Broad Street Surgery

Quality Report

200 Broad St,
Coventry, CV6 5BG
Tel: 024 7668 2486
Website: www.coventrygp.com

Date of inspection visit: 6 January 2015
Date of publication: This is auto-populated when the report is published

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of Broad St Surgery on 6 January 2015. The practice also has a branch surgery at Jubilee Crescent, Coventry, which we did not inspect on this occasion. We found Broad St Surgery provided a good service to patients in all of the five key areas we looked at. This applied to patients across all age ranges and to patients with varied needs due to their health or social circumstances.

Our key findings were as follows:

- The practice had comprehensive systems for monitoring and maintaining the safety of the practice and the care and treatment they provided to their patients
- The practice was proactive in helping people with long term conditions to manage their health and had arrangements in place to make sure their health was monitored regularly
- The practice was clean and hygienic and had robust arrangements for reducing the risks from healthcare associated infections
- Patients felt that they were treated with dignity and respect. They felt that their GP listened to them and treated them as individuals
- The practice had a well-established and well trained team and had expertise and experience in a wide range of health conditions

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. The practice provided opportunities for the staff team to learn from significant events and was committed to providing a safe service. Information about safety was recorded, monitored, appropriately reviewed and addressed. The practice assessed risks to patients and managed these well. There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. The practice was the highest performing practice for the Coventry and Rugby Clinical Commissioning Group (CCG). Patients' care and treatment took account of guidelines issued by the National Institute for Care and Health Excellence (NICE). Patients' needs were assessed and care was planned and delivered in line with current legislation. The practice was proactive in the care and treatment provided for patients with long term conditions and regularly audited areas of clinical practice. There was evidence that the practice worked in partnership with other health professionals and was a founder member of the Coventry Integrated Neighbourhood Team, a multi-disciplinary partnership which involved health professionals from a wide range of fields and Coventry City Council. This aimed to provide "joined up" patient care across different teams for patients aged over 50 who were at high risk of being admitted to hospital. Staff received training appropriate to their roles and the practice supported and encouraged their continued learning and development.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients told us they were treated with compassion, dignity and respect and they were involved in their care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We saw that staff treated patients with kindness and respect and were aware of the importance of confidentiality. The practice provided advice, support and information to patients, particularly those with long term conditions and to families following bereavement.

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice was aware of the needs of their local population and engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice and said that urgent appointments were available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. There was a clear complaints system with evidence demonstrating that the practice responded quickly to issues raised. The practice had a positive approach to using complaints and concerns to improve the quality of the service. The practice was regularly involved with trials of new medicines to improve outcomes for patients.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had a clear vision with quality and safety as its top priority. There was a clear vision to continue to improve the service they provided. The strategy to deliver this vision was regularly reviewed and discussed with staff. High standards were promoted and owned by all practice staff and teams worked together across all roles. Governance and performance management arrangements had been proactively reviewed. They took account of current models of best practice and the practice is the highest performing practice within the Coventry and Rugby Clinical Commissioning Group (CCG). The practice carried out proactive succession planning for when GP partners retired in the future. There was a high level of engagement with staff and a high level of staff and patient satisfaction. The practice gathered feedback from patients and it had an active patient participation group (PPG).

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

This practice is rated as good for the care of older patients. Patients over the age of 75 had a named GP and were included on the practice's avoiding unplanned admissions list to alert the team to patients who may be more vulnerable. The GPs carried out visits to patients' homes if they were unable to travel to the practice for appointments. At the time of our inspection, the practice had just completed delivering its flu vaccination programme. The practice nurse had arranged to do these at patients' homes if their health prevented them from attending the clinics at the surgery. The practice was the pilot site for the Coventry Integrated Neighbourhood Team, a multi-disciplinary partnership involving health professionals from a wide range of fields and Coventry City Council. This aimed to provide "joined up" patient care across different teams for patients aged over 50 who were at high risk of being admitted to hospital.

People with long term conditions

Good

This practice is rated as good for the care of patients with long term conditions, for example asthma and diabetes. The practice had effective arrangements for making sure that patients with long term conditions were invited to the practice for annual and half yearly reviews of their health. Members of the GP and nursing team at the practice ran these clinics. Patients whose health prevented them from being able to attend the surgery received the same service from one of the practice nurses as home visits were arranged. This included patients in the five care homes who were registered with the practice. Patients told us they were seen regularly to help them manage their health.

Families, children and young people

Good

This practice is rated as good for the care of families, children and young people. The practice held weekly childhood vaccination clinics and offered a weekly 'drop in' session for babies and children which did not require an appointment. A practice nurse, health visitor and GP was available for these sessions. Child flu vaccinations were also provided. The practice had been involved in trials of this vaccination. A midwife came to the practice weekly to see expectant mothers. The practice provided a family planning service.

Summary of findings

Working age people (including those recently retired and students)

Good

This practice is rated as good for the care of working age patients, recently retired people and students. The practice provided extended opening hours until 6.30pm for patients unable to visit the practice during the day. The practice also had arrangements for patients to have telephone consultations with a GP. A 'drop in' session for NHS health checks was held every Saturday morning. Patients were actively encouraged to attend this. The practice referred patients to the smoking cessation support provided by University Hospital in Coventry.

People whose circumstances may make them vulnerable

Good

This practice is rated as good for the care of patients living in vulnerable circumstances. One of the GPs was the lead for learning disability (LD) care at the practice and the practice had an LD register. All patients with learning disabilities were invited to attend for an annual health check. The practice was the pilot site for the Coventry Integrated Neighbourhood Team, a multi-disciplinary partnership involving health professionals from a wide range of fields and Coventry City Council. This aimed to provide "joined up" patient care across different teams for patients aged over 50 who were at high risk of being admitted to hospital and ensure relevant action was taken in a timely way when health needs arose.

People experiencing poor mental health (including people with dementia)

Good

This practice is rated as good for the care of patients experiencing poor mental health (including people with dementia). The practice had a register of patients at the practice with mental health support and care needs and invited them for annual health checks. Staff described close working relationships with the local mental health team which worked with the practice to identify patients' needs and to provide patients with counselling, support and information.

Summary of findings

What people who use the service say

We gathered the views of patients from the practice by looking at 30 CQC comment cards patients had filled in and by speaking in person with nine patients, one of whom was involved with the Patient Participation Group (PPG). The purpose of the PPG was to act as an advocate on behalf of patients when they wished to raise issues and to comment on the overall quality of the service. This ensured patient views were included in the design and delivery of the service.

Many patients who gave us their views had been patients at the practice for many years and their comments reflected this long term experience. Data available from the NHS England GP patient survey showed that the practice scored above average nationally for satisfaction with the practice.

All patients were positive about their experience of being patients at Broad St Surgery. They told us that they were treated with dignity and respect and the GPs, nurses and other staff were caring, kind, sensitive and helpful. Patients expressed appreciation for the service they had received and felt doctors and staff treated them as individuals and valued them. Patients also said they were usually able to obtain appointments with ease and could usually get through to the practice on the telephone without difficulty. Some patients told us they would happily recommend the practice to friends and family members.

Broad Street Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector. The inspection team also included a GP specialist advisor and an expert by experience (a person who has experience of using this particular type of service, or caring for somebody who has).

Background to Broad Street Surgery

Broad St Surgery is situated approximately a mile to the north of Coventry city centre. The practice has been in existence in its current location since 1989, but originated from another local practice which was formed in 1975. There is a branch surgery at Jubilee Crescent Coventry, which we did not inspect on this occasion. The practice has over 8,100 patients across its two sites and is also a training practice for student GPs.

The practice is in an area with a high ethnic population. Over one third of the patients are from South Asia and have health needs that reflect that community, for example, a high rate of diabetes. It is a designated deprived area with a high rate of unemployment. The practice has a higher proportion of patients with long term medical conditions and who smoke.

Within Broad St Surgery there is a range of NHS services including blood testing, chiropody and physiotherapy. Bereavement and mental health counselling sessions are held there. The community midwife visits the practice weekly.

The practice has three GP partners and a salaried GP, all male. Chaperones are used for female patients who request the service, which is well advertised throughout the practice. The practice has two practice nurses. The clinical team are supported by a practice manager, and a team of administrative and reception staff.

The practice has a Primary Medical Services (PMS) contract with NHS England. A PMS contract is a contract between general practices and NHS England for delivering primary care services to local communities.

This was the first time the Care Quality Commission (CQC) had inspected the practice. Based on information we gathered as part of our intelligent monitoring systems we had no concerns about the practice. Data we reviewed showed that the practice was achieving results that were above average with the England or Clinical Commissioning Group in most areas.

The practice does not provide out of hours services to their own patients. Patients are provided with information about local out of hours services which they can access by using the NHS 111 phone number.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. This provider had not been inspected before and that was why we included them.

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

Detailed findings

requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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

How we carried out this inspection

Before this inspection, we reviewed a range of information we held about the practice and asked other organisations to share what they knew. These organisations included Coventry and Rugby Clinical Commissioning Group (CCG), NHS England area team and Healthwatch. We carried out an announced inspection on 6 January 2015. During the inspection we spoke with a range of staff (GPs, nurses, practice manager, reception and administrative staff). We spoke with nine patients who used the service, one of whom was a member of the Patient Participation Group (PPG).

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke to were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, the practice introduced extra checks after a cancer patient failed to receive a notification for a scan. The practice apologised and acted quickly to rectify the situation.

We reviewed safety records, incident reports and minutes of meetings where these had been discussed, for the last 12 years. There had been 12 incidents recorded. This showed the practice had managed these consistently over time and could show evidence of a safe track record over the longer term. We were shown records that demonstrated information gained from clinical audits and health and safety audits were assessed with patient safety in mind. For example, a patient with an urgent medical need had a home visit missed due to a communication error between the practice and the patient. As a result a new method for recording home visits had been introduced.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last 12 years and we were able to review these. Significant events were a regular item on the practice meeting agenda and actions from past significant events and complaints were reviewed at the monthly staff meeting. Evidence seen demonstrated that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff knew how to raise an issue for consideration at the meetings and they felt encouraged to do so. We were shown how the practice had identified and discussed an increase in the prescribing of a sleeping tablet. This was in line with other practices in the area. The practice organised and held a workshop with other local practices in April 2014 and has since recorded a 25% reduction in the usage of this medicine.

We were shown the system used to manage and monitor incidents. We tracked three incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken when a psychiatric patient needed immediate psychiatric help and the practice was unable to contact a relevant professional. The patient had to be sent to accident and emergency, which was against the wishes of the GP. The practice raised their concerns at the highest level within the Coventry and Rugby Clinical Commissioning Group (CCG) and as a result was instrumental in the formation of a psychiatric consultant helpline within the CCG. This had resulted in a trained psychiatric professional being available to give telephone advice to healthcare services within the CCG during office hours. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated in staff meetings to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. For example, changes to the use of diabetes medication. Staff also told us alerts were discussed during meetings held for clinical staff to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their training. 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. Safeguarding concerns were discussed at the monthly multi-disciplinary team meetings and GPs told us safeguarding alerts were placed on the records of vulnerable patients.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. We were shown training certificates to demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who the leads were and who to speak to in the practice if they had a safeguarding concern.

Good

Are services safe?

The lead safeguarding GP was aware of vulnerable children and adults who were registered at the practice and records demonstrated good liaison with partner agencies such as the local authority.

A GP told us of a recent incident that involved a victim of domestic abuse. With the patient's permission, the GP contacted Social Services and the police. The patient stayed safely at the surgery until the police were able to arrange to take the patient to a safe place later that same day.

There was a chaperone policy in place, which was visible on the waiting room noticeboard and in consulting rooms. We saw records that demonstrated all nursing staff had been trained to be a chaperone and understood the requirements.

Systems were in place to identify potential areas of concern. For example, to identify children and young people with a high number of accident and emergency attendances and the follow up of children who persistently failed to attend appointments such as childhood immunisations. Clinical staff followed up these concerns.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example, patterns of antibiotic prescribing within the practice. The practice employed a practice medicines co-ordinator who analysed prescription trends and medicine trends to improve patient care and prevent over-prescribing. A pharmacy technician visited the practice weekly to assist with medicine management reviews and recommend best practice. Out of 77 practices within the CCG area, Broad St Surgery had been ranked eighth for best practice in prescribing.

We saw there were Patient Group Directions (PGD) in place to support the nursing staff in the administration of vaccines. A PGD is a written instruction from a qualified and registered prescriber, such as a doctor, for a nurse or appropriately trained person to administer a medicine to groups of patients without individual prescriptions. We saw the PGDs had been signed by all the nurses who administered the vaccines and authorised by a manager. This meant that staff and managers were informed of any changes to the PGD. There was also a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. No stocks of controlled drugs were held.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Cleanliness and infection control

We observed the premises to be visibly clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. The practice used a contract cleaning service. Patients we spoke with told us they always found the practice clean, tidy and had no concerns about cleanliness.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received regular updates. We saw evidence that the lead had carried out an infection control audit during October 2014 and annually in previous years. Any improvements identified for action were completed on time. Minutes of practice meetings showed that the findings of the audits were discussed. No concerns had been identified during the most recent infection control audit.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. They included the safe use and disposal of sharps; use of personal protective equipment (PPE); spills of blood and bodily fluid amongst others.

Good

Are services safe?

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be fatal). We saw records that confirmed the practice carried out annual checks in line with this policy to reduce the risk of infection to staff and patients.

There were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades. We saw evidence that their disposal was arranged through a suitable company.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date, March 2014. A schedule of testing was in place.

Staffing & Recruitment

We were shown how the practice ensured there were sufficient numbers of suitably qualified, skilled and experienced staff on duty each day. There was a staff rota throughout the week and always a member of clinical staff on duty. Some administrative staff were part time, so staff cover was also available if a staff member was unexpectedly absent.

We saw how the practice had monitored their workforce and reviewed their workforce requirements to ensure sufficient staff were available to meet the needs of the population they served. Management confirmed they had sufficient staff on duty throughout the week. At the time of our inspection, the practice had advertised for a new GP partner, but at the time of our inspection had been unable to identify a suitable candidate.

We looked to see what guidance was in place for staff about expected and unexpected changing circumstances in respect of staffing. We saw a selection of policies and procedures in place, for example, staff sickness, and planned absences.

We saw how if a shortfall of GPs ever occurred, for example, as a result of sickness, locum GPs could be used, for which a service level agreement was in place. We were shown the business continuity plan which had been adopted by the practice which advised what to do should there be a shortage of GPs and practice staff. This would help to ensure sufficient availability of GPs to continue the primary care service provision to patients.

The practice had a comprehensive and up-to-date recruitment policy in place which included a full skills assessment. The policy detailed all the pre-employment checks to be undertaken on a successful applicant before that person could start work in the service. This included identification, references and a criminal record check with the Disclosure and Barring Service (DBS). When DBS checks were not required, for example, for administrative staff who did not work alone with patients, a risk assessment had been carried out. We looked at a sample of recruitment files for GPs, administrative staff and nurses. They demonstrated that the recruitment procedure had been followed. All staff were issued with a staff handbook which covered every area of the practice and staff roles. However, the practice had a consistent and long serving staff team and had not needed to recruit administrative staff for the last six years.

Additionally, the practice was also a training practice for doctors and regularly hosted student GPs from university. We saw how they were given appropriate training and supervision with the practice.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative who had received appropriate training for the role.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed during staff meetings.

Good

Are services safe?

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest and anaphylaxis (an allergic reaction).

Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather including flooding, unplanned sickness and access to the building. The practice had carried out a fire risk assessment in July 2014 that included actions required to maintain fire safety. If the practice building was unavailable, we saw arrangements were in place for the use of a local community centre.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care & treatment in line with standards

Patients' needs were assessed and care and treatment was planned and delivered in line with their individual wishes. All patients we spoke with were happy with the care they received and any follow-up needed once they obtained an appointment and said GPs and practice staff provided high quality care.

Clinical staff managed the care and treatment of patients with long term conditions, such as diabetes, asthma and hypertension (high blood pressure). We found there were appropriate systems in place to ensure patients with long term conditions were seen on a regular basis.

Patients who required palliative care (care for the terminally ill and their families) were regularly reviewed. Their details were passed to the out of hours practice each weekend to ensure care would continue when the practice was closed.

Staff showed us how they used the National Institute for Health and Care Excellence (NICE) templates for processes involving diagnosis and treatments of illnesses. NICE guidance supported the surgery to ensure the care they provided was based on latest evidence and of the best possible quality. Patients received up to date tests and treatments for their disorders. We saw records of meetings that demonstrated revised guidelines were identified and staff were trained appropriately.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. Examples of completed clinical audits included the management of children on child protection schemes within primary care. This was initiated after a serious case review had been launched in Coventry following the neglect of a child which made national headlines. Although the practice had not been directly involved with the child concerned, the practice felt it appropriate to review its own procedures as a matter of good practice. The audit aimed to investigate whether patients on the child protection register were suitably followed up when they failed to attend appoints at the practice and to investigate whether children on the child protection register were up to date with their vaccinations.

The practice ensured every child who was on the child protection register had a note placed on their patient record; the immunisation status of all such children was checked and where vaccinations had been missed, parents were contacted by telephone.

Dates had been set to repeat audits to continue to determine their effectiveness. We found other monitoring the practice had carried out included patients with chronic conditions. Some of this monitoring was carried out as part of the Quality and Outcomes Framework (QOF). This is a national performance measurement tool. The practice was the highest performing practice within the Coventry and Rugby Clinical Commissioning Group (CCG) for QOF. The practice had obtained the maximum number of QOF points in eight of the last 10 years.

The practice was able to identify and take appropriate action on areas of concern. For example, a higher than average number of patients had been identified with respiratory tract infections. Historically, Coventry had been below the national average. The telephone triage system was changed to quickly identify these patients to enable them to be seen quickly by a clinician, for example, if a patient mentioned having a cough or a sore throat. Following this, the practice has seen a significant reduction in the prescribing of antibiotics for such patients.

We also saw evidence that the practice organised training events with other local practices to identify and discuss best practice.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending courses such as annual basic life support. All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff had annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was

Good

Are services effective?

(for example, treatment is effective)

proactive in providing training and funding for relevant courses. As the practice was a training practice, doctors who were training to be qualified as GPs had access to a senior GP throughout the day for support.

Practice nurses were expected to perform defined duties which were outlined in their job description and were able to demonstrate that they were trained to fulfil these duties. For example, in the administration of vaccines. We were shown certificates to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. It received blood test results, x-ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances within the last year of any results or discharge summaries that were not followed up appropriately. Any concerns were raised in clinical staff meetings.

The practice held integrated team meetings every two weeks to discuss concerns, for example, the needs of complex patients, those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented. Clinical staff and the GP partners met regularly outside of practice opening times. We saw evidence that clinical updates, difficult cases, significant events and emergency admissions to hospital were discussed and actions identified.

We saw records that confirmed the practice worked closely with the community midwife service, health visitors, community mental health professionals and community drug teams. Clinics were held for blood testing, chiropody and anti-coagulant (blood thinning) testing to which patients were referred.

The practice was part of and had been the pilot site for the Coventry Integrated Neighbourhood Team. This was a multi-disciplinary partnership involving health professionals from a wide range of fields and Coventry City Council. This aimed to provide "joined up" patient care across different teams for patients aged over 50 who were at high risk of being admitted to hospital. This ensured when a medical need arose, all relevant professional agencies would be informed and timely help provided.

Within the waiting room there was a large range of information leaflets about local services. Most of this information was available in other languages. Relevant information was also displayed on a large screen within the patient waiting room.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made most of its referrals through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to the Accident and Emergency (A&E) department.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patient care. All staff were fully trained on the system. This software enabled scanned paper communications such as those from hospital to be saved in the system for future reference. The practice aimed to operate in a 'paperless' way and we shown how documents were securely stored in case of a failure with information technology.

Consent to care and treatment

There were processes to seek, record and review consent decisions. We saw there were consent forms for patients to sign agreeing to minor surgery procedures. We saw that the need for the surgery and the risks involved had been clearly

Good

Are services effective?

(for example, treatment is effective)

explained to patients. We also saw evidence that audits of minor surgery were also carried out. These were carried out at the branch surgery in Jubilee Crescent, Coventry which had an ear, nose and throat suite (ENT).

We saw the process in place to obtain signed consent forms for children who had received immunisations. The practice nurse was aware of the need for parental consent and what action to follow if a parent was unavailable. There was information available for parents informing them of potential side effects of the immunisations. The GPs and nurses that we spoke with demonstrated a clear understanding of the importance of determining if a child was Gillick competent especially when providing contraceptive advice and treatment. A Gillick competent child is a child under 16 who has the legal capacity to consent to care and treatment. They are capable of understanding the implications of the proposed treatment, including the risks and alternative options.

Staff we spoke with had an understanding of the Mental Capacity Act 2005 and demonstrated knowledge regarding best interest decisions for patients who lacked capacity. Mental capacity is the ability to make an informed decision based on understanding a given situation, the options available and the consequences of the decision. People may lose the capacity to make some decisions through illness or disability.

The practice had access to interpreting services to ensure patients understood procedures if their first language was not English.

Health Promotion & Prevention

We saw all new patients were offered a consultation with the practice nurse when they first registered with the practice. If any medical concerns were found, the patient was referred to the GP or another healthcare professional if more appropriate. The practice also offered NHS health checks to all its patients aged 40-75. A 'drop in' session for NHS health checks was also held every Saturday morning. Patients were actively encouraged to attend this and no appointment was needed. The practice's performance for cervical smear uptake was above average compared to others in the Clinical Commissioning Group (CCG) area.

We were shown work the practice had carried out to identify and promote particular health needs within the area. For example, the introduction of the separate weekly 'drop in' sessions for babies and NHS health checks was well attended by patients. Patients who smoked were referred to the smoking cessation support provided by University Hospital in Coventry.

Due to the high prevalence of diabetes within the local community, the practice has undertaken a large amount of appropriate research into effective diagnosis, treatment and management of the condition. The practice undertook research with the University College Hospital diabetes network and the practice nurse had initiated a UK wide study into diabetes through her university placement.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

All patients we spoke with were very happy with the care they received and any follow-up needed once they obtained an appointment. All patients felt they were consistently treated with dignity and respect by all members of staff. Most patients commented on how friendly and helpful all staff and GPs were.

During our inspection we observed within the reception area how staff interacted with patients, both in person and over the telephone. Staff were helpful and empathetic, warm and understanding towards patients. Staff we spoke with told us excellent patient care was crucial and their behaviours displayed this at all times. We saw evidence staff had received customer service training to assist with the way they handled patients.

In February 2014, 225 patients completed a patient survey issued by the practice. Of those patients who responded 92.2% of patients said they found staff at the practice very friendly and helpful. This was above the national average of 89.1%. This sample represented 2.7% of the patient list.

We saw that patients' privacy and dignity was respected by staff during examinations. We saw curtains could be drawn around treatment couches in consultation rooms. This would ensure patients' privacy and dignity in the event of anyone else entering the room during treatment.

Care planning and involvement in decisions about care and treatment

We looked at patient choice and involvement. Staff explained how patients were informed before their treatment started and how they determined what support was required for patients' individual needs. Clinical staff told us they discussed any proposed changes to a patient's treatment or medication with them. They described treating patients with consideration and respect and said they kept patients fully informed during their consultations and subsequent investigations. Patients we spoke with confirmed this. Patients had the information and support available to them to enable them to make an informed decision about their care and treatment needs.

Clinical and administrative staff were able to speak a variety of languages and patients told us they felt GPs understood their needs. Patients told us that their GP listened to them and gave us examples of advice, care and treatment they had received. Some patients indicated that they had long term health conditions and said that they were seen regularly.

Patient/carer support to cope emotionally with care and treatment

Some of the information we received was from patients who were also carers. In these cases patients described the support and compassion they and their relative had received from the team at the practice. Other patients also described feeling well supported emotionally by the practice.

After bereavement, the practice contacted families to check their well-being and to offer the opportunity to speak with a member of the team. A counsellor was available for appointments at the practice. All GPs and relevant staff were informed if a family member had been recently bereaved, so appropriate support could be given. Information was provided about organisations specialising in providing bereavement support, for example, Coventry Carers.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. For example, the practice had a register of patients with mental health support and care needs. Each person on the register was invited for an annual review. Staff explained that they had good working relationships with the local mental health team.

The practice planned its services carefully to meet the demand of the local population. We saw minutes of meetings that demonstrated regular meetings were held to discuss capacity and demand. As a result of this, changes were made to staffing and clinic times when required. Services were also reviewed in the wider context of the local health community. Review meetings were held with the Clinical Commissioning Group (CCG) and a GP attended these.

GPs provided examples of how the practice responded to the needs of the local community. For example, following an emphasis on identifying patients with dementia, we were shown how the practice had exceeded the target of identifying 80% of those patients within six weeks and had been advised by the Clinical Commissioning Group (CCG) that it had reached its target.

The practice had an established Patient Participation Group (PPG) in place. The purpose of the PPG was to act as an advocate on behalf of patients when they wished to raise issues and to comment on the overall quality of the service. This ensured that patients' views were included in the design and delivery of the service. We saw how the PPG played an active role and was a key part of the organisation. Regular meetings were held. We saw how the PPG had been involved with promoting the benefits of the telephone triage system and working on the patient survey.

Tackling inequity and promoting equality

Many patients who used Broad St Surgery spoke English as their secondary language. All GPs and most administrative staff were multi-lingual, so could converse with ease with patients. We noted that information leaflets in the practice were available in a variety of languages, as was the information displayed on the visual display unit in the waiting area.

The practice had an induction loop to assist people who used hearing aids and staff could also take patients into a quieter private room to aid the discussion if required. The practice was fully wheelchair accessible.

Access to the service

The practice opened from 8am to 6.30pm every weekday. In addition, a telephone triage system was operated for patients who could not be offered same day appointments. If following a telephone call back, a patient needed to be seen the same day they would be called into the practice. Outside of these times and during the weekend, an out of hours service was provided by another organisation and patients were advised to call the NHS 111 service. This ensured patients had access to medical advice outside of the practice's opening hours. Additionally, the practice was within walking distance or a frequent direct bus journey to the local walk in centre. This was reflected in the higher than average number of patients from the practice who attended the walk in centre.

Appointments could be booked for the same day, within two weeks or further ahead. Patients could make appointments and order repeat prescriptions through an on-line service. Home visits were available for patients who were unable to go to the practice.

In February 2014, 225 patients completed a patient survey issued by the practice. 91.9% said their GP gave them enough time which was above the national average of 91.5%. 82.5% of patients said it was easy to get through to the practice on the telephone compared with the national average of 68.8%. 78.1% of patients were happy with the waiting time for their appointment once they had arrived at the practice, compared with a national average of 67.8%. This sample represented 2.7% of the patient list.

The information from CQC comment cards and patients we spoke with indicated that the service was easily accessible and that patients were usually able to get an appointment on the same day they phoned if this was needed.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Listening and learning from concerns & complaints

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

We were shown how patients' concerns were listened to and acted upon. There was information about how to complain displayed in the waiting area and within the patient information pack. All of the patients we spoke with said they had never had to raise a formal complaint. The complaints procedure identified how complaints would be dealt with. It also identified the timescales for responding to and dealing with complaints. The practice had a complaints summary which summarised the complaints for each year. This was used to identify any trends. Details of the complaints procedure were displayed in the waiting room and within the patient information pack.

We looked to see whether the practice adhered to its complaints policy. Six complaints had been received within the last 12 months. None related to safety incidents and there were no recurring themes. We found that the complaints had been dealt with appropriately and within the timescales set out in the practice's complaints policy. One complaint related to a patient who felt they had been spoken to in an inappropriate way by a staff member. We saw the patient had received an apology and staff had been given appropriate customer service training.

It was also clear that verbal complaints were dealt with in the same way as written complaints. If a patient telephoned the practice to complain, the practice manager would immediately take the call if available.

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 aimed to provide high quality care. This was referred to on the practice website, in literature produced by the practice and by staff during our inspection. In discussion with staff, it was evident that the team at the practice shared a desire to provide patients with a safe and caring service where people were treated with dignity and respect. The practice vision and values included a desire to understand the potential vulnerability of patients.

The GP partners held quarterly partners' meetings outside of surgery opening times, to discuss important issues such as forward planning, succession planning, practice objectives and future direction and vision. The practice regularly reviewed these objectives at staff meetings.

We spoke with three GPs and four members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these.

GPs and management demonstrated how they embraced change and actively sought opportunities for the practice to be innovative. For example, the practice frequently undertook clinical trials for new medicines. This has included the new nasal flu vaccination for children. The practice was the pilot site for the Coventry Integrated Neighbourhood Team, a multi-disciplinary partnership involving health professionals from a wide range of fields and Coventry City Council. This aimed to provide "joined up" patient care across different teams for patients aged over 50 who were at high risk of being admitted to hospital. The practice has piloted technological innovations. This has included piloting the new electronic prescriptions for the CCG.

Governance Arrangements

The GP partners all had lead roles and specific areas of interest and expertise. This included governance with clearly defined lead management roles and responsibilities. During the inspection we found that all members of the team we spoke with understood these roles and responsibilities. There was an atmosphere of teamwork, support and open communication. The practice held a regular meeting of clinical staff which included discussions about any significant event analyses (SEAs) that had been done. All of the clinical staff attended these meetings and where relevant, other staff also took part in the discussions about SEAs. This helped to make sure that learning was shared with appropriate members of the team. GPs also met regularly to discuss clinical and governance issues. Succession planning was in place for all GP partners, although most were a number of years away from retirement. The practice sought to identify suitable candidates at an early stage to ensure a seamless transition took place.

The practice used information from a range of sources including their Quality and Outcomes Framework (QOF) results and the Clinical Commissioning Group (CCG) to help them assess and monitor their performance. This is an annual national performance measurement tool. The practice was one of the highest performing practice within the Coventry and Rugby Clinical Commissioning Group for the Quality and Outcomes Framework (QOF) and had obtained maximum QOF points in eight of the last 10 years. We saw examples of completed clinical audit cycles, such as emergency admissions of children to hospital. This demonstrated the practice reviewed and evaluated the care and treatment patients received.

Leadership, openness and transparency

The practice had a team of partners, some of whom had worked together over a number of years to provide stable leadership. They were supported by a practice manager who was described by clinical and other staff as playing a crucial role in the management of the practice. Staff told us they felt well supported and that all of the partners were always approachable. The staff we spoke with told us that Broad St Surgery was an excellent place to work where staff felt supported, appreciated and cared for. Staff told us how key practice management were available for contact about staff concerns at evenings and weekends, outside of working hours.

Practice seeks and acts on feedback from users, public and staff

The practice had an established Patient Participation Group (PPG) in place. The purpose of the PPG was to act as an advocate on behalf of patients when they wished to raise issues and to comment on the overall quality of the service. This ensured patient views were included in the design and delivery of the service.

We saw minutes of previous PPG meetings and saw how the PPG has been fully involved in initiatives such as promoting the telephone triage service and the electronic prescription system.

Are services well-led?

Good

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

All staff were fully involved in the running of the practice. We saw there were documented regular staff meetings. This included meetings for clinical staff and meetings that included all staff. This ensured staff were given opportunities to discuss practice issues with each other. Staff were encouraged to think 'outside of the box'. For example, following staff suggestions, Saturday morning NHS health checks were introduced without the need for an appointment. There was a clear culture of openness and 'no blame' in place. This meant staff could raise concerns without fear of reprisals and the practice's whistleblowing procedure supported this.

The practice asked patients who used the service for their views on their care and treatment and they were acted on. This included the use of surveys to gather views of patients who used the service. We saw that there were systems in place for the practice to analyse the results of the survey for information so that any issues identified were addressed and discussed with all staff members. We saw records of discussions within the minutes of staff meetings. All the patients we spoke with on the day of our inspection told us they received a high quality service from the practice. It was clear patients experienced the quality of service that met their needs.

Management lead through learning & improvement

We saw evidence that the practice was focussed on quality, improvement and learning. There was a well-established staff development programme for all staff within the practice, whatever their role. As an example of staff learning and development, the practice nurse had initiated a UK wide study into diabetes as part of a university placement.

The whole practice team had sessions each year for 'protected learning'. This was used for training and to give staff the opportunity to spend time together. Topics such as customer service skills and information technology changes had been covered.

The results of significant event analyses and clinical audit cycles were used to monitor performance and contribute to staff learning.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.