Coventry Road Practice

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We undertook a planned, comprehensive inspection on 18 November 2014. We spoke with patients, staff and the practice management team.

The overall rating for the practice was good. We found the practice was safe, effective, responsive, caring and well led.

The care provided to the six population groups (people with long term conditions, families, children and young people, working age people, older people, people in vulnerable groups and people experiencing poor mental health) was good.

Our key findings were as follows:

- There were systems in place to address incidents and safeguard vulnerable adults and children who used the service. Significant events were recorded, lessons learnt were shared with staff and there was evidence that systems were changed so that patient care was improved.
- We saw evidence that the GPs challenged poor care and worked with other professionals to improve clinical outcomes for patients. The practice had effective procedures in place that ensured care and treatment was delivered in line with appropriate standards.
- Patients were treated with dignity and respect. Patients spoke very positively of their experiences and of the care and treatment provided by staff.
- The practice understood its patient population and planned its services to reflect the diverse needs of its patients
- Systems were in place to monitor the effectiveness of the service, identify and manage risks or learn from previous incidents. There was a clear leadership structure in place, quality and performance are monitored and risks were identified and managed.

We saw an area of outstanding practice including:

- The practice carried out an audit on repeat prescribing and findings were shared with other practices in the locality so improvements could be made.

Summary of findings

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

- The practice should consider the risks from legionella that may affect staff, patients and visitors and take suitable precautions
- The practice should review its recruitment procedures to ensure that only suitable staff are employed to work at the practice.
- Ensure DBS checks are carried out for staff that undertake chaperoning duties.

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 was rated as good for providing safe services. There were effective infection control and medicine management policies and procedures in place. The practice ensured that significant events were documented and analysed with the aim to identify any lessons to be learnt. Staff had an awareness of procedures to safeguard patients. Systems were in place for sharing relevant safety information with the staff team. Multi-disciplinary meetings with other professionals such as health visitors and palliative care teams were held to manage the care for complex cases and vulnerable groups.

Are services effective?

Good

The practice was rated as good for effective. Systems were in place to ensure that all clinicians were up-to-date with both National Institute of Health and Clinical Excellence (NICE) and other locally agreed clinical pathways. We saw evidence where poor care received by patients at hospital was challenged because it was leading to delays in diagnosis. The practice involved the Clinical Commissioning Group (CCG) as well as the management of the hospital to improve practice. CCGs are groups of General Practices that work together to plan and design local health services in England. A member of the practice development team from the CCG told us that the practice undertook a clinical audit to understand why patients were returning significant amounts of unused medicines. The practice then shared the results from that audit with other practices locally so the wastage could be reduced. We reviewed data that showed that the practice was performing better than neighbouring practices in the CCG.

Are services caring?

Good

The service was rated as good for caring. We spoke with three patients who told us that staff were kind, considerate and compassionate and that the practice staff treated them with respect and dignity at all times. We reviewed 30 completed CQC comments cards all of which provided positive feedback about care received at the practice. Patients' privacy and dignity was respected. Patients told us they were involved in making decisions about their care and treatment choices and the GPs and nurses explained their care to them in a way they understood.

Are services responsive to people's needs?

Good

The practice was rated as good for responsive. Patients that had difficulties with their mobility were seen on the ground floor

Summary of findings

consultation rooms. The practice arranged translation service for patents whose first language was not English. The practice also arranged sign language interpreters for some patients. The practice had systems in place that ensured patients with urgent needs were seen with minimal delay. There were a number of ways in which a patient could make an appointment at the practice, including online, by telephone or in person. Home visits were available for patients who were not able to attend the practice. One of the partners was on the board of the CCG met regularly with the CCG to understand local needs and priorities of the local population. The practice has a patient participation group (PPG) to gather patient opinion regarding the service offered. The PPG is a way in which patients and GP practices can work together to improve the quality of the service. There was a clear complaints system with evidence that demonstrated the practice had measures in place to respond quickly if an issue was raised.

Are services well-led?

Good

The practice was rated good for being well led. Leadership roles and responsibilities were well established with clear lines of accountability. There was evidence that the provider had systems in place for assessing and managing risks and monitoring the quality of service provision. There was evidence of improvements made as a result of audits and feedback from patients. Patients' views on the service were listened to and were used to improve services. The practice had a patient participation group (PPG) to promote and support patient views and participation in the development of services provided by the practice.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated good for the care of older people. Patients over the age of 75 years, including those living in care homes had a designated GP. This was an accountable GP to ensure these patients received co-ordinated care. Patients who had difficulties with their mobility were seen on the ground floor. Care plans were in place for these patients to support, monitor and review their health needs. The practice was taking part in an enhanced service to avoid unplanned admissions to hospital. High risk patients were identified and management plans were in place to support those with complex care needs in order to minimise the risk of being admitted to hospital unnecessarily. There was a higher than the national average (England) older population that were registered with the practice. However, data we looked at showed that unplanned admissions to A&E and also patients accessing out of hours service was lower than the local average.

People with long term conditions

Good

The practice was rated as good for the care of people with long term conditions. Practice staff held a register of patients who had long term conditions. There was evidence that patients with long term conditions were reviewed regularly by the GPs and the nurse. Patients on repeat prescriptions were reviewed to assess their progress and ensure that their medications remained relevant to their health needs. There was evidence of multi-disciplinary working with relevant health care professionals to deliver effective and responsive care.

Families, children and young people

Good

The practice was rated good for the care of families, children and young people. Mother and baby eight weeks checks were undertaken at the practice. Immunisation clinics were held by a nurse for children in line with the national immunisation programme. Alerts and protection plans were in place to identify and protect vulnerable children. Young adults had access to sexual health services.

Working age people (including those recently retired and students)

The practice is rated good for the care of working age population. Appointment slots between 5.45pm and 6.15pm were kept clear for working age patients. NHS health checks were available for people

Summary of findings

aged between 40 years and 74 years and there were a number of clinics and services to promote good health and wellbeing for this age group. The practice website gave patients access to book appointments and order repeat prescriptions online.

People whose circumstances may make them vulnerable

Good

The practice is rated good for the care of people whose circumstances may make them vulnerable. Patients who were vulnerable due to their health or social circumstances were offered health checks. Where appropriate, information was shared and referrals were made to relevant agencies and health care professionals to further support the patient's health and wellbeing. The practice had access to interpreting service for patients whose first language was not English as well as sign language interpreters. The practice website was accessible in various languages.

Staff understood their role in safeguarding vulnerable patients and had access to relevant practice policy, procedures and training.

People experiencing poor mental health (including people with dementia)

Good

The practice was rates as good for the care of people experiencing poor mental health. Patients experiencing poor mental health were offered an annual review of their physical and mental health needs. Patients were offered double appointments where required and were referred to other supportive services where appropriate. Practice staff worked in conjunction with the local mental health team to ensure patients had the support they needed. Children or young people presenting with a mental health need were referred to the child and adolescent mental health service (CAMHS) or signposted where appropriate.

Summary of findings

What people who use the service say

We spoke with two patients on the day of our visit and another patient who was part of the patient participation group (PPG) by telephone. The PPG is a way in which patients and practices can work together to improve the quality of the service provided. Prior to the inspection we provided the practice with a comments box and cards inviting patients to tell us about their care. We reviewed 30 comment cards that were completed by patients who had recently used the service. We also looked at the results of the latest national GP patient survey before our visit.

The feedback and comments we received about the practice were overall positive about the service and staff. Patients told us that they were generally satisfied with the service they received. They told us the staff were friendly and helpful and that they felt listened to and involved in decisions about their care. This was also confirmed by the feedback from the national GP patient survey. However, seven comments cards reviewed and patients spoken with told us of the difficulties of getting appointments although they were happy with the rest of the service.

Areas for improvement

Action the service SHOULD take to improve

- The practice should consider the risks from legionella that may affect staff, patients and visitors and take suitable precautions
- The practice should review the recruitment policy and procedure to ensure it fully reflects all areas of robust recruitment so that they can be consistently implemented. This appropriate reference checks.
- Ensure DBS checks are carried out for staff that undertake chaperoning duties.

Coventry Road Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and the team also included a specialist advisor GP with experience of primary care services.

Background to Coventry Road Practice

Coventry Road Practice provides primary medical services for approximately 3654 patients. The practice is open Mondays, Tuesdays, Wednesdays and Fridays from 8:30am until 6.30pm. It closes at 1pm on Thursdays. On a Thursday afternoon an answerphone message directs patients to the out of hours service who provide cover during this time and patients were informed of this on the practice website.

There are three GPs working at the practice (all female). Two of the GPs worked three days a week and another GP worked four days a week. There were always two GPs on duty each day and a practice nurse who works part time. There are two healthcare assistants (HCA) and six administrative staff.

The practice has a General Medical Service contract (GMS) with NHS England. A GMS contract ensures practices provide essential services for people who are sick as well as for example, chronic disease management and end of life care. The practice also provides some enhanced services such as minor surgery. An enhanced service is a service that is provided above the standard GMS contract.

The practice is part of NHS Solihull CCG Clinical Commissioning Group (CCG). A CCG is an NHS organisation that brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services.

We reviewed the most recent data available to us from Public Health England which showed that the practice has a higher than average (England) number of patients who are aged above 65 years and a lower younger population under 45 years of age.

The CQC intelligent monitoring placed the practice in band 5. GP practice has been categorised into one of six priority bands for inspection, with Band 1 representing the highest priority.

The practice has opted out of providing out-of-hours services to their own patients. This service is provided by an external out of hours' service.

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. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework (QOF) data, this relates to the most recent information available to the CQC at that time.

Detailed findings

How we carried out this inspection

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

- Older people
- People with long-term conditions
- 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)

Prior to visiting the practice we reviewed a range of information we held about the service and asked other organisations and health care professionals to share what they knew about the service. We sent the practice a box with comment cards so that patients had the opportunity to give us feedback. We received 30 completed cards where patients shared their views and experiences of the service. We carried out an announced inspection on 18 November 2014. During our inspection we spoke with staff which included GP partners, the practice manager and members of the administration staff. We also spoke to a prescribing support pharmacist and a member of the practice development team from the CCG.

Before our visit we spoke with a member of the Patient participation Group (PPG) to get their feedback on the service. The PPG is a way in which patients and GP practices can work together to improve the quality of the service. On the day of the inspection we spoke with two patients who used the service. We observed the way the service was delivered but did not observe any direct patient care or treatment.

Are services safe?

Our findings

Safe track record

The practice was able to demonstrate it had a good track record for safety. Practice staff used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents and national patient safety alerts. We saw evidence of a recent Ebola safety alert that had been acted on. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses.

Significant events were recorded, analysed and discussed at staff meetings with an aim to take account of any lessons to be learned. For example, we saw that a patient safety incident was acted upon and learning implemented. We saw that the learning was also shared with an external organisation to minimise further reoccurrence.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We saw significant event and incident audits which showed clear evidence of learning which had been discussed in protected learning time (PLT) meetings with staff. Procedure and protocols for managing and reporting incidents were in place. The GP or the practice manager would be alerted to coordinate the investigation of significant events. The event would also be shared with staff in meetings, where they were discussed openly to promote shared learning. We saw an example of learning implemented from an incident involving the prescribing of a medicine. We noted that it was generally clinical staff who reported incidents.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

Training records demonstrated that most staff were up to date with appropriate safeguarding training. Along with safeguarding we saw all staff had recently undertaken training in domestic abuse. Some administration staff needed refresher training for safeguarding and were completing online training. The safeguarding lead had attended external training appropriate for their role and shared their learning with other staff.

There were arrangements in place to share information via regular multi-disciplinary meetings with other health care professionals. Quarterly safeguarding meeting was held with the practice lead health visitor to discuss any safeguarding concerns about children registered at the practice

The practice safeguarding lead GP attended safeguarding leads meetings chaired quarterly by the CCG safeguarding lead community paediatrician. This allowed opportunities for sharing good practice and learning. We were informed that external speakers had attended and delivered talks on safeguarding issues such as child sexual exploitation, private fostering and deprivation of liberty safeguards.

There was a system to highlight vulnerable patients on the patient's electronic records so that staff were aware of any safety concerns when they attended appointments. A nurse we spoke with confirmed that this was in place and demonstrated how the system would work.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). Some of the patients we spoke with were female and told us that they were aware that they could have chaperones but told us that they had not needed one as all the permanent GPs were female.

Medicines management

There were two dedicated fridges where vaccines were stored with a nurse responsible for ensuring regular checks were undertaken and recorded. We saw that there were occasional gaps in the recording of the fridge temperatures. The nurse explained that this was usually when they were away and other staff responsible for monitoring the fridges was also away. We were told that a more robust system would be put in place to ensure this did not happen again. We saw that the fridges were not locked and the rooms

where they were located were not locked when staff were away. Staff told us that they did not normally leave the doors open and assured us that the door will be locked to prevent unauthorised access.

All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of safely.

Cleanliness and infection control

We observed all areas of the practice to be visibly clean, tidy and well maintained. The practice had an infection prevention and control policy (IPC) with a responsible lead. We saw evidence that staff had training in IPC to ensure they were up to date in all relevant areas. Aprons, gloves and other protective equipment were available in all treatment areas as was hand sanitizer and safe hand washing guidance.

The IPC lead told us that the CCG carried out audits yearly. We saw that issues identified were responded to. For example, we noted in one recent audit it had been identified that there was a possibility of infectious disease being passed on via children's toys in waiting room. During our visit we saw the toys were visibly clean. We saw that a cleaning schedule for the toys was in place.

Environmental cleaning of the whole building was undertaken by an external contractor and monitored by the practice manager. We saw that cleaning schedules for all areas of the practice were in place.

A needle stick injury policy was in place. This outlined what staff should do and who to contact if they suffered a needle stick injury.

A legionella risk assessment had not been carried out by the practice. A legionella risk assessment is a report by a competent person giving details as to how to reduce the risk of the legionella bacterium spreading through water and other systems in the work place. However, we saw evidence that the practice sought some advice in relation to carrying out a Legionella risk assessment. The advice did not provide definitive answers on actions to take and the practice had not taken any further steps minimise risks from Legionella. Legionella is a bacterium that can grow in contaminated water and can be fatal. The practice should undertake a risk assessment to ensure any risks to patients from potentially contaminated water is identified and acted on.

Equipment

Patients were protected from the use of unsafe equipment in in the practice. The equipment was checked regularly to ensure it was in working condition. We saw evidence of these checks which also included the annual testing of fire protection equipment such as fire extinguishers. Contracts were in place for annual portable appliance testing (PAT).There were arrangements in place for routine servicing and calibration, where needed, of equipment such as blood pressure cuffs, weighing scales, and blood pressure monitoring equipment.

There was a defibrillator and emergency oxygen was available. A **defibrillator** is lifesaving equipment used to respond to a medical emergency. We saw checks were in place to ensure oxygen and the defibrillator was checked regularly to ensure it was in working order.

Staffing and recruitment

The practice had a relatively small patient list size of approximately 3600 patients. The staffing establishment reflected the patient list size and consisted of three part-time GPs and a practice nurse and HCA. There were also a team of six administrative staff.

We saw that the practice used two regular locums who had been working at the practice before registration with the Care Quality Commission (CQC). One of the locums was a former GP partner and the other locum had been working for the practice for over four years. Although the practice sought assurances that the locums were fit and safe to practice by checking their registration status, some relevant documentation was not available. For example, we did not see any documented evidence that identity checks were carried out for one of the locum GPs. The practice manager told us that they had checked their identity but did not keep a copy in their staff file.

We saw evidence that agreements were in place with locum agencies in the event that they needed GP cover. This provided good continuity of care as patients we spoke with told us that the GP were aware of their needs and knew who they were.

We looked at three staff files to ensure appropriate recruitment procedures were being followed. However, almost all of the staff had worked at the practice prior to registering with the CQC. Therefore, the recruitment rules post registration with the CQC was not applicable. For

example, one of the GP partner had been at the practice for 30 years and another for 20 years while the third partner had been at the practice for seven years. The practice nurse had been working at the practice for over 20 years.

The newest member of staff had been employed for 18 months in an administrative role. We saw that some recruitment processes were followed such as ensuring there were no unexplained employment gaps. However, we saw that there were some gaps such as identification and reference checks. The practice manager told us that telephone references were sough but were not documented.

We found that the practice had undertaken some checks regarding the suitability of staff by carrying out Disclosure and Barring Service (DBS) checks. We saw DBS checks were in place for clinical staff but not for administrative staff that carried out chaperoning duties. A chaperone is a person who serves as a witness for both a patient and a medical practitioner as a safeguard for both parties during a medical examination or procedure. Administration staff may not need to have DBS checks if appropriate risk assessments carried out. However, we did not see any risk assessments that were in place.

Monitoring safety and responding to risk

Records showed that essential risk assessments had been completed, where risks were highlighted measures had been put in place to minimise the risks. Various risk assessments had been reviewed recently, including fire safety and the control of substances hazardous to health (COSHH), medicines management, dealing with emergencies and equipment.

The fire risk assessment had been carried out with evacuation procedures for disabled persons using wheel chair, hearing impaired and blind/visually impaired patients.

Arrangements to deal with emergencies and major incidents

There were arrangements to deal with foreseeable emergencies. We saw that the staff at the practice had received training in medical emergencies such as anaphylaxis and basic life support skills. There were emergency medicines and equipment available that were checked regularly so that staff could respond safely in the event of a medical emergency. All of the staff we asked knew the location of the emergency medicines and equipment.

The practice had an emergency call icon on all computer screens. In the event of a medical/fire emergency this icon would be activated. This alerted staff in other parts of the building to the emergency and requested them to respond to it. There was a fire policy with actions to take in the event of fire and an evacuation plan in place.

The practice had a disaster recovery plan which covered a range of areas of potential risks relating to foreseeable emergencies such as flood or loss of water supply as well as staff incapacity. The plan demonstrated to some extent how these risks could be mitigated to reduce the impact on the delivery of the service.

Appropriate emergency equipment and medicines were available for use in a medical emergency and staff had training to use them.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Care and treatment was delivered in line with recognised best practice standards and guidelines. Clinical staff members spoken with were aware of and had applied guidance issued by the National Institute of Health and Care Excellence (NICE). NICE is an organisation responsible for promoting clinical excellence and cost-effectiveness and producing and issuing clinical guidelines to ensure that every NHS patient gets fair access to quality treatment. We saw evidence that the practice followed local guidance through map of medicine. Map of Medicine offers comprehensive, evidence-based local guidance.

Clinical staff attended regular meetings with relevant professionals and agencies to discuss and review patients who had complex needs, in vulnerable circumstances or were receiving end of life care. This ensured that patients received appropriate support and treatment and that their wishes were respected. We saw evidence where patients with learning disability were offered annual health checks.

Vulnerable patients with long term conditions were regularly reviewed. Patients over 75 years old had a named accountable GP and were started on a care plan to enable increased monitoring and follow up care. Patients with complex conditions were offered extra support through a system of 'Virtual Wards'. A virtual ward is staffed by a team of nurses who work closely with the patients GP and a range of other health and social care professionals. The aim is to improve the quality of life, reduce unplanned hospital admissions, facilitate patients to self-care and provide support and personalised self-management plans.

The practice was undertaking an enhanced service to reduce unnecessary emergency admissions to hospital. GP practices can opt to provide additional services known as enhanced services that are not part of the normal GP contract. By providing these services, GPs can help to reduce the impact on secondary care and expand the range of services to meet local need and improve convenience and choice for patients. The focus of this enhanced service was to optimise coordinated care for the most vulnerable patients to best manage them at home. These patient groups included vulnerable, older patients, patients needing end of life care and patients who were at risk of unplanned admission to hospital. We found that the practice had identified patients appropriately and we saw evidence of personalised care plans put in in place This allowed the practice to proactively assess the needs of their at risk patients with the aim of developing better management strategies. The care plans were reviewed every two weeks to ensure changes to patients needs were incorporated.

Specialist clinics were in place to review patients with long term conditions this included, for example a diabetes clinic with a GP and the practice nurse. The aim of the clinic was to give patients living with diabetes the information needed to manage their condition. Routine checks associated with diabetes care were undertaken and where necessary, referrals for dietary services and annual eye screening were made.

Chronic disease clinics were available with the nurse and GP for conditions such as asthma, chronic obstructive pulmonary disease (COPD), diabetes, IHD (Ischemic heart disease) or stroke. Patients were asked to attend for a check-up via letter or telephone call.

Patients who were receiving end of life care had a named GP and there were arrangements to share information with out of hour's services for when the practice was closed. Meetings were held with the palliative care teams to ensure coordinate care that respected patient's needs and wishes.

Patients with a learning disability and patients with a mental health needs had care plans in place to ensure their needs were assessed and care was planned in accordance to best practice. The practice used a Single Point of Access (SPoA) template for adult for mental health referrals. Single Point of Access accepts all referrals for Adult Mental Health Services, referrals are screened and assessed by nurse assessors and referred to the most appropriate service or therapeutic intervention. However, this had only recently been introduced and we were told that this was not yet very effective.

Management, monitoring and improving outcomes for people

Performance information on patient outcomes was available to staff and the public, which included monitoring reports on the Quality and Outcomes Framework (QOF). QOF is a national performance measurement tool. We saw evidence that the practice was ahead of meetings its

Are services effective?

(for example, treatment is effective)

targets for managing patients with long term and complex needs such as diabetes, asthma and COPD. We saw that the practice achievement for QOF was higher than the average for practices in the local CCG.

The practice reviewed avoidable attendances at the local accident and emergency (A&E) department. Avoidable attendances are those where, if the patient had been seen in the GP practice instead, they could have been assessed and managed by their GP. We looked at the CCG information dashboard for A&E admissions and even though the practice had a higher than national average older patient population. This suggested that patients were managed well at the practice.

There were arrangements in place to ensure women received cervical smear tests by staff that were appropriately trained. Samples were sent to a local NHS hospital to be analysed and reported on in line with national guidance and recall systems.

The practice had a system in place for completing clinical audit cycles. We saw that a number of audits had been completed with actions taken and learning shared where appropriate. For example, the practice was concerned that patients, their carers and family members were bringing in a significant amount of unused medication to the practice for disposal. The practice undertook an audit on the patients that were bringing back the medication and identified that there were problems with the way repeat prescriptions were issued and dispensed by the local pharmacies. Patients were being given all medication on the repeat prescription when only one had been requested by the GP. They also found that there were discrepancies between pharmacies. The practice raised this as a concern to the CCG and the findings were shared with other practices across the CCG though the Protected Learning Time (PLT) sessions.

We saw three case review notes carried out by the practice which resulted in the review to a cancer pathway. The reviews identified possible delays in the diagnosis of cancer. The GPs told us that they identified six cases where they felt there may have been unnecessary delays in diagnosis. They identified poor communication between secondary care, patient and primary care as possible factors. The practice then initiated a meeting with an appropriate lead from Heart of England Foundation Trust (HEFT). The meeting was also attended by representatives of the CCG as well as other representatives from HEFT. The outcome of the meeting had been the review of the pathway which was hoped would result in quicker diagnosis of cancer patients.

Effective staffing

Staff received the appropriate training and support to undertake their role. The practice was undertaking NHS health checks and we saw that the nurse had attended relevant training to deliver the NHS Health Check to the eligible population. Records demonstrated that most of the staff had completed essential training to support safe, effective practice such as basic life support and safeguarding. The nurses told us they had opportunities for Continuing Professional Development (CPD) to enhance their role. For example, a staff member we spoke with told us that they could raise any training needs during their appraisal which would be actioned if appropriate.

Records we looked at showed that staff including the GPs had an annual performance review.

All of the GPs who worked at the practice had undergone or were due external revalidation of their practice. Revalidation is the process by which licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practise medicine.

The practice had protected learning time (PLT) meetings which were used to develop staff knowledge. Staff we spoke with told us that they had discussed safeguarding, capacity and consent including Gillick competency and infection prevention.

Working with colleagues and other services

Discussions with staff and records showed that the practice worked in partnership with other health and social care providers such as social services, local mental health teams and district nursing services to meet patients' needs in an effective way.

Clinical staff attended regular meetings with relevant health care professionals and agencies to discuss and review patients who had complex needs, in vulnerable circumstances or were receiving end of life care. This ensured that their wishes were respected, and they received appropriate support and treatment. For example, we saw there were nine patients on the palliative care list and records of meeting with the palliative care team were available.

Are services effective?

(for example, treatment is effective)

There were effective arrangements to review and report on test results, relevant letters, and referrals and follow up for patients. We saw examples of follow up letters that were sent following test results from histology.

The GPs at the practice attended meetings with local CCGs to ensure they were up to date with any changes. A member of the practice development team from the CCG was attending the practice during our inspection and they told us that the practice was very engaging with the CCG and they had a close working relationship with the GP partners. We saw an example where the practice shared the findings of an audit with other practices across the CCG though the Protected Learning Time (PLT) sessions.

Information sharing

We found that the practice worked with other service providers to meet people's needs and manage complex cases. Multidisciplinary working was evidenced for example joint working arrangements were in place for safeguarding vulnerable children and adults as well as for palliative care patients. Joint working arrangements were also in place with the pharmacist, Community Psychiatric Nurse (CPN) and health visiting team.

The practice had an electronic system to receive and send information to other providers such as the out of hours services. Information received was reviewed daily by a GP at the practice so that any management plans could be followed up.

Consent to care and treatment

Staff were aware of their legal and ethical responsibilities for gaining informed consent prior to treatment. Staff knew how to enable adults with diminished capacity to understand and make their own decisions. We found the healthcare professionals understood the purpose of the Mental Capacity Act (2005). The act provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves.

Clinical staff were able to confirm how to make 'best interest' decisions for people who lacked capacity and how to seek appropriate approval for treatments such as vaccinations from children's legal guardians. We saw an example of a best interest decision that had been taken recently due to concerns from the GP.

All the staff we spoke with were aware of the Gillick competency test. Gillick competence is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions. GPs we spoke with told us that they would apply Gillick or Fraser competency for when a child requested appointments for contraception.

There was a practice policy for documenting consent for specific interventions. The practice carried out minor surgery and we saw examples of typed forms that were used to get formal consent from patients.

Health promotion and prevention

The practice leaflet was available to pick up in the practice and to download online from the practice website. The information leaflet listed the types of health services available at the practice. This included general health promotion advice as well as weight management advice. The practice website also had a 'live well**'** area with a Library of articles covering a wide range of topics covering men's, women's and children's health issues. Patients were given lifestyle advice especially if the practice was made aware of patients who were planning to get pregnant.

There was evidence of specialist clinics to review patients with long term conditions. This included a dedicated diabetes clinic, asthma clinics as well as other clinics such as well man and well woman clinics where patients could discuss their general health, family history, alcohol intake, and smoking and exercise habits. The practice also offered health checks to patients over 75 years and for patients aged 40 to 74 years.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. We looked at the most recent data for all immunisations for the practice which was similar to the average for the CCG.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

On the day of the inspection we spoke with two patients attending the practice and we spoke with a patient who was part of the PPG before our inspection. In addition we looked at 30 completed patient comment cards and feedback from the previous two practice patient surveys that were available.

The evidence from all these sources showed that patient were satisfied with how they were treated in areas such as compassion, dignity and respect. For example, in the most recent GP survey 87% of respondents said the last GP they saw or spoke to was good at treating them with care and concern. This was above the local CCG average. However, patients were not always satisfied with the level of access for appointments and this was reflected in some of the feedback we had received on the comments cards. The patients we spoke with also commented on this. The practice was aware of this as because they had carried out their own survey which had also obtained similar feedback. We saw evidence that this had been discussed and an action plan to address this was developed.

The practice manager told us and we also noted from the practice survey that the reception area did not allow for private conversations. However, staff we spoke with were familiar with the steps they needed to take to maintain patient confidentiality. Furthermore, we saw proposed plans displayed in the waiting area to make changes to the layout of the reception area. This would better facilitate privacy in the reception area.

We saw that consultation rooms allowed for patients confidentiality to be maintained and separate examination rooms promoted patients privacy and dignity.

We saw the reception staff treated people with respect and ensured conversations were conducted in a confidential manner. We saw privacy curtains were available in treatment rooms; and patients confirmed curtains were used during physical examinations to ensure their privacy and dignity.

Care planning and involvement in decisions about care and treatment

Patients we spoke with as part of our inspection told us that their health issues were discussed with them and they felt involved in decision making about the care and treatment they received. Patient feedback from comment cards received were aligned with these views. Patients also told us they felt listened to and that information was explained to them in a way they could understand to help them make decisions about their own health care. The latest national GP survey showed that 80% of respondents said the last GP they saw or spoke to was good at involving them in decisions about their care. This was above average for the locality (CCG).

The practice used the Choose and Book system to refer patient to other services. The Choose and Book system enables patients to choose which hospital they would be seen in and to book their own outpatient appointments in discussion with their chosen hospital. The GPs helped patients with choose and book if patents were unable to do this for themselves.

Patient/carer support to cope emotionally with care and treatment

We discussed bereavement support with the GPs. We saw that there was a system in place to address any bereavement support issues by a GP for non-routine deaths. Family members were contacted to offer support and signposted to other organisations where appropriate. We saw numerous letters from relatives of bereaved patients who were extremely complementary about the care and support provided by the practice staff.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice engaged with the local Clinical Commissioning Group (CCG) to deliver local priorities. One of the GP partners was on the board of the local CCG and we saw evidence proactive working such as taking part in an acupuncture pilot clinic with the aim to reduce clinical referrals to chronic pains clinics. It was also taking part in other pilots for pre-operative assessment with the aim to significantly reduce the number of pre-op assessment appointments that were delivered by hospitals (Heart of England Foundation Trust).

Patients with immediate, or life-limiting needs, were discussed at the monthly clinical meeting to ensure all clinicians involved in their care delivery were up-to-date and knew of any changes to their care needs.

There were arrangements to refer or transfer patients to another service so patients' needs were met at the right time. The practice had referral criteria that helped clinicians to make timely referrals after relevant investigations and tests had been performed.

We saw that the practice had an active PPG. We saw that feedback provided by the PPG were listened to and implemented where appropriate. For example, the PPG member who we spoke with told us that they had asked for hand gels to be available in the reception area and that was made available.

Patients we spoke with commented on the difficulty of access to appointments. This was also reflected in the national GP survey where 66% of respondents said they were satisfied with the surgery's opening hours. This was lower than the local CCG average of 73%. The feedback from completed comment cards told us that although patients were happy with the care provided they found getting appointments difficult. However, the practice manager told us that and late evening appointments were prioritised for working age patients and that previously they had opened extended hours on a Saturday but found that the uptake was poor. They also told us that patients were able to get an appointment if they had an emergency. Young children and elderly patients with long term conditions were also given priority. Patients that were unable to visit the surgery were seen at home. Data we reviewed showed that access rates for A&E and out of hours services were significantly lower than the local average suggesting that the practice was meeting patients' needs by managing their conditions appropriately.

Tackling inequity and promoting equality

Most staff at the practice had been working for more than ten years. The GP partners told us that most patients had also been registered at the practice for many years. The practice staff knew its population well and staff members had a good relationship with patients generally. Patients who were vulnerable due to their health or social circumstances were known to the practice and staff were aware of their needs. For example, we were told how some patients communicated with the surgery via text type due to their disability. Although the practice found it time consuming it enabled the patients to access the service in the way they wished.

The practice was located in a converted house and consultation rooms were on the ground floor and on the first floor. Patients who had mobility difficulties were seen on the ground floor consultation rooms. The practice manager told us that most of the patient were registered with the practice for a long time and would always ask if they needed to be seen on the ground floor consultation room.

The practice had arrangements for accessing interpreting services for patients whose first language was not English. Most of the patients had been registered with the practice for a long time and the practice knew their patient population well. However, staff told us that they had seen newer patient register at the practice mainly from Eastern Europe, as well as Asian patients. There were some Chinese patients with poor English and the practice was able to organise translation service. We saw that the practice website was accessible in many different languages through Google translate.

Staff also told us that they had patients who were hearing impaired and they organised sign language interpreters for them. There was a hearing induction 'loop system' for patients with hearing difficulties.

The practice website outlined how patients could book appointments and organise repeat prescriptions online. Patients could also make appointments by telephone and

Are services responsive to people's needs?

(for example, to feedback?)

in person to ensure they were able to access the practice at times and in ways that were convenient to them. Patients who were unable to attend the practice could also arrange for home visits.

Access to the service

The practice was located I a large converted house. There was a ramp to access the surgery but there were no automatic doors, but staff told us that they would help patients access the surgery if using a wheelchair. There were consultation rooms on the ground floor and on the first floor. Staff told us that they would book patients who had mobility difficulties on the ground floor so that they did not have to climb the stairs. One of the partners we spoke with recognised that there were issues with accessibility and showed us architects plans displayed in the waiting area. These plans detailed some of the proposed amendments to the building including installation of a lift so patients with mobility difficulties did not have to climb the stairs. However, the plans were subject to further change following consultations and risk assessments.

Before our inspection we looked at the national GP survey and saw 66% of respondents are satisfied with the surgery's opening hours. This was lower than the local (CCG) average of 73%. We asked the practice about this and they told us that the practice had tried extended surgery hours on a Saturday during the previous year. They further said that it worked well initially but then the uptake was poor and it was discontinued. The partners told us that they had a higher than the national (England) average older patients who had been with the practice for a long time and they usually preferred to come during normal practice hours. Data we looked at showed that despite a higher than average older population registered at the practice patient's access rates for A&E and out of hours services were significantly lower.

We spoke with two patients on the day of our inspection who told us that they found it difficult to get an appointment. However, if it was urgent they told us that they could get an appointment on the same day. This was also confirmed by the PPG member we spoke with before our inspection.

The practice acknowledged that access to appointment was an on-going problem particularly when GPs were on holiday. The practice used regular locum GPs and the approach was to book extra sessions when demand for appointment was high. The practice had also set up 'open clinics' to reduce waiting time and free up pre booked appointment slots.

There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. This out of hours service was provided by an external service contracted by the CCG. Details of out of hours provider was available on the practice website as well as in the surgery.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. The practice managed complaints proactively. The systems in place enabled the practice to record and monitor complaints. We saw that a review of complaints had been carried out looking at complaints from April 2013 to August 2014. We saw that there were 10 complaints in total and they were analysed to identify trends. Actions taken were recorded and lessons learned were shared with staff in meetings.

Are services well-led?

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high standard of care that fully satisfied the needs and expectations of patients registered with the practice. They aimed to achieve this through effective care pathways and continuously striving for improvement through training, listening to staff and the patient population.

We saw evidence where poor care was challenged. Staff members we spoke with told us that they were supported to develop their skills and knowledge and feedback any improvements to the service. We were told that one of the GP partners had completed a diploma in diabetes care and the plan was to take a lead in diabetes care within the practice. We also saw that the practice had an active PPG and took on board feedback from them to improve service where appropriate.

Governance arrangements

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 there were systems in place to monitor and improve quality and identify risk. All the policies were available to staff via the desktop on any computer within the practice.

Staff were aware of their roles and responsibilities for managing risk and improving quality. GPs and nurses had lead responsibilities for areas such as safeguarding, infection control, and care related to patients with dementia. An administration staff we spoke with told us that apart from reception duties staff also had specific administration roles they were expected to fulfil. They included updating the smear test register and calling or writing to patients about their tests.

Leadership, openness and transparency

We were shown a clear leadership structure which had named members of staff in lead roles. Staff members who we spoke were clear about their own roles and responsibilities. All the staff we spoke with told us they felt valued, supported and knew who to go to in the practice with any concerns. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. We saw that team meetings were held and staff were able to make suggestions.

The practice manager was responsible for human resources and the day to day running of the practice. The practice manager showed us records of staff appraisals which were used to monitor and review staff performance. The practice had a small team and any minor performance issues were dealt with informally, the practice manager told us that there had been no staff performance issues that had required formal procedures to be initiated.

The practice had a whistle blowing policy. Staff were aware that they could access the policy available on the shared drive. Staff told us that they felt confident to raise any concerns about poor care that could compromise patient safety. Whistleblowing is when a staff member is able to report suspected wrong doing at work; this is officially referred to as 'making a disclosure in the public interest'.

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

Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues during their appraisals and at team meetings. We saw evidence from minutes of team meetings where issues were raised by staff and evidence where action had been taken. For example, the practice manager and administration staff suggested that 'open clinics' should be trialled as a way of offering more appointments. This was taken on board by the partners and actioned. Another staff member we spoke with told us that they had a problem with the electronic prescription system and this was discussed at team meetings and feedback was invited on how that could be improved.

We saw that the practice had an active and engaged patient participation group (PPG) to promote and support patient views and participation in the development of services provided by the practice. We saw that the PPG discussed outcome of the survey which identified that patients were not communicated when appointment times were running late. Options to notify patients when a GP was running late was explored including a new screen where the practice could add their own personal messages, however the cost was deemed too high. PPG members then suggested that the GP/Nurses should inform a patient

Are services well-led?

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

themselves when they were running late and this was put in place. On the day of the inspection we did not see this happening. However, appointments were not running late and patients were being seen without too much delay.

We looked at results of the latest national GP patient survey which showed that patients were generally happy with the service being provided. This was also recognised in the practices own survey and the comment cards we had received. However, both surveys also identified that patents wanted better access. This was also confirmed by the feedback we received from comment cards, some of the patients said that although they were happy with the care sometimes they found it difficult to get appointments. This was discussed by the PPG and appropriate action was being taken, this including booking extra locum GP cover when needed. Also, patients said that they would rather listen to easy listening CDs rather than radio. This was actioned for trial for two months pending further review.

Management lead through learning and improvement

The practice carried out a number of audits including diabetes and rapid access cancer referrals. Another audit reviewed routes to new diagnosis of cancer. The aim was to improve cancer survival by identifying and categorising the routes taken by patients to their cancer diagnoses. We saw that the practice carried out an audit in response to concerns over the process for repeat prescription which had resulted in medicines being wasted. The finding of this audit was shared with other practices within the CCG so that improvements could be made.

We saw evidence of patient case reviews that led to the review of a cancer care pathway which was suspected to have led to delayed diagnosis. We saw evidence that the reviews were used to initiate improvements to care for patients.

The surgery closed for training once quarterly for in-house training and development. This Protected Learning Time (PLT) enabled staff to take advantage of learning and development opportunities. Staff members we spoke with told us that they discussed consent and infection control.