Churchfields Surgery

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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We inspected this service on 31 October 2014 as part of our new comprehensive inspection programme.

The overall rating for this service is good. We found the practice to be good in the safe, effective, caring, responsive and well-led domains. We found the practice provided good care to older people, people with long term conditions, families, children and young people, the working age population and those recently retired, people in vulnerable circumstances and people experiencing poor mental health.

Our key findings were as follows:

- Patients were kept safe because there were arrangements in place for staff to report and learn from incidents that occurred. The practice had a system for reporting, recording and monitoring significant events over time.
- There were systems in place to keep patients safe from the risk and spread of infection.
- Evidence we reviewed demonstrated that patients were satisfied with how they were treated and that this was with compassion, dignity and respect. It also demonstrated that the GPs were good at listening to patients and gave them enough time.
- The practice had an open culture that was effective and encouraged staff to share their views through staff meetings and significant event meetings.

We saw an area of outstanding practice:

- The practice had engaged with the expert patients' programme which aimed to educate patients who were living with a long-term health condition to take more control over their health. This was to be achieved through patients understanding and managing their conditions, which would help them lead an improved quality of life. Becoming an expert patient was seen as empowering for people with chronic 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. The practice had a system in place for reporting, recording and monitoring significant events over time. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services. 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 these guidelines were positively influencing and improving practice and outcomes for patients. Data showed that the practice was performing highly when compared to neighbouring practices in the Clinical Commissioning Group (CCG). The practice was using innovative and proactive methods to improve patient outcomes and it linked with other local providers to share best practice.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for almost all aspects of care. Feedback from patients about their care and treatment was consistently and strongly positive. We observed a patient-centred culture. Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. We found many positive examples to demonstrate how people's choices and preferences were valued and acted on. Views from managers of care homes supported by the practice were very positive and aligned with our findings.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice had initiated positive service improvements for its patients that were over and above its contractual obligations. It acted on suggestions for improvements and changed the way it delivered services in response to feedback from the patient participation

Summary of findings

group (PPG). The practice reviewed the needs of its local population and engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these had been identified.

Patients told us it was easy to get an appointment with a named GP or a GP of choice, with continuity of care and urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.

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. The strategy to deliver this vision had been produced with stakeholders and 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 and took account of current models of best practice. The practice carried out proactive succession planning. There was a high level of constructive engagement with staff and a high level of staff satisfaction. The practice gathered feedback from patients using new technology, and it had a very 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

The practice is rated as good for the care of older people. For example, we saw that the practice worked to the Gold Standard Framework (GSF) for palliative care. We saw that regular multi-agency and cross practice meetings were held and recorded. The GSF is a practice based system to improve the quality of palliative care in the community so that more patients received supportive and dignified end of life care, where they chose.

Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example in dementia and end of life care. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. For example, the practice had engaged with the expert patients' programme which aimed to educate patients who were living with a long-term health condition to take more control over their health. This was to be achieved through patients understanding and managing their conditions, which would help them lead an improved quality of life. Becoming an expert patient was seen as empowering for people with chronic conditions.

Staff told us that the practice provided support for patients through the virtual ward scheme. This scheme had been introduced to help support patients with complex needs. The virtual ward was staffed by a team of nurses who worked closely with a patient's own GP and a range of health and social care professionals. The aim of the ward was to improve the quality of life; reduce unplanned hospital admissions; facilitate patients to self-care; to provide end of life care that was appropriate; and provide support and personalised self-management plans.

Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. When needed longer appointments and home visits were available. All these patients had a named GP and structured annual reviews to

Summary of findings

check their health and medicine needs were being met. For those people with the most complex needs the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Systems were in place for identifying and following-up children who were at risk. For example, children and young people who failed to attend appointments or clinics. Immunisation rates were relatively high for all standard childhood immunisations.

Patients told us and we saw evidence that children and young people were treated in an age appropriate way and recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. We were provided with good examples of joint working with midwives, health visitors and school nurses. Emergency processes were in place and referrals were made for children and pregnant women who had a sudden deterioration in health

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offer continuity of care. The practice was proactive in offering a full range of health promotion and screening which reflected the needs of this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with learning disabilities. The practice had carried out annual health checks for patients with learning disabilities.

The practice regularly worked as part of multi-disciplinary teams in the case management of vulnerable patients. The practice had sign-posted vulnerable patients to various support groups and third sector organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff told us they were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours.

Summary of findings

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice had in place advance care planning for patients with dementia.

The practice had identified that there were poor external provisions for patients with mental health issues in the locality. The waiting time for referrals to the Improving Access to Psychological Therapies (IAPT) services was two to three months and the waiting time for the counsellor attached to the practice was one year. The GPs managed this situation by providing psychological support for patients themselves. Additional support information was available from their website.

Summary of findings

What people who use the service say

We spoke with two patients on the day of the inspection. Patients told us they were extremely satisfied with the service they received at the practice. They told us they could always get an appointment at a time that suited them, including same day appointments. They had confidence in the staff and said they were always treated with dignity and respect.

We reviewed the 24 patient comments cards from our Care Quality Commission (CQC) comments box that we had asked to be placed in the practice prior to our inspection. We saw that 19 of these comments were extremely positive. They commented that staff were always friendly and helpful. They also told us they felt listened to and did not have to wait for appointments. Five patients indicated that they had found their experiences at the practice less positive but there was no common themes raised among these.

Patients confirmed on the comment cards that they could see a GP on the same day if they needed to and they could see another GP if there was a wait to see the GP of their choice. Patients we spoke with confirmed that they had always been able to make appointments when they were in urgent need of treatment on the same day of contacting the practice.

We looked at the national GP Patient Survey 2013 and found that patients were generally satisfied with the appointments system, although other results for the patient survey were varied. Data showed that 71% of patients found it easy to get through to the practice by phone which was below the national average; 97% found the last appointment they had was convenient; 84% described their experience of making an appointment as good; 61% usually waited 15 minutes or less after their appointment time to be seen; 77% were satisfied with the practice's opening hours and 83% would recommend this practice to someone new to the area. All these results were above the national average.

Outstanding practice

- The practice had engaged with the expert patients' programme which aimed to educate patients who were living with a long-term health condition to take more control over their health. This was to be achieved through patients understanding and managing their conditions, which would help them lead an improved quality of life. Becoming an expert patient was seen as empowering for people with chronic conditions.

Churchfields Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector and a GP specialist advisor. The team also included a second CQC inspector.

Background to Churchfields Surgery

Churchfields Surgery is located in Bromsgrove in Worcestershire and provides primary medical services to patients. Churchfields Surgery has a General Medical Services (GMS) contract. The GMS contract is the contract between general practices and NHS England for delivering primary care services to local communities. The practice area is centered in Bromsgrove and includes outlying areas of Fairfield, Bourneheath, Catshill and Dodford.

Churchfields Surgery is an approved GP training practice. This means that fully qualified doctors who want to enter into general practice as registrars spend 12 months working at the practice to gain the experience they need to become a GP. Churchfields website tells patients that the practice believes that excellence should be passed on to those training in medicine which is why they host qualified doctors completing their specialist training in General Practice. The practice also supervises a number of medical students. Patients have the option to see the trainees. Patients are asked to sign consent forms prior to their appointments when they see a medical student. Every consultation with a medical student is reviewed by a GP.

The practice has four male and six female GPs, a practice manager, a business manager, six practice nurses, one nurse practitioner who has extended duties such as prescribing certain medicines and referring patients for tests; five healthcare assistants, administrative and reception staff. There were 13355 patients registered with the practice at the time of the inspection. The practice is open on Mondays from 7am to 6.30pm, 8am to 6.30pm Tuesday to Friday. Extended hours appointments from 6.30pm till 8pm on Thursdays and alternate Saturdays 8am till 11.30am for pre-booked appointments only. Home visits are available for patients who are too ill to attend the practice for appointments.

The practice treats patients of all ages and provides a range of medical services. Churchfields Surgery has a higher percentage of its practice population in the 65 and over, and the 75 and over age groups than the England average. The practice provides a number of clinics such as asthma, diabetes, health promotion and teenage lifestyle clinics. It offers child immunisations, minor surgery, family planning, and maternity and child health surveillance services. Practice nurses can be seen by appointment for blood tests, ear syringing, dressings, injections, travel and routine immunisations, blood pressure, diabetic and asthma checks, cervical smears and general health advice. The practice does not provide an out of hours service but has alternative arrangements in place for patients to be seen when the practice is closed.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal

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

This provider had not been inspected before and that was why we included them.

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

How we carried out this inspection

Before our inspection of Churchfields Surgery, we reviewed a range of information we held about this practice and asked other organisations to share what they knew. We contacted Redditch and Bromsgrove Clinical Commissioning Group (CCG), the NHS England local area team (LAT) and the Local Medical Committee (LMC) to consider any information they held about the practice. We spoke with the managers of two residential homes supported by the practice. We also supplied the practice with comment cards for patients to share their views and experiences of the practice.

We carried out an announced inspection on 31 October 2014. During our inspection we spoke with a range of staff that included four GPs, the practice manager, the finance manager, a nurse practitioner, two nurses, a health care assistant and reception staff. We also looked at procedures and systems used by the practice.

We observed how staff interacted with patients who visited the practice. We reviewed 24 comment cards where patients and members of the public shared their views and experiences of the practice.

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

- 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 patients and what good care looks like for them. The population groups are:

- Older people
- People with long-term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

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, national patient safety alerts as well as comments and complaints received from patients. Staff told us they were aware of their responsibilities to raise concerns, and how to report incidents and near misses.

We reviewed safety records and incident reports for the last 12 months. This showed the practice had managed these consistently over time and could evidence a safe track record over the longer term.

The incident log provided details of the event, actions and review of the current situation. The log showed that a variety of events had been recorded. We saw that the practice looked at internal procedures and offered feedback to outside agencies. They made improvements where necessary and shared their learning with outside agencies and the patient involved.

Discussion with the registrars (qualified doctors who want to enter into general practice spend 12 months working at the practice to gain the experience they need to become a GP), and a receptionist made it clear they would feel confident to report any concerns. Another example was given of a recent change in the reception staff rota which had been initiated by the receptionists. This rota provided more comprehensive cover at busy times.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events that had occurred and we were able to review those that had occurred during the last 12 months. Significant events were a standing item on the practice meeting agenda and a dedicated meeting occurred every month to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff told us they were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so.

We tracked five incidents and saw they were comprehensively completed with regard to content, subject matter and procedures followed. For example, a significant event had recorded where a patient had not attended for regular blood tests required of their condition. An action plan was put into place to ensure that patients who needed regular blood tests were followed up if they failed to attend the clinics. The practice had introduced a safety net system using one of the health care assistants as a coordinator. A manual record was established to highlight patients requiring tests or referrals in the future who might be missed and arrangements were made to contact the patient to follow up if they failed to attend. We saw that the protocol for completing patient tests and referrals had been updated in 2014 to reflect these changes.

National patient safety alerts, medical devices alerts and other patient safety alerts were shared with practice staff through the electronic system used by the practice called Docman. Staff we spoke with gave examples of recent alerts that were relevant to the care they were responsible for. They told us that alerts were discussed at practice meetings to ensure everyone was aware of any issues relevant to the practice and what action, if any, needed to be taken. We saw that any action taken had been recorded appropriately and in a timely manner.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records made available to us showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Contact details were easily accessible.

The practice had a dedicated GP appointed as the lead for safeguarding vulnerable adults and children. The GP had been trained to an appropriate level (advanced), and demonstrated they had gained the necessary knowledge from this training to enable them to fulfil this role. Staff confirmed they knew who the safeguarding lead was and that they were able to access policies and procedures through the practice's intranet site. Staff explained to us the processes they would follow in the event they became concerned that a patient may be at risk of harm. For example, staff told us of a concern that had involved a

young person and their family who lived in disadvantaged circumstances. The practice was involved in multi-agency meetings to monitor and ensure the safety of the patient concerned.

Patient's individual records were written and managed in a way that helped to ensure their safety. Records were kept on an electronic system called EMIS, which collated all communications about the patient including scanned copies of communications from hospitals. We saw that the system was used to highlight vulnerable patients and ensured that staff were alerted to any relevant issues when patients attended appointments. GPs appropriately used the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated effective working relationships with partner agencies such as the police and social services.

A chaperone policy was in place and information about the service was visible on the waiting room noticeboard and in consultation rooms. Staff told us that they always asked patients whether they required a chaperone when they received any intimate treatment. Staff told us that chaperone duties were only carried out by clinical staff. We saw records that confirmed that clinical staff had completed chaperone training.

Medicines Management

We saw that the practice had policies and procedures in place for the management of medicines dated June 2014. Staff told us they were aware of these policies and procedures and confirmed they were able to access these as required.

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 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 medicines were kept at the required temperatures. This was being followed by the practice staff, and the action to take in the event of a potential failure was described. The provider may wish to note however, that there were no procedures in place to ensure that non-refrigerated medicines stored in the treatment rooms were kept at the required temperatures.

We saw that standard procedures were in place that set out how the use of controlled drugs was managed. We saw that controlled medicines were stored securely and robust procedures were in place for ordering and dispensing of these medicines. We saw that a clear audit trail was available for the disposal of out of date controlled medicines that belonged to the practice.

The nurses and the health care assistants administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses and the health care assistants had received appropriate training to administer vaccines.

There was a protocol in place for repeat prescribing which was in line with national guidance. We saw this was followed in practice. The protocol complied with the legal framework and covered all required areas. For example, how staff that generated prescriptions were trained and how changes to patients' repeat medicines were managed. This helped to ensure that patient's repeat prescriptions were still appropriate and necessary. A member of the nursing staff was an independent prescriber, a nurse who was specially trained to prescribe any licensed and unlicensed drugs within their clinical competence. They confirmed they received regular supervision and support in their role as well as updates in the specific clinical areas of expertise for which they prescribed.

All prescriptions were reviewed and signed by a GP before they were given to the patient. We saw that blank prescription forms and prescription pads were tracked through the practice and kept securely at all times.

Cleanliness & 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. Patients told us on the comment cards that they always found the practice clean and had no concerns about cleanliness or infection control. Hand hygiene technique signs were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and

hand towel dispensers were available in treatment rooms. We saw hand sanitation gel was available for staff and patients throughout the practice including the reception area.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. For example, personal protective equipment including disposable gloves, aprons and coverings for couches were available for staff to use. Staff described to us how they used these in order to comply with the practice's infection control policy.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice's infection control policy and carry out staff training. We saw records that showed staff had received induction training about infection control specific to their role and there after annual updates. Staff we spoke with confirmed this. We saw evidence that the lead had carried out regular audits and that any improvements identified for action were completed on time. Practice meeting minutes showed that the findings of these audits had been discussed.

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. There were guidelines informing staff what to do in the event of a needle stick injury. We saw evidence that staff had received the relevant immunisations and support to manage the risks of health care associated infections.

The practice had policies and systems in place to protect staff and patients from the risks of health care associated infections. For example, we saw that there was a water flushing protocol in place for the management of Legionella (a germ found in the environment which can contaminate water systems in buildings). This included flushing through showers that were not frequently used. Records were kept to show that these checks had been done.

Equipment

Staff told us they had equipment available so they could carry out diagnostic examinations, assessments and treatments. They told us that equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. We saw that portable electrical equipment was clearly labelled and dated as having been tested in 2014.

We saw records that confirmed that measuring equipment used in the practice was checked and calibrated each year to ensure they were in good order for the safety of patients and staff. We saw that calibration (testing for accuracy) of relevant equipment such as weighing scales and blood pressure monitoring machines had been carried out in 2014.

Staffing & Recruitment

Recruitment and selection processes were in place to ensure that staff were suitable to work at the practice. We saw a policy which outlined the recruitment process to be followed for the recruitment of all staff. The policy detailed all the pre-employment checks to be undertaken before a person could start to work at the practice.

We saw that Disclosure and Barring Service (DBS) checks had been completed for all staff who worked at the practice. DBS checks help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable adults and children.

Patients were cared for by suitably qualified and trained staff. There was a system in place that ensured health professionals' registrations were in date. We looked at a sample of recruitment records for clinical and administrative staff. These showed that pre-employment checks had been done to ensure that clinical staff held up to date qualifications with their governing bodies such as the General Medical Council (GMC) and Nursing and Midwifery Council (NMC). This ensured that GPs and nurses were registered with their appropriate professional body and were considered fit to practice.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of

staff, including nursing and administrative staff, to cover each other's annual leave. Reception staff told us about recent changes that had been made to their rota which they had initiated. This had improved reception cover and improved the service for patients.

Monitoring Safety & 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 medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy in place. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

The practice building was managed by a separate company. They undertook annual and monthly checks of the building and the environment. We looked at records that confirmed these checks took place. For example, we saw that the fire system had been inspected by an external contractor quarterly, and the most recent check had been done on 29 October 2014.

Identified risks were discussed at GP partners' meetings, within team meetings and shared with all staff by email. For example, the infection control lead confirmed that they cascaded information to all staff by email to implement any changes identified through audits. We saw that the last audit of infection control had been carried out in 10 September 2014 and the findings and action plan resulting from this had been shared with staff. Staff we spoke with confirmed this.

Emergency processes were in place and referrals were made for patients with long term conditions who experienced a sudden deterioration in their health. Longer appointments and home visits were made available. All these patients had a named GP and structured annual reviews to check their health and medicine needs were being met. We saw that the GPs worked with relevant health and care professionals to deliver a multidisciplinary package of care for those people with the most complex needs.

The GPs and practice manager informed us there were sufficient appointments available for high risk patients, such as patients with long term conditions, older patients, and babies and young children. Patients were offered appointments that suited them, for example same day, next day or pre-bookable appointments with their choice of GP. There was a system in place that ensured patients with long term conditions were invited for regular health and medicine reviews, and followed up if they failed to attend.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage medical emergencies. We saw records that showed all staff had received training in basic life support and staff confirmed they knew how to respond to a medical emergency should one occur. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). All staff asked knew the location of this equipment and records we saw confirmed these were checked regularly. Minutes of the practice's significant event meetings showed that a medical emergency concerning a patient had been discussed and that the practice had learned from this and shared this learning appropriately.

We saw that a policy for emergency drugs and equipment was in place, dated August 2014. The policy detailed the location of the drugs and equipment and the procedure for the management of controlled drugs. We saw that emergency medicines were available in the treatment rooms where clinics were held.

Processes were also in place to check that emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use. Staff were able to tell us where these were kept.

There were systems in place to respond to emergencies and major incidents within the practice. Risks identified included power failure, loss of main surgery building, loss of medical records, staff shortage and access to the building. The business continuity plan provided action plans and important contact numbers for staff to refer to which ensured the service would be maintained during any emergency or major incident. For example, contact details of a heating company to contact in the event of failure of the heating system, and utility services such as electricity and water suppliers. The practice manager and GPs confirmed that copies of this plan were held off site with designated management staff.

The practice had carried out a fire risk assessment in November 2013 which gave details of actions required to

Good

Are services safe?

maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills. We saw that risk assessments had been completed for risks associated with spillages, contamination and disposal.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence (NICE). GPs demonstrated that they followed local commissioner's protocols regarding clinical decisions such as changes in care pathways.

We saw minutes of practice meetings where new guidelines were disseminated. The implications for the practice's performance and for patients were discussed and any required actions were agreed. The staff we spoke with and evidence we reviewed confirmed these actions were aimed at ensuring that each patient was given the support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate.

The GPs attended educational meetings facilitated by the Clinical Commissioning Group (CCG), and engaged in annual appraisal and other educational support. The annual appraisal process requires GPs to demonstrate that they have kept up to date with current practice, evaluated the quality of their work and gained feedback from their peers.

GPs told us they each led in specialist clinical areas such as diabetes, joint injections, respiratory disease, heart disease, mental health, and drug and alcohol use. The practice nurses supported this work, which allowed the practice to focus on specific conditions. The nurse practitioner confirmed that they only prescribed for their specialist areas of respiratory, allergies and minor illnesses, dermatology (skin), gynaecology, family planning and contraception.

GPs told us that the practice used the significant specialist expertise within its partnership to maximum effect and patients were often cross referred to other GPs as a result of this. Clinical staff told us they ensured best practice was implemented through regular training, networking with other clinical staff and regular discussions with the clinical staff team at the practice. We were told that GPs were very approachable and that clinical staff would have no hesitation in asking for support or advice if they felt they needed it.

One of the GPs at the practice was developing practice guidelines on the treatment and investigation of atrial fibrillation (abnormal heart rhythm) and the choice of anticoagulation drugs (drugs that work to reduce the clotting of blood) which was expected to be shared by the practice across the CCG area.

The practice was part of the NHS funded Research Network and had taken part in University led clinical trials which it felt was relevant and did not have too much time impact on patient care. These had included research into cholesterol levels in children and a pilot study involving vitamin D and dementia screening.

There were systems in place that ensured babies received a new born and eight week development assessment.

Every patient over 75 years had a named GP, this included patients who lived in the care homes the practice supported. We spoke with representatives from two of these care homes. They confirmed that needs assessments were completed when required. They told us weekly visits were made by one of the GPs. They told us this was a good practice and that the GPs worked with the staff at the homes to ensure people got the best care possible.

The practice met the quality and outcomes framework (QOF) targets for mental health care plans. GPs told us that patients with mental health difficulties received an annual health review of their physical and mental health, medicine and revision of their care plan. The practice undertook the recommended learning disability examinations. We saw patient records which confirmed this.

The practice used the gold standard framework (GSF) for managing terminally ill patients. The GSF is a practice based system to improve the quality of palliative care in the community so that more patients received supportive and dignified end of life care, where they choose.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice made sure that patients were referred on need and that age, sex and ethnicity was not taken into account in this decision-making process.

Good

Are services effective?

(for example, treatment is effective)

Management, monitoring and improving outcomes for people

The practice routinely collected information about patients care and outcomes. The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). QOF is a national performance measurement tool used to assess performance. For example, we saw an audit regarding the prescribing of analgesics and non-steroidal anti-inflammatory drugs. Following the audit, the GPs carried out medicine reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes.

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. These roles included data input, clinical review scheduling, child protection alerts management and medicines management. The information staff collected was then collated by the practice manager to support the practice to carry out clinical audits.

The practice showed us 10 clinical audits that had been undertaken in the last year. Two of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, following new guidance the practice had carried out an audit on the prescribing of medicines used in heart failure after a heart attack from September 2013 to March 2014. The audits showed that no further action was required by the practice. The audits had confirmed 100% agreement with the guidance was already in place at the practice. Other examples included audits to confirm that the GPs who undertook minor surgical procedures were doing so in line with their registration and NICE guidance.

The practice team made use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The practice nurse told us they had done cervical screening audits and these were reviewed by senior clinical staff. Clinical staff told us audits were done and were discussed at meetings. They gave examples of infection control and hand wash audits. The staff we spoke with discussed how as a group they reflected upon the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around quality improvement.

There was a protocol for repeat prescribing which was in line with national guidance. Staff confirmed that they followed this protocol. They told us they regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for patients with long-term conditions such as diabetes and that the latest prescribing guidance was being used. The computer system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe this outlined the reason why they had decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

Effective staffing

Staff employed at the practice included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with training in areas such as basic life support. A good skill mix was noted amongst the GPs. GPs had additional interests in areas such as diabetes, asthma, heart disease prevention, dermatology (skin) and minor surgery. All GPs were up to date with their yearly continuing professional development requirements and all had either been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a more detailed assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

We saw records that confirmed staff had received annual appraisals. We saw that action plans had documented each person's identified learning needs and future objectives had been set. Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses. As the practice was a training practice, doctors who were in training to be qualified as GPs were offered extended appointments and had access to a training lead GP for support throughout the day.

Good

Are services effective?

(for example, treatment is effective)

Registrars (fully qualified doctors who spend 12 months working at the practice to gain the experience they need to become a GP) who worked at the practice told us that they had received a good clear induction and were very well supported. They told us they had no hesitation in taking any concerns to one of the GP partners either during or after a consultation, whichever was appropriate. They had an appropriate understanding of child protection procedures and consent. The registrars gave positive feedback about the practice.

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, for the administration of vaccines, blood tests, ear syringing, dressings, injections, travel and routine immunisations, blood pressure, diabetic and asthma checks, cervical smears and general health advice. Those with extended roles were trained in the diagnosis and management of patients with complex medical conditions such as diabetes and respiratory disease.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. Blood results, x-ray results, letters from the local hospital including discharge summaries and out of hours providers were received both electronically and by post. The practice had a system that identified the responsibilities of all relevant staff in passing on, reading and taking action on any issues arising from communications with other care providers on the day they were received. The GP who saw the documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system worked well. We were told there were no instances within the last year of any results or discharge summaries which had not been followed up appropriately.

The practice held multidisciplinary team meetings to discuss the needs of complex patients, such as those with end of life care needs or children who were considered to be at risk of harm. These meetings were attended by district nurses and palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Midwives based in the community held clinics at the practice each week to help them care for antenatal patients. Often the same midwife attended the patient at home when their baby was delivered. Attending for antenatal appointments was seen as a good way for both to become familiar with each other before the baby was born. A part-time clinical counsellor was employed by the practice to provide support for patients with emotional or psychological problems. Patients could only be referred to the counsellor after they had seen the GP.

We spoke with the managers from two care homes whose patients were cared for by the practice. They told us the practice supported patients through regular weekly visits to the home. They also confirmed that the GPs would attend outside these arrangements if necessary and responded promptly to any concerns they had.

Information Sharing

The practice had systems in place to provide staff with the information they needed. An electronic patient record system (EMIS) was used by all staff to coordinate, document and manage patients' care. All staff were trained in using the system. The use of the record system was also discussed at clinical patient care meetings to ensure a consistent approach in the use of these records by clinical staff. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Patients registered with the practice had been encouraged to sign up to the electronic Summary Care Record. Summary Care Records provide healthcare staff treating patients in an emergency or out of hours with faster access to key clinical information. Information for patients about this was available on the practice website, with a form available to enable patients to opt-out from having a Summary Care Record if they chose.

Consent to care and treatment

We saw that the practice had policies on consent, the Mental Capacity Act (2005), and assessment of Gillick competency of children and young adults. Gillick competency helps clinicians to identify children under 16 years of age who have the capacity to consent to medical examination and treatment.

Staff told us they completed Mental Capacity Act training through an on-line course. Clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. Staff told us the patient was encouraged to be involved in the

Good

Are services effective?

(for example, treatment is effective)

decision making process. They described that even if a patient attended with a carer or relative, they would always speak with the patient and obtain their agreement for any treatment or intervention. Clinical staff told us that if they thought a patient lacked capacity, they would ask their GP to review them.

Clinical staff told us that patients had a choice about whether they wished to have a procedure carried out or not. For example, a practice nurse told us how they would talk through procedures with the patient if they appeared anxious or uncertain. They told us they would discuss any concerns or anxieties they had.

Patients with learning disabilities and patients with dementia were supported to make decisions through care plans which they were encouraged to be involved in. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. We saw examples of records that confirmed care plans were in place and that reviews had been carried out.

The practice had not needed to use restraint in the last three years, but staff were aware of the distinction between lawful and unlawful restraint.

Health Promotion & Prevention

The practice had met with the Public Health team from the local authority and the CCG to discuss the implications and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the local area. This information was used to help focus health promotion activity.

It was practice policy to offer all new patients registering with the practice a health check with the health care assistant or practice nurse. The GP was informed of all health concerns detected and these were followed-up in a timely manner. We noted a culture amongst the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by carrying out opportunistic medicine reviews or to review the patients long term condition.

The practice had numerous ways to identify patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept a register of all patients with learning disabilities and these patients were offered annual physical health checks. Similar mechanisms were in place to identify at risk groups such as patients who were obese, those patients likely to be admitted to hospital and those patients receiving end of life care. These patient groups were offered further support in line with their needs.

The practice offered a full range of immunisations for children, travel vaccines (including yellow fever) and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was slightly higher than the average for the CCG, and again there was a clear policy and procedure in place for following up non-attenders by either the named practice nurse or the GP. Flu vaccination clinics were held every autumn. The practice advised flu vaccination to all those patients over the age of 65 and to those patients with chronic diseases such as asthma, diabetes, heart disease, and kidney disease.

We saw that a range of health promotion leaflets were available in the reception area, waiting room, treatment rooms and on the practice's website. Clinical staff we spoke with confirmed that health promotion information was available for all patients. They told us that they discussed health issues such as smoking, drinking and diet with patients when they carried out routine checks with patients. Staff confirmed that patients were given information to access other services as was needed, such as the bereavement service Cruse.

Churchfields Surgery operated a patient carer protocol, to identify carers they could signpost to support agencies for help should they need it. The practice had carer support information available for patients in the waiting room which gave contact details for Worcestershire Association of Carers support group.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey and a survey of patients undertaken by the practice. The evidence from all these sources showed patients were satisfied that they were treated with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'among the best' for patients rating the practice as good or very good. The practice was also well above average for its satisfaction scores on consultations with GPs and nurses. Information showed that 90% of practice respondents said they would recommend the practice and 91% reported an overall good experience of the practice.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 24 completed cards and all but five were positive about the service experienced. Patients commented that they felt the practice offered an excellent service and staff were efficient, helpful and caring. They noted that staff treated them with dignity and respect. The less positive comments indicated that patients were unhappy for different reasons but there were no common themes to these. We also spoke with two patients on the day of our inspection. They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consultation room. Curtains were provided in consultation rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments.

We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. Staff confirmed they ensured patient's dignity was maintained by making sure the door was closed and that screens were used to enable patients to undress in private. Patients were made comfortable and staff told us they offered a chaperone service if patients preferred. Clinical staff confirmed they had received chaperone training. They told us that information was made available to patients to inform them that a chaperone option was available to them. We saw leaflets in the reception area and information on the practice website that confirmed this.

We observed that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. Staff told us if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected they would raise these with the practice manager. The practice manager told us they would investigate these and any learning identified would be shared with staff. We saw minutes of staff meetings that had taken place which showed that incidents had been discussed and learning identified.

We spoke with the managers of two care homes supported by the practice. They told us the everyone at the practice were caring and very professional.

There was a clearly visible notice in the patient reception area and on the practice's website informing patients of their zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions. For example, data from the national patient survey showed 88% of practice respondents said the GP and the nurse were good at involving them in decisions about their care. 90% of patients responded that they would recommend the practice to new patients. Both of these were above the average for the Clinical Commissioning Group (CCG).

Good

Are services caring?

Staff demonstrated knowledge regarding best interest decisions for patients who lacked capacity. Staff told us that the patient always came first and were always encouraged to be involved in the decision making process. They described that they would always speak with the patient and obtain their agreement for any treatment or intervention even if a patient attended with a carer or relative. The nurses told us that if they thought a patient lacked capacity, they would ask their GP to review them.

The practice was able to evidence joint working arrangements with other appropriate agencies and professionals. For example, palliative care was carried out in an integrated way. This was done using a Multidisciplinary Team (MDT) approach with district nurses, palliative care nurses and hospitals. We saw that the Gold Standard Framework (GSF) palliative care meetings were held and recorded. The GSF is a practice based system to improve the quality of palliative care in the community so that more patients received supportive and dignified end of life care, where they chose.

The practice had identified that there were poor external provisions for patients with mental health issues in the locality. The waiting time for referrals to the Improving Access to Psychological Therapies (IAPT) services was two to three months and the waiting time for the counsellor attached to the practice was one year. The GPs managed this situation by providing psychological support for patients themselves. There was also additional supportive information available on the practice website that patients could access.

Patient/carer support to cope emotionally with care and treatment

Patients we spoke with during the inspection and the comment cards we received were positive about the emotional support provided by the practice. For example, comments confirmed that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room and on the practice website also signposted people to a number of support groups and organisations. The computer system used by the practice alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Staff told us that families who had suffered bereavement were called and visited by their GP. Staff were aware that families could be sign-posted to other services for support. GPs would assess the support needed and were able to make appropriate arrangements such as a referral to the primary care mental health worker.

End of life care and bereavement information was available to patients and their relatives/carers in the waiting rooms. This included information to advise patients what to do if a death occurred at home or in hospital. Staff told us families who had suffered bereavement were called by their usual GP. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and or signposting to a support service. The managers of the care homes told us that GPs always gave support where it was needed, and this often included the family members of patients at the home.

The patients we spoke with on the day of our inspection and the comment cards we received confirmed the information available to them and the support they had received. For example, they told us that staff had responded compassionately when they needed help and had provided support when required.

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. For example, the practice had committed to an Expert Patients Programme (EPP) which provides courses designed to help patients with long-term conditions. The programme gave patients the tools, techniques and confidence to manage their condition better on a daily basis.

Expert patients are defined as people living with a long-term health condition who are able to take more control over their health by understanding and managing their conditions, leading to an improved quality of life. Becoming an expert patient was empowering for people with chronic conditions. GPs told us that people who had trained in self-management tended to be more confident and less anxious. They made fewer visits to the doctor, were able to communicate better with health professionals, took less time off work, and were less likely to suffer acute episodes that required admission to hospital.

The NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) told us that the practice regularly engaged with them and other practices to discuss local needs and service improvements that needed to be prioritised. GPs told us they attended these quarterly meetings and shared information with practice staff where actions had been agreed to implement service improvements and manage delivery challenges to its population.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from their patient survey. For example, the practice had introduced a new telephone answering system with call waiting. This informed patients where they were in the queue and the real-time telephone monitoring displayed the average wait time and duration of call for that day. On the day of our inspection 133 calls had been taken by early afternoon with an average answer time of one minute 20 seconds. The average call duration was one minute.

Longer appointments were available for patients who needed them and for those with long term conditions.

Patients were also given appointments with a named GP or nurse. Home visits were made to local care homes on a specific day each week. Additional visits were made to those patients who needed a consultation outside of these routine visits.

Tackle inequity and promote equality

The practice proactively removed any barriers that some people faced in accessing or using the service. Staff we spoke with told us there was a small minority of patients who accessed the service where English was their second language. They told us that usually the patient was accompanied by a family member or friend who would translate for them. Staff told us they would arrange for an interpreter if required and that information could also be translated via the internet. The practice's website offered translation of information into 80 languages for patients.

Female GPs worked at the practice and were able to support patients who preferred to see a female doctor. This also reduced any barriers to care and supported the equality and diversity needs of the patients.

There were arrangements in place to ensure that care and treatment was provided to patients with regard to their disability. For example, there was a hearing loop system available for patients with a hearing impairment and clear signage informing patients where to go. There was a disabled toilet and wheelchair access to the practice for patients with mobility difficulties.

The practice had recognised the needs of different groups in the planning of its services such as carers and vulnerable people who were at risk of harm. The computer system used by the practice alerted GPs if patients were at risk of harm, or if a patient was also a carer. For example, where patients were also identified as carers we saw that information was provided to ensure they understood the various avenues of support available to them should they need it. GPs told us that travellers lived nearby on a seasonal basis. The practice was prepared to meet their needs and recognised the difficulty in the lack of continuity for patients in their situation.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last

Good

Are services responsive to people's needs?

(for example, to feedback?)

12 months and that equality and diversity was regularly discussed at staff appraisals and team events. We saw records that showed the GP lead had completed equality and diversity training.

Access to the service

Comprehensive information was available to patients about appointments on the practice website. This included details on how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out of hours service was provided to patients on leaflets, through information displayed in the waiting room and on the practice website.

The practice was open on Mondays from 7am to 6.30pm, 8am to 6.30pm Tuesday to Friday. Extended hours appointments were available from 6.30pm till 8pm on Thursdays and Saturdays 8am till 11.30am for pre-booked appointments only. Extended hours appointments were beneficial to patients who had work commitments.

Home visits were available for patients who were too ill to attend the practice for an appointment. The practice had early morning appointments available on Mondays for those patients who found it difficult to attend during normal surgery hours.

Patients were generally satisfied with the appointments system, although results for the national patient survey 2013 were varied. Data showed that 71% found it easy to get through to the practice by phone which was below the national average; 97% found the last appointment they had was convenient; 84% described their experience of making an appointment as good; 61% usually waited 15 minutes or less after their appointment time to be seen; 77% were satisfied with the practice's opening hours and 83% would recommend this practice to someone new to the area. All these results were above the national average.

Patients confirmed on the comment cards that they could see a GP on the same day if they needed to and they could see another GP if there was a wait to see the GP of their choice. Patients we spoke with confirmed that they had always been able to make appointments when they were in urgent need of treatment on the same day of contacting the practice.

The practice building was accessible to patients. The practice operated from the newly purpose built medical centre which had opened in May 2011. The building had been designed to meet the requirements of disabled patients and patients with special needs. The practice operated over two floors with lift access. The practice building was large, with wide corridors for patients with mobility scooters to move freely around the building. Patients were able to move around the building independently. Facilities included two lifts, disabled toilets, onsite physiotherapy, dentist, pharmacy, optician and free disabled parking.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities. Information leaflets for health promotion were available for patients to take away with them should they wish to do so.

Churchfields Surgery was an approved GP training practice. Fully qualified doctors who want to enter into general practice spend 12 months working at the practice to gain the experience they need to become a GP. The website told patients that the practice believed that excellence should be passed on to those training in medicine which is why they hosted qualified doctors completing their specialist training in General Practice. The practice also supervised a number of medical students. Consulting with these trainees was optional for patients. Patients were advised that signed consent to see a medical student would be sought prior to their appointment and a GP reviewed their appointment after every consultation.

Listening and learning from concerns and complaints

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

We found that there was an open and transparent approach towards complaints. We saw that the practice recorded all complaints and actions had been taken to resolve each complaint as far as possible. We tracked three complaints and found these had been handled satisfactorily, in a timely way with learning identified where appropriate.

We saw that 22 complaints had been logged for the previous 12 months. The modes of complaint included verbal, e-mail, phone calls, letters as well as those where complaint forms had been completed. This indicated patients knew how to complain and all complaints were looked and actioned however serious or otherwise they were. The detail behind two complaints had been interrogated and the summary accurately represented them.

Prior to this complaint period there had been frequent complaints about the telephone answering at the practice. In response to these the practice had introduced a new telephone answering system with call waiting. This informed patients where they were in the queue and the real-time telephone monitoring displayed the average wait time and duration of call for that day.

Accessible information was provided to help patients understand the complaints system on the practice's website, posters displayed in the waiting room and in the reception area. Patients recorded on comment cards that they were aware of the process to follow should they wish to make a complaint. None of the patients had ever needed to make a complaint about the practice. Staff told us they were aware of what action they would take if a patient complained. Staff confirmed that complaints were discussed at practice meetings and they were made aware of any outcomes and action plans.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. Evidence showed that lessons learned from individual complaints had been acted on.

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. We found details of the vision and practice values were part of the practice's strategy and aims for their patients. These values were clearly displayed in the waiting areas and in the staff room.

The practice vision and values included to provide high quality, safe and effective services in a pleasing environment. Information was made available to patients on the practice's website. This included the practice's aim to work in a way that was mutually respectful, that promoted learning and adaptability to ensure that patients received appropriate healthcare.

Their aim was to endeavour to treat all their patients with dignity, respect and honesty and asked all patients to offer the same commitment in return. We spoke with eight members of staff and they all knew about and understood the vision and values for the practice. They knew what their responsibilities were in relation to these.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. We looked at eight of these policies and procedures. All eight policies and procedures we looked at had been reviewed annually and were up to date. Staff confirmed they had read the policies and procedures and knew how to access them should the need arise.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. QOF is a scheme which rewards practices for providing quality care and helps to fund further improvements. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, the practice had completed a number of clinical audits which included medicine used to reduce blood clots in coronary artery disease and antibiotic prescribing. Following the audits the GPs carried out medicine reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes.

The practice held monthly governance meetings. We looked at minutes from the last three meetings and found that performance, quality and risks had been discussed. We found that the practice had robust arrangements for identifying, recording and managing risks. The practice manager showed us their risk log which addressed a wide range of potential issues, such as spillages. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. Staff showed us risk assessments that had been completed for risks identified such as needle stick injuries.

Leadership, openness and transparency

There was a clear and visible leadership and management structure in place with responsibility for different areas shared amongst partners. There were two managers, one with clinical and one with administrative responsibility. The staff were organised into medical, nursing and reception teams. These operated as separate teams that were linked by managerial input.

Named members of staff had lead roles. For example, one of the partners was the lead for safeguarding and the Caldicott Guardian. Caldicott Guardians are senior staff in the NHS and social services appointed to protect patient information. Clinical staff also had lead roles such as the lead nurse for infection control. We spoke with eight members of staff and they were all clear about their own roles and responsibilities. Staff felt valued, well supported and knew who to go to in the practice with any concerns. Staff told us they felt very much supported by all partners of the practice.

Staff told us that there was a positive, open culture and focus on quality at the practice. Staff told us they had the opportunity and felt comfortable to raise any issues at team meetings. We saw examples where staff had been supported and encouraged to develop their skills through discussions at team meetings and through individual appraisals. The practice managers told us that they met with the GPs each week and information from those meetings was shared with staff. Staff told us that the GPs

Are services well-led?

Good

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

and practice managers were very supportive. GPs and registrars also confirmed that there was an open and transparent culture of leadership, encouragement of team working and concern for staff well-being.

We found the practice to be open and transparent, and prepared to learn from incidents and near misses. Weekly practice meetings were held where these were discussed. Lessons learned from these discussions were shared with the team. We saw the system in place for the dissemination of safety alerts and National Institute for Health and Care Excellence (NICE) guidance. Clinical staff told us they acted on alerts and kept a record of the action they had taken.

Staff told us that the practice was well led. We saw that there was strong leadership within the practice and the senior management team were visible and accessible.

The capability of the leadership team was evident in the design of the practice's new premises and the organisation within it. This varied from the macro level of premises design, to the micro level of an emergency grab bag containing drugs and a defibrillator which was kept behind the reception counter. This was accompanied with a clear laminated emergency procedure instruction sheet located on the desk above it.

One member of administrative staff told us they were confident in how they would proceed if a patient collapsed. They were clear that they would be able to use the defibrillator if there was no one more experienced available at the time. This confidence to act and the confidence in raising any concerns with the leadership team reflected the ethos within the practice. Succession planning was managed by sharing the managerial responsibility between the partners.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example, induction policy, recruitment and equal opportunities policy which were in place to support staff. Staff told us there was a staff handbook that was available to all staff. Staff we spoke with knew where to find these policies if required.

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

The practice had gathered feedback from patients through patients' surveys completed 2013 - 2014 and complaints received. The practice had an active virtual patient representative group (PRG) which has steadily increased in size. The PRG had carried out annual surveys since the group was started in 2012. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PRG. The results and actions agreed from these surveys had been made available on the practice website.

The PRG consisted of 69 members, which represented just over 0.5% of the practice population. Members represented various population groups. For example, 24 males and 39 females from the working age and recently retired population group, and three males and three females from the older people age groups.

The practice received 383 responses, which represented 2.9% of the current practice population, the results of which were fed back to the PRG. The practice also placed a link to the results on the practice website and a paper copy was made available for patients at the practice. Staff told us the practice shared the results of surveys with the whole team for discussion at staff meetings. We saw minutes of meetings that confirmed this. Meetings gave staff the opportunity to give feedback on any of the findings from the survey report. We saw from minutes that staff meetings were held regularly. Practice discussions and information sharing took place during these meetings. Staff told us that they felt able to make contributions and suggestions at all times, and their views were actively sought and acted upon.

In addition to meetings the practice had gathered feedback from staff through appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

An action plan was produced from the results of the patients' survey which identified issues with telephone access, website underused, and issues with booking routine appointments. The practice carried out a telephone audit and as a result employed additional reception staff to assist at busy times of the day. The website was promoted to encourage patients to access for appointment bookings, cancellations and ordering repeat prescriptions. Two GPs had taken responsibility for updating the website and practice booklet. They continually monitored the information contained on the website, in the practice booklet and on the patient information screen for accuracy and relevance. GPs, nursing staff and administration staff

Are services well-led?

Good

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

told us they continued to opportunistically promote the website. The practice believed that in completing these actions the issues about booking routine appointments would become easier for patients. The practice acknowledged the need to continue to strive to improve these areas.

The practice had a whistle blowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice. Staff confirmed they knew who to talk with in the event they had any concerns.

Management lead through learning & improvement

The practice held regular meetings that ensured continued learning and improvements for all staff. We saw minutes of staff meetings, clinical staff meetings and management team meetings that showed discussions had taken place on a range of topics. This included significant events, complaints and palliative care for patients, with actions to be completed where appropriate. The practice had planned that in the future they would also record formally all of the many positive comments made to the practice to provide a more balanced view when compared with the complaints received.

We saw how the practice responded to areas that needed to be improved. For example, we saw from meeting minutes that the practice had identified the need to review admissions to hospital by patients on their register, and identify the reasons for this. Where admissions had been considered avoidable the practice planned to review care plans three monthly to try to reduce further admissions.

The practice was able to evidence through discussion with the GPs and via documentation that there was a clear understanding among staff of safety and learning from incidents. Concerns, near misses, significant events (SEs) and complaints were appropriately logged, investigated and actioned. For example, we saw that significant event reporting had been discussed at the practice meeting held in September 2014. We saw that the details of the incident, who was involved, and action taken had been discussed.

Staff told us that the practice supported them to maintain their clinical professional development through training, clinical supervision and mentoring. Staff told us that the practice was very supportive with training and that they had regular protected time provided for learning. Staff told us that information and learning was shared with staff at practice meetings. For example, minutes of the meetings were emailed to all staff members. The practice planned to establish an audit trail for the minutes by getting read receipts or initials on paper minutes to ensure that all members of staff had actually seen these.

The practice was a well-established GP training practice. Only approved training practices can employ GP registrars and the practice must have at least one approved GP trainer. A GP registrar is a qualified doctor who is training to become a GP through a period of working and training in a practice. We spoke with the practice's current GP registrars. They confirmed that they had a named GP trainer at the practice and felt well supported by the whole team.