Church View Surgery

Quality Report

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Date of inspection visit: 9 July 2015
Date of publication: 10/09/2015

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of Church View Surgery on 9 July 2015. Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well-led services. It was also good for providing services for the 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, and people experiencing poor mental health (including people with dementia).

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- The practice was clean and hygienic and had arrangements for reducing the risks from healthcare associated infections.
- There were systems in place to maintain the health and safety.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said urgent appointments were available on the same day.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. However, waiting times for certain GPs were significantly longer at times.
- Information about services and how to complain was available and easy to understand.

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

The provider should:

- Ensure all staff are aware of contingency plans in place
- Ensure arrangements are made to enable all GPs to run consultations on time.
- Ensure a current legionella risk assessment is in place and actions identified are followed.

Summary of findings

- Ensure changes to appointment system are monitored to assess impact.

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 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 patients 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. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

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 several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. Patients said they could get an appointment usually within two weeks with most urgent appointments available the same day. Patients also stated that waiting time to be seen was longer for some GPs. Information about how to complain was available and easy to understand and evidence showed that the practice responded appropriately to issues raised. Learning from complaints was shared with staff.

Are services well-led?

Good

The practice is rated as good for being well-led. There was a leadership structure and staff felt supported by management. The

Summary of findings

practice had a number of policies and procedures to govern activity and held regular meetings. There were systems in place to monitor and improve quality and identify risk. The practice sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

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. Nationally reported data showed that outcomes for patients were good for conditions commonly found in 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. It was responsive to the needs of older people, and offered 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 care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, GPs 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 care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. All consultation rooms were on the ground floor which made the practice accessible for pushchairs and appointments were available outside of school hours. There were policies, procedures and contact numbers to support and guide staff should they have any safeguarding concerns about children. The clinical team offered immunisations to children in line with the national immunisation programme. Immunisation rates were comparable to local and national average.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible. The practice offered extended

Summary of findings

opening hours to assist this patient group in accessing the practice. NHS health checks were available for people aged between 40 and 74 years. The practice offered a range of health promotion and screening services which reflected the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks for people with a learning disability and 95% of these patients had received a follow-up. It offered longer appointments for people with a learning disability.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Ninety percent of people experiencing poor mental health had received an annual physical health check with a completed plan of care. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia. Patients with dementia were offered longer appointments. The GP partners had attended training in the Mental Capacity Act 2005 to ensure all care provided was in patients' best interests.

Summary of findings

What people who use the service say

We gathered the views of patients from the practice by looking at 32 CQC comment cards patients had filled in and by speaking in person with nine patients. This included three patients who were members of the Patient Participation Group (PPG), one of whom was the chair. The PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care.

All patients we spoke with and received comment cards from were happy with the staff and GPs at Church View Surgery. All the patients said GPs and practice nurses respected them and were always helpful and friendly. However, 10 comments cards also stated that they found it difficult to get an appointment and often waited a long time after their appointment time. Most patients we spoke with also said the same. All the patients stated that they could get an appointment if it was an emergency.

We looked at results of the latest national GP patient survey which was published January 2015. Out of the 307 surveys, 92 were completed and returned, representing a completion rate of 30%. Findings of the survey were also compared to the average for practices in the local Clinical Commissioning Group (CCG) and the national average. A CCG is a group of General Practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services. The results of the national GP survey showed the practice scored below average within the Sandwell and West Birmingham Clinical Commissioning Group (CCG) for satisfaction with the practice for most areas, although some areas were above average. For example, 95% of respondents had confidence and trust in the last GP and nurse they saw or spoke to compared to the local and national average of 92% and 95% respectively. Seventy eight percent of respondents say the last GP they saw or spoke to was good at treating them with care and concern, against a CCG average of 80% and a national average of 85%.

The practice generally performed worse than the local and national average for waiting times for appointments. Thirty eight percent of respondents said they usually waited 15 minutes or less after their appointment time to be seen. This was below the local average (54%) as well as the national average (58%). Patients also waited longer after their appointment time to be seen. With 26% of respondents stating they felt they did not have to wait too long to be seen. This was below the local and national averages of 47% and 57% respectively.

Areas for improvement

Action the service SHOULD take to improve

- Ensure all staff are aware of contingency plans in place
- Ensure arrangements are made to enable all GPs to run consultations on time.
- Ensure a current legionella risk assessment is in place and actions identified are followed.
- Ensure changes to appointment system are monitored to assess impact.

Church View Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and included a GP specialist advisor.

Background to Church View Surgery

Church View Surgery is a registered with the Care Quality Commission (CQC) to provide primary medical services. . The surgery serves a population of approximately 5800 patients. The practice is open Mondays and Fridays from 8.15am to 6.15pm; Tuesdays and Thursdays from 7am to 6.15pm. On Wednesdays it is open from 8.15am to 8pm. Extended early opening hours are offered on Tuesdays and Thursdays from 7am. Late opening hours are offered on Wednesdays until 8pm.The practice has opted out of providing out-of-hours services to their own patients. This is provided by an external out of hours service.

There are three GP partners (two male and one female). There are also two part time practice nurses, two healthcare assistants, a practice manager and a team of reception staff. The practice has a General Medical Services (GMS) contract with NHS England.

This was the first time the CQC had inspected the practice. Data we reviewed showed that the practice was achieving results that were average or in some areas slightly above average with Sandwell and West Birmingham CCG in most areas.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people

Detailed findings

- Working age people (including those recently retired and students)
- People living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Before inspecting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced inspection on 18 June 2015. During our inspection we spoke with a range of staff including two GP partners, two practice nurses, a health care assistant, the practice manager, one reception staff and two administration staff. We also spoke with nine patients including three members chair of the PPG, one of whom was the chair. We also received 32 comment cards from patients. We observed how patients were being cared for and staff interactions with them.

Good

Are services safe?

Our findings

Safe track record

The practice prioritised safety and 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. All the staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. The practice used an electronic system to report incidents which was shared with Sandwell and West Birmingham Clinical commission Group (CCG). CCGs are groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last two years. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of 32 significant events that had occurred during the last two years and saw this system was followed appropriately. Significant events were a standing item on the practice meeting agenda and a dedicated meeting was held quarterly 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.

Significant events were recorded on an electronic system available commercially. This is a type of patient safety software for healthcare risk management, incident and adverse event reporting. The practice manager told us that any incidents reported on this system would be received by the CCG who could use the system to analyse any trends. We saw that 10 significant events were raised in 2015 and a total of 22 significant events were raised in 2014. We saw example of an incident where a GP referred a patient for scans to the local hospital. However, the scans were not comprehensive and were not performed as instructed by the GP. The GP raised this as an incident which was shared with the CCG. We also saw evidence that the incidents manager and a consultant at the hospital were informed so that action could be taken to reduce re-occurrence.

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 all staff had received relevant role specific training on safeguarding. Staff members we spoke with 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 safeguarding concerns and how to contact the relevant agencies. We saw relevant information and contact details were displayed in all the consultation rooms we looked in to.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil these roles. For example, the lead GP told us how they had recently made a safeguarding referral after telephoning the local safeguarding team at the local authority for more advice.

All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern. The practice had a safeguarding protocol and we saw that this was discussed in the practice meeting in September 2014. We also saw that the practice staff had information on domestic care pathways for any necessary referrals.

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. We spoke with the practice nurse who was responsible for monitoring medicines

Records showed and fridge temperature checks were carried out which ensured medicines were stored at the

appropriate temperature. 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.

The practice used a commercially available electronic system to manage all its medicines and vaccines. This system incorporated a complete auditable stock control system for managing all the practices medicines and vaccines. A staff member we spoke with demonstrated this to us. They told us that the system allowed them to keep track of the amount of medicines, the batch number (which allowed recording on patients' electronic notes when administered), and the supplier. The system also highlighted medicines that were due to expire soon in blue and medicines that had expired in red allowing the practice to better manage their medicines.

Cleanliness and infection control

We observed the premises to be visibly clean and tidy. We saw there were cleaning schedules in place and displayed in each area of the practice to ensure the cleaner was aware of the areas they needed to clean. We saw cleaning records were kept and we spoke with the assistant practice manager who carried out spot checks on the cleaning. We saw records were available to confirm the spot checks. We saw a recent record of a spot check highlighted the need to ensure paper towel holders required dusting. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control. We spoke with the lead who told us that they attended the link worker scheme organised by the CCG. This was attended by infection prevention leads from other practices locally. They told us that they shared learning with the practice. During the last meeting a speaker from a local hospital lab discussed the need to ensure all clinical information was included with samples by GPs when requesting further tests. They told us that they had shared this with the practice team so that tests would not be delayed due to missing information.

We saw evidence that the CCG had carried out annual infection control audits for each of the last three years and that any improvements identified for action were completed on time. For example, the last audit was carried out in March 2014; this showed that the practice achievement in regards to infection control was 78%.

Minutes of practice meetings showed that the findings of the audits were discussed with staff. Actions identified in the audit had been actioned and a re-audit was carried out in June 2014 where the practice had achieved 97% compliance. The major action related to the upholstered seating in the reception area which was identified as an infection control risk. The practice carried out a risk assessment which led to a six monthly steam cleaning of the seats. The assistant practice manager showed us records to confirm steam cleaning of the seats was being carried out by an external contractor.

We saw a seat that had an opening and represented a risk to cross infection. The practice manager told us they had arranged for this to be repaired.

The practice had carried out a legionella risk assessment in June 2013 and we saw that it was due again in June 2015. Legionella is a bacterium which can contaminate water systems in buildings. The practice manager told us that this had not been carried out but they were in the process of organising this. We also saw that the actions from the risk assessment to record the cold and hot water temperatures from taps in the surgery had not been followed. The practice manager explained that this was due to a misunderstanding but assured us that this was now going to be done.

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. We saw records that demonstrated all portable electrical equipment had been tested to ensure they were safe to use. We saw records that demonstrated that all medical devices had been calibrated in April 2015. This included devices such as weighing scales, nebulisers, spirometer and blood pressure measuring devices.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment for most staff. For example, proof of identification, references, qualifications and registration with the appropriate professional bodies.

Good

Are services safe?

We saw that criminal records checks through the Disclosure and Barring Service (DBS) were in place for clinical staff. DBS checks help to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. Some reception staff carried out the role of a chaperone and we saw that DBS checks were carried out for these staff. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure.

We spoke with the assistant practice manager whose role was to plan and monitor the number of staff and mix of staff needed to meet patients' needs. They explained how they managed this with the rota system that was 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. Some of the staff worked part time and the assistant practice manager told us that the system of offering overtime worked well.

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 regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. For example, the practice organised access of large vehicles for deliveries and collection of clinical waste outside of busy periods. The practice also had a health and safety policy and a manual handling risk assessment was in place. We saw records that confirmed fire drills were carried out six monthly.

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, anaphylaxis (allergic reaction) and diabetes. 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.

Emergency equipment such as oxygen and an automated external defibrillator was kept with the emergency medicines. (An AED is a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm).

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, adverse weather including flooding and access to the building. However, some of the staff we spoke with were not aware of the plan. The practice manager told us that they had discussed this with staff but would ensure this was covered again in team meetings.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

During our inspection, we were told by staff how patients' needs were assessed and care and treatment was planned and delivered in line with their individual needs and preferences. All patients we spoke with were happy with the care they received from the practice.

Clinical staff managed the care and treatment of patients with long term conditions, such as diabetes, asthma and chronic obstructive pulmonary disease (COPD). COPD is the name for a collection of lung diseases including chronic bronchitis, emphysema. Typical symptoms are increasing shortness of breath, persistent cough and frequent chest infections. We found there were appropriate systems in place to ensure patients with long term conditions were seen on a regular basis.

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and could access local Clinical Commissioning Group (CCG) guidelines online such as the two weeks referral forms. CCGs are groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services.

The practice had signed up to a number of enhanced services available to practices from the CCG. An enhanced service is a service that is above the contractual requirement of the practice and is commissioned to improve the range of services available to patients. The increased the range of services provided and included minor surgery. The practice had also signed up to the unplanned admissions review scheme commencing from August 2015.

We were provided with data from the local CCG of the practice's performance for antibiotic prescribing, which was lower than the CCG targets.

Management, monitoring and improving outcomes for people

There was a system in place for carrying out clinical audits. Clinical audits are quality improvement processes that seek to improve patient care and outcomes through the systematic review of care and the implementation of change. The process requires that recommendations and actions are taken where it is found that standards are not being met. The practice had conducted an antibacterial audit and findings showed that all clinicians adhered to prescribing protocols. The practice had also conducted an audit on oral nutritional supplements (ONS) in November 2014 where all patients above 18 years of age prescribed with ONS (sip feeds) in the previous six months were reviewed. In total, 20 patients were reviewed and the findings showed that 19 patients were on sip feeds inappropriately and were stopped. Other actions identified as a result of the audit were taken for example referral to the dietician for advice.

Minor surgery was undertaken at the practice and we saw consent forms were in place.

Doctors in the surgery undertook minor surgical procedures in line with their registration and NICE guidance. The staff were appropriately trained and kept up to date.

The practice also used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions e.g. diabetes and implementing preventative measures. The results are published annually. The practice had achieved 95% of the total QOF target in 2014, which was slightly above the local and national average of 93.6% and 93.5% respectively. Specific examples to demonstrate this included performance for diabetes related indicators, chronic kidney disease as well as chronic obstructive pulmonary disease (COPD). COPD is the name for a collection of lung diseases, including chronic bronchitis and emphysema.

The practice had a palliative (end of life) care register and had regular contact with multidisciplinary teams and attended relevant meetings to discuss the care and support needs of patients and their families. Review of previous data showed that the practice achievement for these indicators was above the local and national average.

Effective staffing

Practice staff included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff had attended training courses that were relevant to their roles. They included safeguarding and

Good

Are services effective?

(for example, treatment is effective)

annual basic life support. All staff including nursing staff undertook annual appraisals that identified further learning needs. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. For example, an administration staff member told us that they were supported to attend a course for their current role. Two other clinical staff members told us how they were supported to attend courses

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those patients with complex care needs. 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 these communications. Out-of -hours reports, 111 reports and pathology results were all seen and actioned by a GP on the day they were received. If a GP was away, the duty GP would check results communicated to them and ensure they were actioned. We were shown the system for doing this.

The practice held multidisciplinary team meetings quarterly to discuss patients with complex needs. For example, those with end of life care needs or children on the at risk register. These meetings were attended by district nurses and palliative care nurses and decisions about care planning were documented in a shared care record. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate.

Information sharing

The practice used several systems to communicate with other providers. For example, the practice used telephones as well as fax to provide information to out-of-hours services.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record system to coordinate, document and manage patients' 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.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it. We saw that the staff had attended training on MCA within the last two years. There was a mental capacity assessment guideline available and was last reviewed by GPs in January 2015.

The GPs we spoke with demonstrated a clear understanding of the Gillick competencies. The Gillick competencies help clinicians to identify children under 16 years of age who have the legal capacity to consent to medical examination and treatment.

The practice had a process to ask for, record and review consent decisions that were needed from patients. We saw there were consent forms for patients to sign agreeing to minor surgery procedures.

Health promotion and prevention

Latest data we looked at showed that the practice performance in relation to health promotion activities such as cervical screening, diabetes checks, cardiovascular disease prevention as well as child health surveillance was in line with local and national rates.

It was practice policy to offer a health check to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering smoking cessation advice to smokers. Data showed that 92% of patients with a long term condition had their smoking status registered. Of that 90% were given advice and 2% had stopped smoking as a result.

The practice offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that, since April 2015, 22% of patients in this age group took up the offer of the health check. Ninety eight percent of those patients aged over 75 and on eight or more medicines had received a review.

Good

Are services effective?

(for example, treatment is effective)

The practice was proactive in promoting health and health screening services. Data provided to us showed that the practice had carried out 81% (1065 patients) of cervical cancer screening for the eligible patients over the past five years.

The practice's chronic disease management data showed that 39% of patients with diabetes had received a medication review since April 2015. The figures for asthma, chronic obstructive pulmonary disease (COPD) and dementia were 35%, 39% and 31% respectively.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients completed CQC comment cards to tell us what they thought about the practice. We received 32 completed cards and the majority (23) were positive about the service experienced. Patients said they felt the service had improved in regards to access to appointments and staff were polite and caring. However, six patients also commented on the difficulties around access to appointments and waiting times to be seen. We also spoke with nine patients including three members of the patient participation group (PPG) including the chair person. They all said that they were satisfied with the care provided by the practice and said their dignity and privacy was respected. PPGs are groups of patients registered with a practice who work with the practice to improve services and the quality of care.

The practice had carried out its own patient survey where 200 patients were asked about various aspects of their care. We saw that 157 responses were received by the practice. All the patients answered positively when asked if they were treated with dignity and respect.

We reviewed the most recent data available for the practice on patient satisfaction from the national GP Patient Survey dated January 2015. The results of the national GP survey showed the practice achievement to be slightly below local (Sandwell and West Birmingham Clinical Commissioning Group (CCG)) and national average in most areas. A CCG is a group of General Practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services. Data showed that 78% said the last GP they saw or spoke to was good at treating them with care and concern; this was slightly lower than the CCG average of 80% and national average of 85%. Seventy one percent said that the last GP they saw or spoke to was good at involving them in decisions about their care. This was also slightly below the local and national average of 76% and 81% respectively. We also saw that 95% respondents also stated that they had confidence and trust in the last GP they saw or spoke to. This was above the local average of 92% and same as the national average which was also 95%. The practice manager was aware of this and stated that they would be addressing this when new GP partner was back from annual leave.

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk. There was a system to allow only one patient at a time to approach the reception desk. We saw that a marker had been laid on the floor and information displayed on the reception informed patients to stay behind the marker if there was a patient before them. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled some confidentiality to be maintained. Additionally, 77% of respondents said they found the receptionists at the practice helpful. This was slightly lower than the local CCG average of 82% and national average of 87%.

Care planning and involvement in decisions about care and treatment

We spoke with nine patients on the day of the inspection including three members of the PPG. Most patients 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. Some patients stated that they could spend as long as they liked with the GPs and at times had spent much longer than 10 minutes. Patient feedback on the comment cards we received were positive and aligned with these views of most of the patients we spoke with.

The national GP Patient Survey information we reviewed showed that the practice achievement in some areas was similar to the local average. For example, 82% of patients who responded to the survey stated that the last GP they saw or spoke to was good at explaining tests and treatments. The local CCG average was also 82%. The practice achievement was slightly lower than the local

Good

Are services caring?

average for question around involvement with 71% of patients stating that the last GP they saw or spoke to was good at involving them in decisions about their care. The CCG average was 76%.

Translation services were available for patients who did not speak English as a first language. One of the GP partners we spoke with told us that they had recently used a local interpreter for a family who were unable to speak English. The GP partner also informed us that patients with carers were recorded on patient notes. We saw a carer's corner in the practice reception with information about other services and support for carers. Staff members and one of the GP partners we spoke with told us they would direct carers to appropriate information and services if needed.

Patient/carer support to cope emotionally with care and treatment

Almost all the patients we spoke with on the day of our inspection and the comment cards we received stated that staff responded compassionately when they needed help and provided support when required.

A GP partner we spoke with told us that the palliative care management at the practice identified carers and people close to the patient. After bereavement they were offered support and advice to appropriate agencies.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient survey. For example, it was recognised that access to appointment was an issue and the practice offered extended hours. Waiting time for appointments were also recognised as an issue and the practice offered double slots for patients who required an interpreter or those with complex chronic management needs. However, the practice did not have a mechanism in place to monitor the impact these were having on access to appointments.

The practice manager also told us that they had taken on a new GP partner as a result of a senior GP partner retiring. They said the previous partner was very popular with patients and this often meant that access was more of an issue with them. They said that things had improved as a result of the new GP partner starting. Most patients we spoke with confirmed that access to appointments had improved but it still was an issue. Staff members we spoke with stated that things had improved but it was still an issue.

Tackling inequity and promoting equality

The practice had access to an interpretation service if this was needed. Travellers and homeless people could also register at the practice to allow them to access NHS services. We spoke with an administration staff who told us that they liaised with the Clinical Commissioning Group (CCG) as well as the provider of the electronic patient record system on how they could register patients with no fixed abode on the system.

The practice was designed with full accessibility in mind. This included 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.

There were male and female GPs in the practice; therefore patients could choose to see a male or female doctor.

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

Access to the service

Appointments were available from 8.15 am to 6.15pm Mondays to Fridays and from 7am to 6.15pm on Tuesdays and Thursdays. On Wednesdays it was open from 8.15am to 8pm. 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 the practice's opening hours.

Appointments could be booked for the same day, or 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. Information in the surgery and on the practice website informed patients to phone before 11.30am to request a home visit and we saw that a GP had carried out home visits on the day of our inspection.

The GP National Patient Survey results demonstrated that 88% of patients who responded said they found it easy to get through to the practice by telephone. This was above the average for the Sandwell and West Birmingham Clinical Commissioning Group (CCG) of 63% and national average of 73%. CCGs are groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services. Additionally, 66% of patients described their experience of making an appointment as good. The CCG average was 76% with a national average of 73%.

However, we saw that the practice had significantly scored lower than the local and national average for waiting times. We saw that 26% of respondents to the survey felt that they didn't normally have to wait too long to be seen. This was below the local average of 47% and national average of 58%. Also, 38% of respondents also stated that they usually waited 15 minutes or less after their appointment time to be seen. This was below the local CCG average of 54% and the national average of 65%.

In addition, the practice carried out its own patient survey in September 2014. These revealed patients were very happy with the care received from staff including GPs and nurses. However, it also highlighted issues around the difficulty in getting a timely appointment and the waiting times to be seen. We spoke with nine patients including three members of the Patient Participation Group (PPG).

Good

Are services responsive to people's needs?

(for example, to feedback?)

PPGs are groups of patients registered with a practice who work with the practice to improve services and the quality of care. Some patients we spoke with told us that they often waited two to three weeks to get a routine appointment and at times waited over an hour to be seen after their appointment time. Patients confirmed that they were seen in an emergency although some were advised to visit the local walk in centre if they could not get an appointment. We spoke with the practice manager who told us that they had made changes to the appointment system offering more appointments with double appointments where necessary. They also told us that a new GP partner had started which had improved things. Patients we spoke with confirmed that access to appointments had improved but they were still waiting between one and two weeks for a routine appointment. It was unclear if changes to appointment system such as offering longer appointments where relevant had an impact. This is because the impact on appointment time had not been evaluated.

Patients we spoke with told us that the waiting time to been seen was particularly longer for one of the GPs. Patients were very happy with the consultation with the GP and said that the GP took as long as they needed. Some patients said that they had spent 30 minutes with the GP if necessary. We noted that analysis of the patient survey highlighted issues with GPs not starting their surgeries on time as well as surgeries running over. We found, on the day of our inspection, that the consultations with one GP did not start on time as they had arrived late. .

Listening and learning from concerns and complaints

Church View Surgery 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. 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 summarised the complaints for each year to identify any trends. For example, we saw that the practice received two complaints from April 2014 to March 2015. The complaints were regarding emergency appointments and we saw that practice had reviewed its emergency appointment protocol but felt there were no changes required to the protocol.

We looked to see whether the practice adhered to its complaints policy and saw that the patient was contacted and the matters resolved appropriately.

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

We saw a document entitled 'business plan 2007-12'. This detailed some objectives and future plans but nothing recent had been developed. The practice manager told us that there had been changes at the practice with a senior partner leaving and another partner starting. The practice manager stated that, in the very near future, they planned to develop a vision and strategy for the practice going forward.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at a selection of these policies and procedures and saw that they had been reviewed annually and were up to date. Staff members we spoke with told us that they had access to them electronically.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead staff member for infection control and one of the GP partners was the lead for safeguarding. Staff members we spoke with were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns. For example, one of the administration staff told us that they had received training which allowed them to progress in to their current role. They said the practice manager was supportive and could raise any issues with them.

Leadership, openness and transparency

We saw that practice staff held regular quarterly meetings. The minutes of some of the meetings we looked at showed that all aspects of the running of the practice were discussed as well as ways of taking corrective actions to meet patient's needs.

All staff we spoke with described the GPs and management as being very approachable and had no concerns about any aspect of the practice, its staffing or relationship with patients. Most of the staff had been working at the practice for a long time and told us the practice was a great place to work and there were excellent working relationships within the team.

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

The practice had a Patient Participation Group (PPG) in place. This was a group of patients registered with the practice who work with the practice to improve services and the quality of care. We spoke with three members of the PPG on the day of the inspection including the chair. They explained that they attended meetings quarterly and minutes of meetings we looked at confirmed this. The PPG members told us how they had fed back issues around access and delays to appointments. They stated that changes were made but did not result in significant improvements.

The practice had also gathered feedback from patient surveys. Most of the findings related to access and we saw evidence that the practice was responding to them. For example, the practice was offering late and early appointments for patients who were unable to attend during normal working hours. Longer appointments were offered for complex cases to reduce delays during consultations.

Management lead through learning and improvement

Staff files we looked showed that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training. Staff members we spoke with told us that practice was supportive if they wanted to develop and progress their career.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients. For example, the practice had recorded 10 incidents for 2015. One of the incidents involved a patient referred to hospital. The GP was not happy with the care received at the hospital and they raised this with the CCG and the hospital.