

Woodend Health Centre

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Wood End Health Centre on 16 August 2016. Overall the practice is rated as good.

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

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events. Learning outcomes were shared with staff and were embedded within the practice. Learning was also shared with other local practices.
- Risks to patients were assessed and well managed. These included safeguarding of children and vulnerable adults, medicines management and health and safety precautions which included the practice's ability to respond to an emergency.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Clinical audit drove quality improvement in all areas of activity. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.

- Patient feedback from CQC comment cards completed showed that patients were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- 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 if patients could not attend the daily walk in clinic.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- As part of the practice strategy, new partners had been recruited for their passion and enthusiasm in striving to improve health care for patients who faced social deprivation and potential inequalities.
- The practice was forward thinking and led and participated in pilots aimed at improving healthcare for its patients.
- The provider was aware of and complied with the requirements of the duty of candour.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as good for providing safe services.

Good



- There was an effective system in place for reporting and recording significant events. All staff knew how to report incidents and a number of documents we were provided with supported this assurance process.
- Lessons were shared to make sure action was taken to improve safety in the practice. Detailed records included analysis of the events and risk assessment to reduce potential recurrence. We saw evidence of how learning outcomes had become embedded amongst practice staff.
- When things went wrong patients received information, reasonable support and a verbal or 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 in place to keep patients safe and safeguarded from abuse. This included appropriate training of staff in safeguarding, infection control procedures, management of medicines and staff recruitment procedures.
- Risks to patients were assessed and well managed. This included health and safety, ensuring sufficient staff were in place to meet patient needs and suitable emergency procedures if a patient presented with an urgent medical condition.

Are services effective?

The practice is rated as good for providing effective services.

Good



- Our findings at inspection showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines.
- We also saw evidence to confirm that the practice used these guidelines to positively influence and improve practice and outcomes for patients across its population groups.
- Data showed that the practice was performing highly when compared to practices nationally. For example, in the Quality and Outcomes Framework (QOF) the practice received 100% of

Summary of findings

total points available. This was above the CCG average of 94% and national average of 95%. Overall exception reporting was 6.3% which was better than the CCG average of 8.3% and national average of 9.2%.

- 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 worked with other health care professionals regularly to understand and meet the range and complexity of patients' needs.

Are services caring?

The practice is rated as good for providing caring services.

- Data from the National GP Patient Survey (July 2016) showed patients rated the practice higher than others for particular aspects of care including frontline customer service, but lower than other practices for GP and nurse led consultations. For example;

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%.

84% 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%.
- The practice management had analysed all patient feedback received and taken proactive measures to improve patient experience. This included adjustments of its walk in surgery service.
- Patient comment cards completed showed that they were treated with compassion, dignity and respect and were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand. This was also included on the practice website.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality. Information about confidentiality was provided to patients in the practice information leaflet.

Good



Are services responsive to people's needs?

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 CCG to secure

Good



Summary of findings

improvements to services where these were identified. As part of its federated working agreements, the practice offered extended hours appointments to 9.30pm weekdays and during weekends on site.

- Patients said they found it easy to make an appointment with a named GP. The National Patient Survey showed that 66% of patients were usually able to see or speak to their preferred GP compared to the CCG average of 57% and national average of 59%. We found there was continuity of care, with urgent appointments available the same day if patients did not attend the daily morning walk in clinic.
- The practice had good facilities and was well equipped to treat patients and meet their needs. A wide variety of services were offered to meet patient needs on site. These included a smoking cessation clinic, psychological therapies clinic, carers clinic and phlebotomy clinic (for taking blood).
- 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.

Are services well-led?

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

- The practice had a clear vision with quality and safety as its top priority. The strategy to deliver this vision was regularly reviewed and discussed with staff. As part of the strategy, new partners had been recruited for their commitment to improving health care for patients who faced social deprivation and potential inequalities.
- 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 governance meetings.
- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk. The practice both led and participated in pilots aimed at improving patient care and supporting financial efficiencies. Clear outcomes were identifiable.
- High standards were promoted by all practice staff. The practice sought to share these standards and learning acquired across

Good



Summary of findings

64 practices within the federation it was working alongside. These included learning from significant events and training of other clinical staff across the locality where gaps in provision had been identified.

- The practice's federated working arrangements had benefitted its patients through extended hours appointments being made available in the evenings and over weekends.
- The practice proactively sought feedback from staff and patients, which it acted on. This included the recruitment of a new female GP. The patient participation group was active.

Summary of findings

The six population groups and what we found

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

Older people

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

Good



- The practice offered proactive, personalised care to meet the needs of the older people in its population. The practice had 284 patients who were aged over 75 years old and 260 had received medicine reviews in the last 12 months.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- The practice had undertaken an osteoporosis audit to improve clinical management and care for patients. Outcomes included the identification of a number of patients who required care and treatment, which was subsequently received. The audit also resulted in the implementation of a template to assist clinical staff in the management and coding of patients.
- The practice had provided flu vaccinations to 72% of its patients aged 65 and older. CCG data supplied showed that the CCG uptake was 69%.

People with long term conditions

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

Good



- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- National data showed the practice was performing above the local CCG average for its achievement within 11 diabetes indicators. The practice achieved 100% of the available QOF points compared with the CCG and national average of 89%.
- Data also showed that 95% of patients with chronic obstructive pulmonary disease (COPD) had received a confirmed diagnosis. This was above the CCG average of 91% and national average of 90%. Exception reporting was better than CCG and national averages.
- Longer appointments and home visits were available when needed.
- 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.

Summary of findings

Families, children and young people

The practice is rated as good for the care of families, children and young people.

Good



- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances.
- Immunisation rates for all standard childhood immunisations ranged from 81% to 100%. This was comparable to CCG averages which ranged from 82% to 98%.
- The practice had undertaken a safeguarding audit to ensure all relevant information was recorded on its computer system. One of the audit outcomes resulted in contact with Social Services to share risk information.
- The practice offered the C-Card scheme, a free condom and sexual health advice service for young people.
- 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.

Working age people (including those recently retired and students)

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

Good



- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice provided daily walk in clinics where no appointment was required and offered extended hours appointments during weekday evenings and over weekends. Telephone appointments were also available for working aged patients if they requested.
- The practice was participating in a prescription ordering direct (POD) initiative which enabled patients to request repeat prescriptions via a centralised telephone system.
- 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.
- 83% of women aged over 25 but under 65 had received a cervical screening test in the previous five years. The practice was performing above the CCG average of 81% and national average of 82%.

Summary of findings

People whose circumstances may make them vulnerable

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

Good



- The practice held a register of patients living in vulnerable circumstances including those with a learning disability. There were 86 patients on the learning disability register. We were informed that all of these patients had been invited to attend for an annual review and 77% of these patients had attended.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients. Documentation supported that patients received ongoing care and support from the appropriate health care service(s).
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations. A number of self-help organisation contact details were made available for patients on the practice's website. These included a mental health helpline, alcohol and drug support and the Samaritans.
- The practice offered a HIV near patient testing service to those patients who required this service.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

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

Good



- 91% of patients with a mental health condition had a documented care plan in place in the previous 12 months. This was above the CCG average of 84% and above the national average of 88.3%.
- 75% of patients diagnosed with dementia had had their care reviewed in a face to face meeting in the last 12 months. This was below the CCG average of 82% and national average of 84%.
- The practice regularly worked with multidisciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.

Summary of findings

- The practice had a system in place to follow up patients who had attended accident and emergency (A & E) where they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

The National GP Patient survey results were published in July 2016. The results showed the practice was performing in line with local and national averages. 370 survey forms were distributed and 102 were returned. This represented a 28% response rate.

- 95% of patients found it easy to get through to this practice by phone compared to the CCG average of 73% and national average of 73%.
- 79% 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 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 national average of 85%.
- 83% 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 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 all of which were all positive about the standard of care received. Feedback included that staff were caring, approachable, helpful and listened to patients. A number of comment cards made particular reference to individual staff who took time to explain care and treatment and responded kindly to questions asked. Four comment cards did make reference to the waiting time to see a GP and difficulty in obtaining an appointment outside of usual working hours.

The practice's results from the NHS Friends and Family test showed that since January 2016, 64 patients would recommend the practice to their friends and family and three were unlikely to recommend the practice. Comments included that staff were friendly, patients were seen quickly and the surgery was well run.

Woodend 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.

Background to Woodend Health Centre

Woodend Health Centre is located in the north of the city of Coventry in the West Midlands.

There is direct access to the practice by public transport from surrounding areas. There are parking facilities on site as well as public parking on street.

The practice currently has a list size of approximately 8007 patients. We were informed that 500 new patients had chosen to register since April 2016 as a result of a nearby practice which had closed.

The practice holds a General Medical Services (GMS) contract with NHS England. The GMS contract is between general practices and NHS England for delivering primary care services to the local communities. The practice provides GP services commissioned by NHS Coventry and Rugby Clinical Commissioning Group (CCG). A CCG is an organisation that brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services.

The practice is situated in an area with very high levels of deprivation. It has the highest levels of deprivation within Coventry and has the eighth highest deprivation score within the United Kingdom. The practice has a higher than

national average number of children and young adults population. It has lower than the national average number of adults who have reached retirement age and older aged people.

A lower number of patients registered at the practice are in paid work or full time education (55%) compared with the local CCG and national averages (63%).

The practice is currently managed by two GPs (male and female). The practice also has two salaried GPs (male and female). They are supported by three female part time practice nurses and two female phlebotomists. The practice also employs a practice manager, office manager and a team of reception, clerical and administrative staff.

The practice is open on Mondays to Fridays from 8.15am to 6pm. Appointments are available Mondays 8.15am to 11am, 3.15pm to 6pm, Tuesdays 8.15am to 11am, 2pm to 5.30pm, Wednesdays 8.15am to 11am, 3.30pm to 6pm, Thursdays 8.15am to 11am, 3.30pm to 5.30pm and Fridays 8.15am to 11am, 3.30pm to 6pm. The practice has started to operate extended hours services through the GP alliance it is affiliated with. Practice patients can therefore be seen at the practice site each weekday evening up until 9.30pm and during daytime hours every weekend by pre-booking an appointment. Outside of this cover, out of hours service is provided by WMAS. Patients can also contact NHS 111.

As part of our inspection process we checked the regulated activities the practice was registered to provide. Whilst family planning was being provided, the provider had not registered this service with CQC. Action has since been taken by the practice to apply for this activity to be included in their service provision.

Detailed findings

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.

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 16 August 2016. During our visit we:

- Spoke with a range of staff (GPs, nurses, the practice manager, administrative and clerical staff) and spoke with a member of the practice's patient participation group (PPG).
- 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.

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.

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received information, reasonable support and a verbal or written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice carried out a thorough analysis of the significant events. The practice had recently made an arrangement with a neighbouring practice to share details of their significant events. This was undertaken to promote good practice within the locality and to ensure that both practices had considered all risks and possible actions from events recorded. We reviewed a record produced by the neighbouring practice which showed specific points had been highlighted for discussion at one of their learning events. Other action had also been taken by the other practice to reduce particular risks.

We reviewed safety records, incident reports, patient safety alerts including Medicines and Healthcare products Regulatory Agency (MHRA) and minutes of weekly meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, an administrative error resulted in a delay of a patient referral being made. As a result of the incident, a new procedure was introduced to ensure that the error could not be repeated. We reviewed other reports which demonstrated how learning had been effective. For example, two similar incidences occurred which involved patients who had presented at the practice requiring urgent medical attention. As a result of the first incident, the practice management identified a need for further staff

training and policy in relation to the management of patients presenting with emergencies. Analysis following the second incident showed that practice staff had all responded in line with the updated training they had been provided with.

Overview of safety systems and processes

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

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs would attend safeguarding meetings when requested and had provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to an appropriate level to manage safeguarding children concerns (level three).
- A notice in the waiting room advised patients that chaperones were available if required. The practice had adopted a policy that only clinical staff could act as chaperones. 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 maintained appropriate standards of cleanliness and hygiene. We observed the premises to be visibly clean and tidy. One of the practice nurses was the infection control clinical lead who liaised with the local infection prevention control lead to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken

Are services safe?

to address any improvements identified as a result. The last audit in September 2015 identified removal of fabric curtains in treatment rooms. These had been replaced with disposable ones.

- 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 were in place for handling repeat prescriptions which included the review of high risk medicines. We reviewed a sample of anonymised patient records where particular high risk medicines had been prescribed. These showed that appropriate monitoring was in place. The practice had also utilised their computer system to design a tool which enabled instant ease of access to patients' blood test results. The GPs told us this was an effective tool and had contributed to ensuring that patient safety was always prioritised.
- The practice carried out regular medicines audits, with the support of the local Clinical Commissioning Group (CCG) pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation.
- We reviewed four personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identity, references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available and staff had received training. The practice had up to date fire risk assessments and carried out fire drills. All electrical

equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).

- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for the different staffing groups to ensure enough staff were on duty. We were told that staff were trained to support each other which meant that staff annual leave could be appropriately planned and co-ordinated.

Arrangements to deal with emergencies and major incidents

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

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The practice held an agreement with another local practice to use their facilities in the event of an emergency. The plan included emergency contact numbers for staff.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards.

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from the National Institute for Health and Care Excellence (NICE) and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through risk assessments, audits and 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 were 100% of the total number of points available with 6.3% overall exception reporting. (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 2014/15 showed:

- Performance for diabetes related indicators was 100% which was above the CCG average of 89% and national average of 89%.
- The percentage of patients with hypertension having regular blood pressure tests was 90% which was above the Clinical Commissioning Group (CCG) average of 83% and above national average of 84%. Exception reporting was 2.5% which was better than the CCG average of 3.7% and better than the national average of 3.8%.
- 95% of patients with chronic obstructive pulmonary disease (COPD) had received a confirmed diagnosis.

This was above the CCG average of 91% and national average of 90%. Exception reporting was 3.4% which was better than the CCG average of 8.2% and national average of 9.8%.

- 84% of patients with a diagnosis of depression had received a review after their diagnosis. Performance was similar to the CCG average of 85% and the same as the national average. Exception reporting was 20.1% which was better than the CCG average of 24.4% and national average of 24.5%.
- 91% of patients with a mental health condition had a documented care plan in place in the previous 12 months. This was above the CCG average of 84% and above the national average of 88%. Exception reporting was 15.1% which was above the CCG average of 10.1% and above the national average of 12.6%.

We discussed the overall high achievement in QOF and general low exception reporting with the practice management. We were informed that the practice was proactive in contacting their patients to attend for reviews. This involved telephone calls being made to patients inviting them to attend the practice. The practice told us they knew their patient demographic well and a large number of their patients responded positively when they received telephone calls. The practice had also adopted a process for managing repeat prescribing reviews for those patients with long term conditions. We were told that patients were reminded to book appointments for reviews two months prior to when they were due. Further reminders were then given to any patients who had not booked appointments and they were told restrictions would be placed on prescriptions being issued. The practice told us this was highly effective and assisted in keeping exception reporting low as only a few numbers of patients were required to be recalled after their annual review date. We looked at records and spoke with a variety of staff, all of which supported this proactive approach.

There was evidence of quality improvement including clinical audit.

- We were provided with a number of clinical audits completed in the last two years. We reviewed a full cycle osteoporosis audit which was undertaken to improve clinical management and care for patients. Outcomes included the identification of a number of patients who

Are services effective?

(for example, treatment is effective)

required intervention, which was subsequently received. The audit also resulted in the implementation of a template to assist clinical staff in the management and coding of patients.

- The practice provided minor surgery to its patient population and had audited its effectiveness of procedures and joint injections undertaken. Outcomes included that there were no incidents of post-operative infection or other complications.
- The practice had recently audited its prescribing of controlled drugs to ensure they had not been prescribed to patients for a period over one month. The practice had undertaken the audit to ensure patients had been closely monitored. Outcomes included assurance that safe prescribing was in place.
- The practice had undertaken a safeguarding audit to ensure all relevant information was recorded on its computer system. One of these outcomes resulted in contact with Social Services to share risk information.

Effective staffing

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

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions. One of the practice nurses had updated her skills in spirometry. Spirometry is a test used to help diagnose and monitor certain lung conditions.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate

training to meet their learning needs and to cover the scope of their work. One of the practice nurses had recently obtained a teaching qualification and was planning to utilise this to assist training other practice nurses within the city of Coventry. Staff received ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and there was facilitation and support for revalidating GPs. We spoke with the trainee GP on the day of our inspection and we were informed that sufficient time was allocated to discuss caseload and review learning. All staff had received an appraisal within the last 12 months.

- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of training modules and in-house training.

Coordinating patient care and information sharing

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

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

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs. We saw detailed anonymised records of meetings held. We noted that the practice had undertaken post death analyses to identify any learning points if patients had not received their desired end of life care.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

Are services effective?

(for example, treatment is effective)

- 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. We were provided with examples which demonstrated staff knowledge and understanding.
- 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 practice had designed and implemented their own template to use to record consultations where a consideration of mental capacity impacted on the outcome of providing treatment.
- The process for seeking consent was monitored through patient records audits. These included an audit of minor surgical procedures undertaken where it was identified that appropriate written consent had been obtained in every procedure.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example, patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were signposted to the relevant service. In house services were provided for those who wanted to stop smoking and for those who wanted to improve their physical and mental wellbeing. The practice provided data which showed that 78% of their patients who were recorded as smokers had been offered smoking cessation support.

The practice's uptake for the cervical screening programme was 83%, which was similar to the CCG average of 81% and the national average of 82%. The practice had nominated a

member of staff as a smears champion. Their role involved inviting patients to attend and issuing reminders for those who did not attend for the procedure. If a patient chose not to have the procedure, written confirmation was obtained. The practice ensured a female sample taker was available.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. Data showed that uptake for bowel cancer screening in the previous 30 months was 44% which was lower than the CCG average of 59%. Data from 2015 showed that uptake for breast cancer screening in the previous 36 months was 55% which was lower than the CCG average of 71%. The practice told us they had recognised low uptake for the national screening programmes and had taken measures to identify those patients who had not attended for screening. They had sought to encourage uptake by way of an educational letter sent to these patients.

Childhood immunisation rates for the vaccinations given were similar to CCG averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 81% to 99% within the practice. The CCG rates varied from 82% to 98%. Five year old vaccinations ranged from 96% to 100% within the practice. The CCG rates ranged from 93% to 98%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. The practice sent birthday cards for those patients aged 40 to invite them to attend for a health check. The practice provided data that showed they had undertaken 1274 health checks within the last 5 years. The practice had a total of 2535 eligible patients. Appropriate follow-ups for the outcomes of health assessments and checks were made where abnormalities or risk factors were identified.

Are services caring?

Our findings

Kindness, dignity, respect and compassion

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

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consulting and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

All of the 21 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with a member of the patient participation group (PPG). They also told us they were highly satisfied with the care provided by the practice and said their dignity and privacy was always respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

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

- 84% 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%.
- 86% of patients said the GP gave them enough time compared to the CCG average of 87% and the national average of 87%.
- 96% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 95% and the national average of 95%.

- 83% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 85% and national average of 85%.
- 87% 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

The majority of comment cards we reviewed showed that patients felt involved in decision making about the care and treatment they received. Comments showed that these patients also 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. A number of comments made particular reference to individual staff who took their time to answer questions in a way that patients fully understood. We also saw that care plans were personalised.

Results from the National GP Patient survey showed how patients responded questions about their involvement in planning and making decisions about their care and treatment. Results were generally below local and national averages. For example:

- 82% 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%.
- 80% 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%.
- 78% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 85% and national average of 85%.

We spoke with practice management regarding the mixed feedback from the patient survey. We were advised that the practice had analysed feedback in response to the survey. They had concluded that results may have been affected by those patients who had attended the walk in surgery where GPs were under time pressure to see a large volume of patients. As a result, alterations had been made to the walk in surgery service. These included increasing the

Are services caring?

length of appointment time, limits on the number of patient consultations and break times for GP staff. In respect of feedback regarding nursing staff, the practice had employed an additional part time nurse to ease pressure on nursing time to see patients. The practice told us that positive feedback regarding receptionists had been passed to these staff who were praised for their delivery of customer service.

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. The practice also employed a member of the reception team who spoke Polish and they could therefore assist patients.
- Patients had access to a sign language service if they required this.
- The practice's website was able to be translated by patients in a number of different languages.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available which told patients how to access a number of support groups and organisations. Information about support services was also available on the practice website.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 262 patients as carers (3.3% of the practice list). Newly registered patients were asked if they had carer responsibilities and if so, these were recorded on their notes with an alert to notify staff. Staff in the practice referred patients to a local carers association for further help and support. The carers association also held fortnightly sessions within the practice which ensured ease of access for patients. Carers were offered the seasonal flu vaccination.

Staff told us that if families had suffered bereavement, their usual GP contacted them and sent them a sympathy card. This contact was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

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.

- The practice offered a daily morning walk in clinic where those who required urgent appointments could sit and wait to be seen by one of the GPs. Patients were not required to pre-book an appointment to attend this clinic.
- Patients had access to extended hours appointments through the practice's federated working agreements. Pre-bookable appointments were available to see a GP at the practice site from when usual surgery hours closed to 9.30pm on weekday evenings. Patients could also book appointments during daytime hours at weekends.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day pre-bookable appointments were available for children and those patients with medical problems that required them to be seen urgently.
- There were longer appointments available for patients with a learning disability.
- The practice offered a range of minor surgical procedures, which included removal of lumps, bumps and joint injections.
- The practice offered the C-Card scheme, a free condom and sexual health advice service for young people.
- A range of family planning and contraception services were available.
- Patients who experienced depression or had other mental health problems could be referred to an on-site therapy service which was available on a weekly basis.
- A phlebotomy service was available to patients on site.
- The practice offered HIV testing to any of its patients who required this test.
- A smoking cessation clinic was available on site for those patients who would benefit from this support.
- Patients were able to receive travel vaccinations available on the NHS as well as some of those only available privately.

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

Access to the service

The practice was open between 8.15am to 6pm Mondays to Fridays. Appointments were available Mondays 8.15am to 11am, 3.15pm to 6pm, Tuesdays 8.15am to 11am, 2pm to 5.30pm, Wednesdays 8.15am to 11am, 3.30pm to 6pm, Thursdays 8.15am to 11am, 3.30pm to 5.30pm and Fridays 8.15am to 11am, 3.30pm to 6pm. Extended hours appointments were offered to patients up until 9.30pm weekday evenings and during daytime hours each weekend. In addition to pre-bookable appointments that could be booked from one to five days in advance, urgent appointments were also available for people that needed them.

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

- 73% of patients were satisfied with the practice's opening hours compared to the CCG average of 75% and national average of 76%.
- 95% of patients said they could get through easily to the practice by phone compared to the CCG average of 73% and national average of 73%.
- 66% of patients were usually able to see or speak to their preferred GP compared to the CCG average of 57% and national average of 59%.

The practice had very recently started to host the extended hours service from its site. Practice patients had previously been able to pre book appointments at another nominated local practice through its federated working agreements. The practice management had analysed data which had shown that patients had underutilised that service because of patient unwillingness or inability to travel there.

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

The practice had a system in place to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

The practice had adopted a system of coding housebound patients on their computer records. For any other patients who requested a home visit, the nominated on-call doctor would make a decision based on the patients' clinical

Are services responsive to people's needs?

(for example, to feedback?)

needs and mobility. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice had a comprehensive and effective system in place for handling complaints and concerns.

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

- We saw that information was made available to help patients understand the complaints system. The practice's information leaflet included detail on how to report concerns to the practice as well as to external organisations. We also saw that this was available on their website.

We looked at four complaints received in the last 12 months and found they were satisfactorily handled, dealt with in a timely way with openness and transparency. Lessons were learnt from individual concerns and complaints and also from an analysis of trends. Action was taken as a result to improve quality of care. For example, the practice had implemented changes in its procedures when registering new patients. This arose as a result of an incident when the practice had registered a new patient and had not had sufficient information at the time to enable appropriate treatment to be made.

Are services well-led?

Good 

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients.

- The practice objectives included promoting and providing the highest quality primary care services to its patients. Practice management told us that they considered that every consultation counted. Staff we spoke with all knew and understood the practice values.
- The practice had a strategy and supporting business plans which reflected the vision and values and were regularly monitored.

Governance arrangements

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

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. Staff were supported through regular one to one sessions, meetings, training programmes and appraisals.
- Practice specific policies were implemented and were available to all staff. Discussion of policies took place through induction, training and staff meetings.
- A comprehensive understanding of the performance of the practice was maintained. This was demonstrated in management review of data relating to hospital admissions where patients were identified that had not needed to attend for emergency care. Subsequent action was taken to educate and inform these patients of other services available. The practice had also utilised data to identify non-attenders of national screening programmes and had made contact with these patients to encourage uptake. The management had reviewed its performance against QOF data and other CCG statistical information and this drove quality improvement.
- The practice continuously monitored its effectiveness when they participated in new initiatives and pilot schemes. For example, its involvement in a CCG led prescription ordering direct scheme (POD) had resulted in 2% reduction in the volume or number of medicines prescribed per patient and 4% reduction in the costs of medicines prescribed per patient.

- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements. For example, the practice led in a new trial to optimise the care of patients with asthma. Outcomes included better diagnosis, improved patient compliance with medicine and an increase in educational awareness amongst 37 patients.
- There were robust arrangements in place for identifying, recording and managing risks, issues and implementing mitigating actions. This was demonstrated in the practice's management of significant events, complaints and trends analyses.

Leadership and culture

The practice was part of a federation of 64 practices and the senior GP partner undertook the lead role of chairperson.

On the day of inspection the partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. The practice had undergone a number of changes over recent years. These included the appointment of the senior GP partner in 2011 and retirement of the second partner in 2014. The practice had recently appointed a new partner who had commenced in post and a third partner had since been recruited and was due to start this year. Whilst the practice was situated in an area of very high deprivation, we were informed that recruitment of GPs had not presented any difficulties. We were informed that the partners had been selected for their commitment to improve health care for patients who faced social deprivation and potential inequalities. Our discussions with one of the new partners supported this.

One of the practice nurses had been supported by the practice to undertake a teaching qualification, which she had completed. The nurse told us that she had been asked, along with three other nurses in the locality, to form part of a new teaching team to help provide training for all practice nurses within Coventry. This was because the CCG had identified a gap in training provision. The team were planning to deliver some of the sessions through protected learning time events (PLT) and areas of training included immunisations, vaccinations and anaphylaxis. (Severe and extreme allergic reaction).

Are services well-led?

Good 

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

All staff we spoke with told us the partners were approachable and always took the time to listen to all members of staff. One staff member told us that nowhere else would compare to working at this practice.

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

- The practice gave affected people information, reasonable support and a verbal and written apology.
- The practice kept detailed written records of verbal interactions as well as written correspondence.

There was a clear leadership structure in place and staff felt supported by management.

- Staff told us the practice held regular team meetings and we reviewed documented minutes where all staff were invited to attend and contribute.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. We noted team away days were held three times a year.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. The practice management offered developmental opportunities to staff and this was reflected in the promotion of the practice manager from her previous role as a receptionist.
- All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.
- The practice had received two CCG locality awards in 2016. These included a Lifetime Award for Contribution to Practice Nursing in respect of one of the practice nurses and the Practice Manager of the Year – going the extra mile nominee award.

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

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

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. The PPG met regularly, carried out patient surveys and submitted proposals for improvements to the practice management team. For example, as a result of patient feedback obtained, the practice had recruited a female GP. The female GP had met with the PPG to introduce herself prior to her post commencing. The practice had also implemented a fast and simple way for patient feedback to be obtained by using a smiley face card which could be marked by patients if they were happy or unhappy with the service they received. This was introduced as a result of discussions held between the practice and the PPG. It was considered this would be useful for any patients who did not speak English as a first language.
- The practice had gathered feedback from staff through informal discussions held and through practice meetings and staff appraisals. Staff told us they would provide feedback and discuss any issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. For example, the practice had led on the work involved in optimising the care of patients with asthma. Outcomes included better diagnosis, for example, in an extract of data we reviewed, 3 patients had their medicines reduced and 1 patient had their medicine increased. Other outcomes included an increase of educational awareness amongst patients reviewed and additional assurance for health professionals when making decisions to reduce medicines prescribed.

As a result of the practice undertaking federated working, it had been able to offer its patients extended hours appointments in the evenings and weekends. The federation had also targeted Accident and Emergency admissions by placement of GPs in the hospital

Are services well-led?

Good 

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

environment. The practice informed us that approximately 20% of patients attending A & E were being appropriately treated by GPs in the hospital department. They told us they had successfully reduced lengths of stay for the frail elderly.

The practice told us they had plans to share good practice and safety across the federation. This included the review of safety alerts and ensuring a fully comprehensive understanding and application of the Mental Capacity Act.

One of the practice nurses had completed a teaching qualification. At the request of the Clinical Commissioning

Group (CCG) they had assisted to fill a gap in training provision for all practice nurses working within Coventry. The nurse was one of four within the locality to form part of the new teaching team.

The practice was seeking to innovate medical student training. They had applied through the local medical school to be a medical student teaching practice. One of the partners was trained in medical student training in preparation for the new academic term in January 2017. As a result of the lead nurse becoming a nurse mentor, the practice was due to start training second and third year student nurses from one of the local universities. This would facilitate new nurses into practice.