm they had seen this information. The practice had a system for receiving safety alerts and an administrator who was responsible for dissemination of these. We saw a comprehensive log of alerts which was kept on the practice computer system and showed the relevance to the practice, the actions taken and links to the practice meeting where they were discussed as well as links to local and national guidance regarding the topic. We saw that actions had been taken as stated in the practice log.

Overview of safety systems and processes

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

- The practice had arrangements to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. In 2014 the practice had been involved in an 'Improving Interagency Teamwork for the Protection of Children' project. This had led to the safeguarding GP lead developing the practice safeguarding documentation to ensure that all information was collected and available when viewing the patient safeguarding records on the computer system. We saw examples of revised templates and comprehensive records, providing all information to inform the multi-disciplinary team meetings, and summaries of all actions that had taken place regarding children at risk. The practice maintained detailed records of actions taken regarding child protection which demonstrated rapid and appropriate responses to child protection concerns. They had created full summaries to demonstrate learning and how following processes correctly and thoroughly had resulted in positive outcomes for children and their families. For example, we looked at five child protection

summaries which showed the actions of the practice and how working with the multi-disciplinary team had resulted in access to appropriate treatment and support for children and their families and had resolved many issues. Summaries showed the practice had considered all aspects of the child's life and listened to children and their families and involved them in their care. 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 were also contact details in all clinical rooms of who to contact in the event of safeguarding concerns and the safeguarding lead had developed a simple guide for additional guidance which was available in clinical rooms. There was a safeguarding lead GP and the lead nurse was the safeguarding deputy and they were supported by a designated member of the administrative team to co-ordinate information and meetings. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities. All GPs and nurses were trained to level three in child safeguarding and all other staff had received training appropriate to their role. Children who had not attended their appointments for immunisation were followed up and this was communicated to the health visitor.

- A notice in all consultation rooms advised patients that chaperones were available if required. 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).
- The practice premises were new and purpose built and equipped with facilities to maintain high levels of hygiene and cleanliness. Soap dispensers, glove and apron dispensers and sharps boxes were wall mounted and all areas of the practice were visibly clean and tidy. All seating and work surfaces were wipeable and flooring impermeable. The lead nurse was the infection control clinical lead who was trained for the role. The nursing team and non-clinical staff had received infection control training. There was an infection control policy available on the practice intranet and staff were aware of this. The lead nurse had carried out an infection control audit in July 2016 and there were no outstanding items to be addressed.
- 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). Processes for handling repeat prescriptions included the review of high risk medicines. We reviewed a sample of anonymised patient records and saw that appropriate blood tests had been carried out for patients on high risk medicines within the correct timescales. However, we noted that the repeat prescribing authorisations had been made for six months for these patients, which was not in line with the practice high risk medicines protocol. This had been an oversight and the practice took immediate action to amend this to a maximum of three authorisations, or less where applicable. They also carried out a full audit on the day to ensure that all patients had received the appropriate monitoring and this was confirmed. The practice raised this issue with the local head of medicines management team to share learning and ensure clarity in guidance for practices.
- The practice had employed clinical pharmacist who carried out regular medicines audits and shared results with the GPs to ensure prescribing was in line with best practice guidelines for safe prescribing. We saw the practice had carried out audits on antibiotic prescribing and made changes on the system to provide more rapid access to guidance. They also encouraged practitioners to consider specific tests prior to prescribing for some patients.
- Blank prescription forms and pads were securely stored and there were systems to monitor their use. All three nurses were nurse practitioners and independent prescribers and could therefore prescribe medicines for specific clinical conditions. They reported receiving support from the GPs for this extended role. Health care assistants were trained to administer vaccines and medicines against a patient specific prescription or direction from a prescriber and we saw evidence of patient specific directions signed by the GPs.

Good

Are services safe?

- We reviewed four personnel files which were complete and contained evidence of appropriate recruitment checks such as: proof of identity; references; qualifications; registration with the appropriate professional body and the appropriate checks through the DBS. There was also evidence of up to date training records and certificates.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster which identified the health and safety representative for the practice. The practice had up to date fire risk assessments and carried out regular fire drills. We noted the last fire drill had taken place in November 2016. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. This had been carried out in September 2016 by an external contractor. The practice had a variety of other risk assessments 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 made for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. The practice manager had involved the reception and administration staff in a process to record their busy times in order to ensure the correct amount of resource was allocated at appropriate times.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements to respond to emergencies and major incidents.

- The practice had an allocated telephone number to dial in the event of an emergency which would ring all telephones in the practice. There was an instant messaging alert on the computers in all the consultation and treatment rooms which notified staff of any emergency.
- All staff received annual basic life support training and there were emergency medicines available should they be needed. For example, nurses who carried out immunisations all had medicines to deal with anaphylaxis available to them.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks.
- Emergency medicines were easily accessible to staff 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 to respond to major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice had access to, and utilised a full range of clinical protocols on their intranet including the GP Gateway which was a locally agreed set of guidelines and protocols to ensure care was delivered in line with current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems to keep all clinical staff up to date. Changes in NICE guidance or local guidelines were shared and discussed at clinical meetings. Staff had access to guidelines from NICE and the nursing team showed us they had access to a range of clinical guidelines online such as the vaccinations and immunisations programme and a selection of practice nursing information websites. All information available allowed staff to deliver care and treatment that met patients' needs.
- 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. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results from 2015/16 showed the practice had achieved 97% of the total number of points available compared to the Clinical Commissioning Group (CCG) and the national average of 95%. The practice exception reporting rate was 8% which was below the CCG and national averages of 9% and 10% respectively. The practice demonstrated they were proactive in trying to ensure patients attended for monitoring and screening often using a personal contact via telephone to promote uptake. (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).

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2015/16 showed:

- Performance for diabetes related indicators was 96% which was higher than the CCG and national averages of 90%. Exception rates for most indicators were below the CCG and national average.
- Performance for mental health related indicators was 98% which was higher than the CCG and national averages of 90% and 93% respectively. Exception rates for all indicators were below the CCG and national average.

The practice used specialised templates to identify patients at risk of admission to hospital and those who may benefit from input from the Integrated Neighbourhood Teams (INT). They also hosted the INT team in the building as well as the AgeUK GP navigator who conducted home assessments of frail elderly patients. The dementia navigator service who provided support for carers and relatives of patients with dementia was also based in the practice.

- The practice had been involved in a project to explore the benefits of using a Frailty Assessment Tool for frail elderly patients, which had demonstrated a reduction in length of stay in hospital as a result. For example, the average length of stay had reduced from 11 to four days for frail elderly vulnerable adults. The practice had also recently become involved in the Social Prescribing pilot project with Age UK in Coventry, which was to be formally introduced in the practice in January 2017. (Social prescribing is a means of enabling primary care services to refer patients with social, emotional or practical needs to a range of non-clinical services which are often provided by the voluntary sector). This approach had been shown to help improve people's mental health outcomes, improve community wellbeing and reduce social exclusion. Staff had been trained in readiness for this.

There was evidence of quality improvement including clinical audit.

- There had been seven clinical audits completed in the last two years, five of these were completed audits where the improvements made were implemented and monitored. The remaining two had second cycle audits planned for 2017. Audits had been undertaken on areas such as patients with HIV who had not attended for cervical cytology. This resulted in additional measures to track patients and encourage uptake of screening and an outcome of 100% of patients receiving screening in

2015. This was repeated in 2016 and all patients had been contacted individually and only one had not attended for screening. The practice also added a flag on the computer system to alert clinicians to any high risk patients to offer cytology and encourage attendance.

- The practice had carried out an audit on the prescribing of antibiotics for patients suffering with urinary tract infections which resulted in GP Gateway guidance, local Area Prescribing Committee guidance and public health information being included in the antibiotic prescribing template to promote best practice.

Effective staffing

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

- The practice had a thorough induction programme for all newly appointed staff. This included a checklist which covered management areas as well as competencies which were signed off at the end of the induction period. All staff were required to complete training such as safeguarding, infection prevention and control, fire safety, health and safety and information governance. Newly appointed staff received a one month and three month review. We spoke with a recently employed staff member who reported being well supported during their induction period and that this support had continued.
- The practice reviewed their workforce requirements regularly and could demonstrate how they ensured role-specific training and updating for relevant staff. For example, all nurses were nurse practitioners and had completed additional training in long term conditions such as diabetes. Reception staff had received additional training regarding carers and social prescribing. The GPs all had specific clinical interests and expertise in areas such as women's health and family planning, diabetes, elderly medicine, dermatology and orthopaedics. One of the GPs had expertise in emergency medicine and trauma and carried out clinical work at the local hospital. They also had a clinical leadership role for the CCG and a responsibility for GP referral pathways across Coventry and Rugby CCG.
- The nurse practitioners administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. One of the nurses had a special interest in this area and was an assessor for cervical screening specimen takers. 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 as well as monthly practice learning sessions with other practices from the CCG area.
- 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 staff had received an appraisal within the last 12 months. The practice manager kept an up to date record of training, appraisals and revalidation.
- 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.

Coordinating patient care and information sharing

The practice ensured that 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. The practice had developed a 'fast track' tracker with the secretaries which allowed them to keep a log and monitor referrals.

The practice was committed to working together 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 was evidenced specifically by the involvement and commitment to the INT project, although we saw a significant number of examples of working with other agencies such as the midwife, health visitor, district nurses, mental health team and Age UK. This also included when

patients moved between services, when they were referred, or after they were discharged from hospital. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs. The practice received out of hours reports via their computer system which were sent to the individual GPs .

Consent to care and treatment

Staff sought patients' consent to care and treatment 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, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and recorded the outcome of the assessment.
- The process for seeking consent was monitored through patient records audits.
- The practice checked all mobile telephone numbers for patients when they reached 16 to ensure they were correct to ensure confidentiality was not breached.

Supporting patients to live healthier lives

The practice used specific tools that 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. For example, the Coventry Stop Smoking Service advisor attended the practice for one session each week which staff could signpost patients to. There was also information regarding this service on the practice website.
- The practice lead nurse was also the lead nurse for the CCG and an assessor for cervical cytology. They demonstrated a genuine commitment to maintain high cervical screening rates and had introduced measures to achieve this. For example, the practice had a co-ordinator for recalling patients and a system to identify all patients who had not responded to three invitations for screening. Initially, a member of the administration team had contacted patients. However, they identified that this had not initiated a response and they reviewed their approach. The co-ordinator notified the lead nurse who ensured that all patients who had not responded after three invitations were contacted by a nurse. We saw that in July and August 2016, 51 patients had not responded after three invitations. Following a telephone call from the nurses explaining the importance of the screening and offering appointments suitable to patients, 17 of these had subsequently attended. The practice's uptake for the cervical screening programme was 82%, which was higher than the CCG average of 75% and the national average of 76%. The practice exception reporting rate for cervical screening was 4% which was significantly below the CCG and national averages of 8% and 6% respectively. There were failsafe systems 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. One of the nurses gave an example where a patient was moving area when attending for their cervical cytology, and whilst they had stressed the importance of ensuring they checked for the result, the nurse had followed up the result and notified the patient of the need for further treatment.
- The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. For example:

The percentage of females, aged 50-70, screened for breast cancer in last 36 months was 78% compared to the CCG average of 71% and national average of 72%.

The percentage of patients aged between 60-69 years, screened for bowel cancer in last 30 months was 63% compared with the CCG and national average of 58%.

The practice had a GP lead for women's health and family planning and another GP who both had a and a special interest in this area of health. The practice offered long acting reversible contraception (LARC) which included implants and intrauterine contraceptive device fitting (IUCD). The practice increased the number of sessions available for this service in response to increasing teenage pregnancies. We noted as a result that the practice termination of pregnancy rates had reduced significantly since 2013. For example, in 2013/14 there had been 30 cases, 2014/15 there had been 21 cases and in 2015/16 this

Outstanding ☆

Are services effective?

(for example, treatment is effective)

had reduced to 13 cases. Sessions were advertised on the TV screens in the waiting area, social media and during opportunistic promotion in consultations. There were booklets for young people available on the reception desk providing information regarding sexual health and promotion of chlamydia screening and contraception services available.

Childhood immunisation rates for the vaccinations given were high. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 98% to 99%. These were higher than the national rates of 73% and 93%. The rates for five year olds ranged from 96% to 99% which were above the national rates of 81% and 95%.

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 years. The practice encouraged the uptake of NHS Health Checks, for example, they sent a birthday card to all patients on their 40th birthday inviting them for a health check. The card explained the check and what the patient should expect. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified. The practice had carried out 296 health checks since January 2016. Similarly, the practice also sent a birthday card to all patients reaching their 65th birthday which highlighted their eligibility for a flu vaccine. The health care assistants and nurses visited patients who lived in local care homes and housebound patients and provided flu vaccinations. We saw from minutes of meetings that the GPs had agreed to offer flu vaccinations opportunistically in order to achieve maximum uptake. They had also shared flu clinic dates through social media and information for patients on the internet.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

During our inspection we observed that members of staff were courteous and helpful to patients and treated them with dignity and respect. They assisted patients with their appointments and directed them to the correct part of the building. Reception staff were based on the ground floor and did not take incoming telephone calls for appointments whilst working on the reception desk as the practice had an appointments hub located on the first floor of the building.

- 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 and rooms were sound proofed so that conversations taking place in these rooms could not be overheard.
- Reception had access to a separate room if patients needed to discuss anything in private or if they were distressed.

All of the 21 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients consistently reported that they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. Patients commented on exceptional care both from GPs and nurses and mentioned all GPs and nurses by name highlighting their patience and kindness when dealing with their health issues. They commented on how they benefitted from an understanding and compassionate GP during times of acute ill health as well as learning to live with a long term condition.

We spoke with a member of the Patient Participation Group (PPG). 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. We also spoke with six patients who told us the GPs and nurses were excellent.

Results from the National GP Patient Survey 2016 showed patients felt they were treated with compassion, dignity and respect. The practice was above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 95% 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%.
- 87% of patients said the GP gave them enough time which was the same as the CCG and the national average.
- 98% of patients said they had confidence and trust in the last GP they saw compared to the CCG and national averages of 95%.
- 89% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG and national average of 85%.
- 95% 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 national average of 91%.
- 90% of patients said they found the receptionists at the practice helpful compared to the CCG average of 86% and the national average of 87%.

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. They told us that GPs explained their condition and took time to ensure they had understood their condition and the medicines they were being prescribed. Patient feedback from the comment cards we received was also very positive and aligned with these views. We also saw that care plans were personalised.

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

- 89% 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%.

Good

Are services caring?

- 79% 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 national average of 82%.
- 86% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average and national average of 85%.

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

- 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. The practice also had GPs who spoke some of the more popular languages such as Tamil, Hindi and Guajarati.
- Information leaflets were available in easy read format. For example, there was a pictorial information booklet for patients with a learning difficulty to inform them about their health check.
- The practice had a care co-ordinator who contacted patients with a learning disability by telephone to offer an appointment to provide an opportunity to co-ordinate the appointment time with their carers availability.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were limited as the practice had made the decision to provide and maintain high quality up to date information electronically via their new website. This was bespoke and had been developed using input from the Patient Participation Group (PPG) with the intention of providing improved patient information and health education and patients described it as an exceptional resource for patients. The use of social media had also been implemented to access a wider audience. Carers and flu information was available at the reception and both nurses and GPs were able to access condition specific information which could be printed off for patients as and when required which ensured that information was always up to date. The clinical staff also had access to specific patient resources such as information packs for newly diagnosed diabetic patients.

The practice had focussed on increasing the number of carers they had identified on their register. They had provided staff with training regarding carers to facilitate improved services for carers and develop a better understanding of how carers can get assistance. They had worked closely with the Coventry Carers Trust, Coventry City Council, Age UK and the Alzheimer's Society and held carers information days supported by these organisations. The Coventry Carers Trust held monthly sessions at the practice providing 30 minute appointments offering advice and support to patients who were carers. The practice had a identified 356 patients as carers which represented 2.25% of the practice list size and demonstrated enthusiasm and commitment to continue to increase this number. Carers were offered health checks and flu vaccinations and referral to support services. The practice entered patients' details onto the computer system to alert GPs if a patient was a carer. We saw examples where identification of a carer had had a positive impact on families. For example, one nurse noted a carer having difficulties in managing their relative's care and suggested they may benefit from a discussion with a GP or the Admiral Nurses. This resulted in the carer being supported to develop structured arrangements in preparation for deterioration of the patient's condition. Admiral Nursesare specialist dementianurseswho give expert practical, clinical and emotional support to families living with dementia to help them cope.

Staff told us that if families had suffered bereavement, their usual GP contacted them and offered an appointment or additional support if necessary.

Good

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 Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. As a result of the new purpose built premises the practice was able to offer a significant number of services to the local population. For example:

- A phlebotomy (taking blood samples) service was available for patients in the local area.
- The practice employed a counsellor who attended the practice two days each week for patients requiring additional emotional support.
- Staff from the Improving Access to Psychological Therapies (IAPT) service attended the practice for patients who needed additional psychological support.
- Extended hours appointments were available every day from 7.20am until 8am and on Saturday mornings from 8.30am until 11.30am for working patients and those patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability or complex needs.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Patients who needed an appointment on the same day could access the duty GP who would assess whether an appointment was necessary that day. There was open access for children who needed to see a GP urgently.
- Child health appointments were available where new babies received a medical check from the GP prior to receiving their immunisations and the mother received a post-natal examination.
- The midwife attended the practice four times a week to provide assessment, support and advice to women during pregnancy.
- Patients were able to receive travel vaccinations available on the NHS and privately and the practice offered yellow fever vaccination.
- There were disabled facilities, electronic door access throughout the building, a hearing loop and translation services available as well as a lift to the first floor. The reception desk had two lower areas to facilitate patients using wheelchairs who attended reception.
- The practice hosted appointments for carers support sessions from Coventry Carers Trust. The practice had recognised that the number of carers they had identified could be increased and as a result took action using the practice patient survey to encourage patients to make themselves known to the practice. This resulted in an additional 81 patients being identified as carers increasing the number to 356.
- A counsellor was employed by the practice and was available for the GPs to refer to when patients needed emotional support.

The practice produced a monthly newsletter to inform patients of forthcoming events, information and news of the practice generally. For example, there were dates of the carers support sessions, cardio pulmonary resuscitation training sessions, opening times, the patient survey headlines and useful contact numbers such as the mental health helpline.

The practice was involved with the Coventry City Council Healthy Walks pilot project. One of the nurses had engaged with the project and was encouraging patients and staff to participate in health walks around the area. They had been proactive and highlighted to the council that facilities were not adequate and more paths were required to facilitate safe walking. The practice had also worked closely in partnership with the Coventry City Council and CSW Sports and had planned to refer patients to a sports pilot project offering patients with long term conditions or weight problems an opportunity to attend physical exercise sessions in a supportive environment.

Access to the service

The practice was open between 8am until 6.30pm Monday to Friday and appointments were available during these times. Extended hours appointments were offered from 7.20am until 8am Monday to Friday and from 8.30am until 11.30am on Saturday mornings. During the flu season the practice opened some Saturdays. In addition to pre-bookable appointments, urgent appointments were also available for people that needed them and GPs had a prompt call back system for patients requesting an appointment on the day.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice utilised a texting service to remind patients of their appointment and to remind them that their flu vaccination was due. They also used social media sites to promote access to practice issues and health initiatives. For example, we saw messages regarding mental health issues and World Aids Day.

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

- 78% of patients were satisfied with the practice's opening hours compared to the CCG and national averages of 75% and 76% respectively.
- 81% of patients said they could get through easily to the practice by telephone compared to the CCG and national averages of 73%.
- 78% of patients said their experience of making an appointment was good compared to the CCG and national averages of 72% and 73% respectively.

People told us on the day of the inspection that they were able to get appointments when they needed them.

All requests for home visits were directed to a specific administrator who recorded these in the GPs visit book. The request was also added to the appointment screen in order for the GP to view this. Staff always tried to allocate the patient's usual GP. If patients stated they needed an urgent GP visit they were connected to the duty GP immediately who would determine the need for medical attention. All staff at the practice were aware of the need for these decisions to be taken by a clinician and were aware of their responsibilities in transferring requests to the correct person.

Listening and learning from concerns and complaints

We saw the practice had an effective system for handling complaints and concerns. They had a designated member of the administration staff who worked with a lead GP in responding to complaints.

- The practice had a complaints policy and procedures which were in line with recognised guidance and contractual obligations for GPs in England. Leaflets regarding how to make a complaint were available on the reception desk.
- We saw that information to help patients understand the complaints system was available in the practice leaflet and the practice website also contained information regarding how to complain.

We looked at seven complaints received in the last 12 months and found they had been handled appropriately in a timely way. We noted that the outcomes had identified changes which had been actioned. Lessons were learnt from individual concerns and action was taken to as a result to improve the quality of care. For example, the practice had identified a flaw in the handling of specimens and had initiated a review of the protocol. We also saw training needs identified for reception staff in data protection and noted that where applicable complaints were escalated as significant events for additional discussion and learning. We noted that patients were invited to discuss their complaints and actions were agreed with patients. There was however, no confirmation in writing of the outcomes.

Are services well-led?

Outstanding ☆

(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 which was:

- To deliver the right patient care, in the right place, at the right time, through a skilled and committed workforce, in partnership with local health economies.

This was accompanied with a clear set of values which we saw were reflected in their long term planning, the day to day running of the practice, and staff attitudes and approach to patients and their work.

Staff told us they had been involved in the development of the strategy to achieve the vision. This continued to involve communication, networking and collaborative working with patients, voluntary agencies such as Age UK and the Alzheimer's Society, other health agencies, such as mental health, medicines management and secondary care. We saw evidence of close working with the Clinical Commissioning Group (CCG), the Coventry and Warwickshire Partnership Trust and the community to achieve this.

The practice had developed a five year plan and visited this regularly to discuss and review their progress towards delivery of the plan. The practice strategy and business plans had been developed to reflect the vision. Aspects of the plan had already been developed and implemented, such as the planning and building of the new premises. The building had been developed with consideration to how the detail of the premises would impact on the delivery of the practice vision and how it could facilitate future development and delivery of services in the community closer to patients' homes.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and quality care. This outlined the structures and procedures and ensured that:

- 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.
- A comprehensive understanding of the performance of the practice was maintained and shared with all staff.
- 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. We saw evidence of how the practice reviewed their systems and shared changes with staff when identified. For example, we noted a recent fire drill where the learning points had been highlighted and shared with staff via the staff briefing session. We also saw how learning points from incident reporting were shared in the same manner.
- The practice had developed a systematic approach to safety for safeguarding following involvement in a project, where one of the GPs had reviewed the practice's documentation and approach to safeguarding to provide more in-depth and comprehensive system.

Leadership and culture

They practice told us they prioritised safe, high quality and compassionate care and we saw evidence to confirm this. For example, the development of practice safeguarding protocols and improved documentation with the involvement of all staff and multi-disciplinary teams. Staff told us the partners were approachable and very supportive and always took the time to listen to all members of staff. They commented on how, despite the disruption of working in temporary accommodation during the building of the new premises, the partners were visible and available to staff and maintained involvement and gave feedback to staff.

The provider was aware of and had systems 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.

The practice had systems to ensure that when things went wrong with care and treatment:

- There was an open culture within the practice and staff told us they had the opportunity to raise any issues at team meetings and any other time they needed to and felt confident and supported in doing so.

Are services well-led?

Outstanding ☆

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

- Staff said they felt respected, valued and supported, particularly by the partners and practice manager in the practice. All staff were involved in discussions about how to develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the services they delivered. For example, when designing the new building staff were asked if they had any specific ideas that they felt had not been included in plans. Nurses told us how they had been able to highlight practical ideas they had. For example, the need for handwashing posters was eliminated by the introduction of hand washing instruction diagrams incorporated on the soap dispensers.

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. They had identified that the Patient Participation Group (PPG) required additional membership and had encouraged patients to join by including this in the practice's own survey. This resulted in an increase in their membership of the PPG to 98 for the main group and to 134 for the virtual PPG. Patients had fed back to the practice that email and text message was the preferred method of communication. The practice had been proactive in collating email addresses from patients and were able to distribute their patient survey to a wider representation of patients, achieving a response from 873 patients in their latest survey. The PPG had been actively involved and engaged in the planning of the new premises and were kept up to date of its development throughout. The chair of the PPG met monthly with the practice manager and the core group met bi-monthly.

The PPG engaged well with the practice and were involved in the practice patient survey. They made suggestions and proposals for improvement and we saw evidence of this. For example, the patient survey had been thoroughly analysed and each area was discussed with the PPG and actions agreed together. These included actions such as updating the website with specific information regarding minor illness appointments and carrying out an audit to identify peak times for telephone calls to enable the practice to increase call handlers to address this.

The practice had gathered feedback from staff through staff away days and generally through staff meetings, appraisals and discussion. Staff told us they were encouraged to give feedback and be involved in practice issues and developments. They told us they felt they could discuss any concerns or issues with colleagues and management. The practice had two apprentices at the time of inspection and we spoke with one of them who commented on how well they were supported and that both management and clinical staff had supported them since they started at the practice. All staff told us they felt involved and engaged to improve how the practice was run.

Continuous improvement

We saw a significant focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and pro-active in exploring funding bids for improvement schemes and engaging in pilot schemes to improve outcomes for patients in the area. For example, the Coventry and Warwickshire Partnership Trust were the local sexual health commissioners, and the practice had been engaging with them regarding further enhancing sexual health services at the practice. This had resulted in an agreement to base a sexual health nurse practitioner at the practice to provide a drop-in service for patients in their cluster group to commence early 2017.

The practice had expertise in cardio pulmonary resuscitation (CPR) training and demonstrated a commitment to promote education and training to the public and patients regarding this with the aim of providing people with the knowledge to enable them to saving lives in an emergency. The practice offered training in CPR to their own patients and any other people in the community. Sessions accommodated 10 people and had taken place monthly since September. This had been taken up by eight people in the first month and six in the second. Sessions had been arranged for December, January, and February with plans to continue.

The practice had planned the building with consideration to how services may be developed further in the future and there would be sufficient space to accommodate services closer to patients' homes. The practice worked closely with the local GP federation and had key members of staff on the board. They were continuing to develop and work up plans and business cases to promote and introduce new services in the community and prevent the need to attend

Are services well-led?

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hospital services. For example, the introduction of the social prescribing project, the development of Integrated Neighbourhood Teams (INT) for the local area providing co-ordinated care involving all relevant agencies which put the elderly frail patients at the heart of their care using Age UK care navigators. and integration of the frailty pathway. There were plans to host a diabetes education service, weight management service, diabetic eye and foot screening, abdominal aortic aneurysm (AAA) screening and for the introduction of a mental health nurse practitioner in April 2017. The sports activity pilot project was also planned to commence in January 2017 to promote the health of patients with long term conditions, which had involved joint working with the Coventry Council and Coventry Sports foundation.

The practice engaged well with the CCG and met with the CCG practice support team to discuss areas of improvement and development. They also engaged with the locality buddy peer groups where referrals to secondary care were discussed to determine if they were appropriate. We saw significant evidence of participation and intended participation in pilots for new initiatives which may improve provision of care and treatment. For example, one of the GPs had led a pilot programme in 2014 to introduce an Integrated Neighbourhood Team (INT) with the aim of bringing together all professionals and care providers delivering care to older people and vulnerable patients to improve efficiency and deliver outcomes such as reduced admissions to hospital, providing better support in patients' homes and joint visiting with GPs, community nursing, therapists, social workers, mental health services and the voluntary sector. Patients received a care navigator from Age UK to ensure care was organised and co-ordinated consistently allowing patients to always be involved and informed of their care and how it was provided. The success of the pilot project had led to the introduction of three INTs in the area. The practice told us they would now be hosting this service.