New Road Surgery Bromsgrove

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 carried out a comprehensive inspection of New Road Surgery on 18 November 2014. We found that New Road Surgery provided a good service to patients in all of the five key areas we looked at. This applied to patients across all age ranges and to patients with varied needs due to their health or social circumstances.

Our key findings were as follows:

- The practice had comprehensive safety systems and a focus on openness and learning when things went wrong.
- The practice was proactive in helping patients with long term conditions to manage their health and had arrangements in place to make sure their health was monitored regularly.
- All staff were actively engaged in activities to provide effective and responsive care and treatment to patients.
- The practice was clean and hygienic and had robust arrangements for minimising the risks from healthcare associated infections.
- Patients felt that they were treated with dignity and respect. They felt that their GP listened to them and treated them as individuals.
- The practice had a well-established and well trained team with expertise and experience in a wide range of health conditions.
- The leadership team had a shared purpose and motivated and encouraged the staff team to deliver the best care they could.

There were also areas where the practice needs to make improvements.

The practice should:

- Develop their system of completed clinical audit cycles, include minor surgery in this and be more proactive about using these to foster further development and shared learning.
- Develop their recruitment policies and procedures to include more detail about the steps the practice takes to gather all of the required information about new staff. This should include how they reach decisions

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about which applicants they should request a Disclosure and Barring Service check for and which information must be in place before new staff have contact with patients.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. The practice used every opportunity to learn from internal and external incidents, to support improvement. Information about safety was highly valued and was used to promote learning and improvement. Risk management was comprehensive, well embedded and recognised as the responsibility of all staff. 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 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. The practice had developed a highly qualified and experienced team which worked in partnership with other health professionals to help make this happen. The practice used the gold standards framework for end of life care. They had a register of patients who needed care and support though this stage of their lives and took part in meetings with other professionals involved in their care.

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 to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality. Views of external stakeholders 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 was aware of the needs of their local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice and said that urgent appointments were available the same day. The practice had good facilities and was well equipped to treat

Summary of findings

patients and meet their needs. There was a clear complaints system with evidence demonstrating that the practice responded quickly to issues raised. The practice had a positive approach to using complaints and concerns to improve the quality of the service.

Are services well-led?

Good

The practice is rated as good for providing well-led services. The practice had an open and supportive leadership and a clear vision with quality, caring and safety as its top priorities. The practice promoted high standards and the team took pride in delivering a high quality service to its patients. There was a clear leadership structure and staff felt supported by management. The practice had well organised management systems and met regularly with staff to review all aspects of the delivery of care and the management of the practice. The practice had systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and this was acted upon. The practice had a developing patient participation group (PPG). A PPG is made up of a group of patients registered with a practice who work with the practice team to improve services and the quality of care. There was evidence that the practice had a culture of learning, development and improvement.

Summary of findings

The six population groups and what we found

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

Older people

Good

This practice is rated as good for the care of older people. Patients over the age of 75 had a named GP and GPs carried out visits to patients' homes if they were unable to travel to the practice for appointments. The practice exceeded the national average for providing flu vaccinations to patients over the age of 65. The practice provided a responsive service to patients living in a local care home. The practice provided medical care to older patients in a local community hospital where they did a daily 'ward round' and took part in a 'virtual ward' scheme aimed at reducing hospital admissions and discharge delays. The practice provided other professionals and its own staff with clear information about patients receiving end of life care who might need an urgent response if they requested medical assistance. The practice were using the gold standards framework for end of life care. They had a register of patients who needed care and support though this stage of their lives and took part in meetings with other professionals involved in their care.

People with long term conditions

Good

This practice is rated as good for the care of people with long term conditions. An example of outstanding practice was the investment in staff development and training. As a result the practice had three nurse practitioners who were also nurse prescribers as well as further six practice nurses. This enabled them to provide a wide range of weekly clinics for patients with long term conditions. In addition the practice had appointed a new nurse to specialise in diabetes two years in advance of the existing nurse's retirement during which the new team member had been able to complete extended training and establish themselves within the practice team. This had ensured a well organised handover process and continuity of care for patients.

The practice had effective arrangements, including weekly clinics and well organised recall systems for making sure that people with long term conditions received regular health checks. Patients told us their GPs supported them and involved them in discussions about their care and treatment. NHS and private physiotherapy clinics were based within the practice. The practice provided other professionals and its own staff with clear information about patients receiving end of life care who might need an urgent response if they requested medical assistance. The practice was using the gold

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standards framework for end of life care. They had a register of patients who needed care and support though this stage of their lives and took part in meetings with other professionals involved in their care.

Families, children and young people

Good

This practice is rated as good for the care of families, children and young people. The practice held a weekly baby clinic, and a weekly childhood vaccination clinic. Childhood flu vaccinations were also provided. The practice ran a women's health clinic each week and provided a family planning service. The GPs and nurses worked closely with other professionals including midwives and health visitors where this was necessary, particularly in respect of children living in vulnerable circumstances.

Working age people (including those recently retired and students)

Good

This practice is rated as good for the care of working age people, recently retired people and students. The practice provided extended opening hours for people unable to visit the practice during the day. These were on Monday evenings and early on Tuesday mornings. The practice also had appointments available for three hours one Saturday morning a month. Patients could book appointments online and there were arrangements for patients to have telephone consultations with a GP where this was suitable. Students and other young people were offered Meningitis C vaccinations.

People whose circumstances may make them vulnerable

Good

This practice is rated as good for the care of people living in vulnerable circumstances. Three GPs at the practice specialised in the care and treatment of patients who misused alcohol and illegal substances. Two of these GPs were trained to provide specialist prescriptions for patients in recovery from drug misuse and worked in partnership with a shared care scheme, 'Pathways Worcestershire' to provide support, medical care and prescriptions.

The practice had a learning disability (LD) register and all patients with learning disabilities were invited to attend for an annual health check. Staff told us that the practice did not have any homeless people or traveller families currently registered at the practice. Staff at the practice worked with other professionals to help ensure people living in difficult circumstances had opportunities to receive the care, support and treatment they needed. The staff team were aware of their responsibilities regarding information sharing and dealing with safeguarding concerns.

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People experiencing poor mental health (including people with dementia)

Good

This practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice held a register of people experiencing poor mental health and invited them to attend for an annual health check. The practice worked closely with a link worker from the local NHS community mental health team. This worker visited the practice twice a week and GPs were able to discuss patients' mental health care and treatment needs with them. The practice also provided in-house counselling services from a Relate counsellor, and when necessary referred patients to NHS psychology services.

The practice was alert to the complex needs of people who were living with dementia and data showed that the practice was above the national average for making sure patients with dementia had their care reviewed each year.

Summary of findings

What people who use the service say

We gathered the views of patients from the practice by looking at 27 Care Quality Commission (CQC) comment cards patients had filled in. On the day of the inspection we spoke with four patients and a member of the New Road Surgery Patient Participation Group (PPG). A PPG is a group of patients registered with a practice who work with the practice team to improve services and the quality of care. Data available from Public Health England and the NHS England GP patient survey showed that the patients had reported positive views about the practice. The practice had higher than average scores in respect of overall satisfaction with the care they received, the opening hours and the numbers of patients who would recommend the practice.

Information written by patients in the comment cards and from those we spoke with gave a positive picture of patients' experiences at New Road Surgery. Patients told us that the staff placed high importance on their privacy and dignity and treated them with compassion and sensitivity. Some patients went into detail about the attentiveness of their GP and described improvements to their health and well-being as a result of the prompt care and treatment they had received. Several commented on their GP giving them the time and attention they needed and said that their GP listened to them and involved them in making decisions about their care and treatment. Patients described New Road Surgery as a caring GP practice with a professional and dedicated team. Members of families with carer responsibilities or young families told us the practice was supportive and acted promptly when a child or older person became unwell.

A small number of patients commented on finding it difficult to get through on the telephone or to make an appointment that suited them while most said that they were able to do so easily or did not comment on this.

Areas for improvement

Action the service SHOULD take to improve

- Develop their system of completed clinical audit cycles, include minor surgery in this and be more proactive about using these to foster further development and shared learning.
- Develop their recruitment policies and procedures to include more detail about the steps the practice takes to gather all of the expected information about new staff. This should include how they reach decisions about which applicants they should request a Disclosure and Barring Service check for and which information must be in place before new staff have contact with patients.

New Road Surgery Bromsgrove

Detailed findings

Our inspection team

Our inspection team was led by:

The inspection team was led by a Care Quality Commission (CQC) inspector and included a GP specialist advisor, a practice manager specialist advisor and Expert by Experience. Experts by Experience are members of the inspection team who have received care and experienced treatments from a similar service.

Background to New Road Surgery Bromsgrove

New Road Surgery is situated in an area of Bromsgrove with low levels of social and economic deprivation. It has around 12,500 patients. The practice is in a spacious converted commercial building with a separately operated pharmacy within the same building. The practice has a large free car park with disabled spaces nearest to the entrance. The practice population reflects the national average across most age groups for both men and women apart from a slightly higher proportion of people aged between 35 and 50 and those between 65 and 69. People living at a local care home are registered with the practice.

The practice has five partners and two salaried GPs. Four of the GPs are male and three are female. The practice has three nurse practitioners, six practice nurses, two health care assistants and a phelbotomist. A nurse practitioner is a registered nurse who has acquired the knowledge base, decision-making skills, and clinical competencies for expanded practice. One of the nurse practitioners was also the practice nurse team manager.

The clinical team are supported by a practice manager, finance manager and a team of reception staff and medical secretaries. Some of the practice team are part time. This provides some inbuilt flexibility for covering annual leave and sickness.

New Road Surgery is a training practice providing GP training places for up to three GP registrars. A GP Registrar or GP trainee is a qualified doctor who is training to become a GP through a period of working and training in a practice. Only approved training practices can employ GP registrars and the practice must have at least one approved GP trainer.

The practice has a patient participation group (PPG), a group of patients registered with a practice who work with the practice team to improve services and the quality of care.

The practice has a General Medical Services (GMS) contract with NHS England.

Data we reviewed showed that the practice was achieving results that were in line with national or Clinical Commissioning Group average in most areas and higher in some.

The practice does not provide out of hours services to their own patients. Patients are provided with a telephone number to obtain details of the local out of hours GP arrangements.

Detailed findings

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme 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 references to the Quality and Outcomes Framework data in this report relate to the most recent information available to CQC at the time of the inspection.

How we carried out this inspection

Before this inspection, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. These organisations included Redditch and Bromsgrove Clinical Commissioning Group (CCG), NHS England Area Team and Worcestershire Healthwatch. We carried out an announced visit on 18 November 2014. We sent CQC comment cards to the practice. We received 27 completed cards which gave us information about those patients' views of the practice.

During the inspection we spoke with four patients and a total of 13 staff including the practice management and support team, GPs, GP registrars, practice nurses, a healthcare assistant and a phlebotomist (a person trained to take blood). We also spoke with a member of the practice's Patient Participation Group (PPG) who came in to the practice to meet with us.

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

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

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

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

Good

Are services safe?

Our findings

Safe Track Record

The practice had a critical and significant event policy and clear systems for reporting, recording and monitoring these. The policy had been in place for six years and the management team had reviewed and updated it every year. The records of significant events dated back to 2008 and were cross referenced to relevant team meeting minutes. The well-established policy and history of recording showed that the practice had a long standing commitment to monitoring safety.

The staff we met understood the importance of recognising, reporting and recording significant events. The policy supported them in this by providing comprehensive examples of situations that could be defined as an 'event'. The practice had a reporting form to record the details of individual events and the practice expected all staff to complete one if they needed to report something. Where more than one member of the team was involved in an event, they were expected to record this individually.

Learning and improvement from safety incidents

National and local safety alerts arrived at the practice by email and all the GPs and nurses received a copy. These were checked to see if any applied to the practice and were discussed at staff meetings as necessary.

We saw evidence that the team discussed significant events at meetings held every two to three months specifically for this purpose. This gave all practice staff opportunities to discuss actions and decisions made to prevent adverse events happening again. Whichever team member had reported the incident took the lead in presenting the issue at the meetings. The practice view was that it was important for the whole team to be involved in discussions when things went wrong. They believed this improved communication within the practice and supported a culture of openness, mutual respect and shared learning. The staff we spoke with confirmed that they were involved in these meetings and that the discussions were always open and constructive.

Minutes of meetings contained details of the events discussed and the changes in practice procedures they had made as a result. These included changes to the arrangements for dealing with hospital discharge letters, monitoring of prescriptions, communication with the pharmacy next door and communication with patients about test results.

Reliable safety systems and processes including safeguarding

The practice had a chaperoning policy based on national and local guidance. The policy highlighted diversity considerations, confidentiality, safeguarding and consent. It made specific reference to the Mental Capacity Act 2005 when chaperoning a vulnerable adult. In house training was provided for staff who fulfilled this role. This was mainly done by the practice nurses. Signs were displayed within the practice to inform patients that chaperones were available and there was a checklist for staff within the policy as a reminder of the arrangements. Two of the patients who completed comment cards mentioned their appreciation of being offered this service.

The practice had a lead GP and lead nurse for safeguarding and staff we spoke with knew who they were. Staff had a good understanding of their roles and responsibilities regarding safeguarding including their duty to report abuse and neglect. Members of the team we spoke with knew how to access information about safeguarding on the practice's computer system.

The practice had a children and young people safeguarding policy and an adult safeguarding policy. These were based on the local NHS Trust policies and had been tailored to the needs of the practice. They provided clear guidance for staff about identifying and reporting abuse and neglect. The policy included information about important contact numbers for the multi-disciplinary child and vulnerable adult safeguarding teams and decision making flow charts to assist staff. The local multi agency safeguarding forms were available in the practice for staff to use when needed. The practice had reviewed both policies annually to ensure they were up to date and provided correct information. The practice had clear systems which made sure that relevant staff were aware of any child known to be at risk or who was in the care of the local authority.

We saw evidence that staff regularly completed safeguarding training for children and vulnerable adults at a suitable level according to their role at the practice. The practice training records showed that staff had all completed training during 2013 and 2014 with only four

staff identified as needing updates. Staff we spoke with confirmed that they had completed on-line training. The practice had decided they would prefer to provide more face to face training in this subject but had not yet been able to identify a suitable training provider for this.

The practice took part in regular multi-disciplinary meetings about safeguarding and liaised with health visitors, midwives and district nurses as necessary.

The practice computer system provided clear information for staff so that they were aware of any patients who may be vulnerable or at risk. This included patients receiving care at the end of their lives as well as children who had a child protection plan in place. This system was also used to ensure staff safety, for example to alert female staff if they should not see a patient alone.

The practice had a whistleblowing policy which included information about the rights and responsibilities of staff. The document included information about whistleblowing legislation and relevant organisations including the General Medical Council (GMC) and CQC.

Medicines Management

We saw that the practice had policies and procedures relevant to the safe management of medicines and prescribing practice. There was a lead GP for medicines management and the nurse manager received any national alerts about medicines safety issues by email. They had a structured system for recording that they had seen these, checked them and circulated to appropriate members of the team. The nurse manager told us that whenever medicines alerts were received the practice did a patient search to identify anyone who had been prescribed the medicine detailed in an alert. They provided an example of a recent alert about a medicine prescribed for epilepsy. The practice contacted all patients using this medicine and provided prescriptions for an alternative.

Patients could order their repeat prescriptions in person, online or by telephone. There was a dedicated team of staff who dealt with repeat prescription requests so that they gave their full attention to this and were not distracted by other tasks. There was a process for prompting patients who needed to have their medicines reviewed by a GP and this was done at suitable intervals depending on the specific requirements relating to individual medicines. There was a separately operated pharmacy within the practice building. This made it convenient for patients to collect medicines after an appointment.

Several patients commented that their medicines were reviewed annually or more often and that the GPs and nurses explained what their medicines were for and how to take them.

The practice had audited their prescribing of antibiotics during 2013 and 2014 and these audits showed that they had low prescribing rates for these medicines. This was consistent with national data which showed that the practice prescribing patterns were in line with or better than the national average (depending on the type of antibiotic). This is important because over use of antibiotics can cause long term resistance to these medicines by some bacteria. The practice also provided us with details of a completed clinical audit cycle from 2013 and 2014 about a review of prescribing for another medicine. The practice had recorded that as a result of this work they had demonstrated a significant improvement in their practice. This included providing repeat prescriptions to fewer patients, improved documentation and improved reasoning evident within the medical records. They also recorded that the GPs were more aware of new prescribing recommendations from the Medical and Healthcare Products Regulatory Agency (MHRA) for this medicine.

We looked at the arrangements for storing prescription pads and for monitoring when GPs took these from stock ready to use. The practice had a very robust system for this. A specific member of the administration team was responsible for recording all new prescription pads when they arrived at the practice. The practice stored prescription pads securely and followed national guidelines for the safe storage, recording and use of prescriptions.

The nine practice nurses were responsible for maintaining vaccine stocks. We saw that the practice had robust arrangements for the receipt, storage and recording of all vaccines coming into the practice. The nurse manager showed us the records the practice kept which enabled them to know exact stock levels in the building at any given time. The record also provided an audit trail of batch numbers and expiry dates. The practice had a policy and procedure to help make sure that vaccines and other medicines at the practice were stored at the correct

temperatures. This included the action to be taken to make sure vaccines were not spoiled in the event of a refrigeration failure at the practice. We saw evidence that staff monitored and recorded the temperatures of the fridges where vaccines and other temperature sensitive medicines were stored.

We saw that the practice had completed a vaccine safety checklist during 2014. This was required by the Worcestershire Health and Care NHS Trust and related to the safe storage, transport, refrigeration and monitoring of vaccines.

Five nurses at the practice were trained nurse prescribers who had received additional training to allow them to prescribe medicines for patients in specific circumstances. We spoke with a healthcare assistant who was trained to give flu vaccinations and vitamin B12 injections. They were aware of and understood the requirement for appropriate directives to be in place to allow them to administer these to patients.

Cleanliness & Infection Control

The practice was visibly clean and most patients specifically remarked on the cleanliness of the practice. Some mentioned that hand washing facilities and hand gel were always available. The practice team told us that as part of their forward planning they had identified that some of the treatment rooms needed to be updated.

The nurse manager was the lead for infection prevention and control (IPC) and the practice manager was the lead for legionella precautions. Legionella is a bacterium that can grow in contaminated water and can be potentially fatal. The practice had a legionella risk assessment and monitored the hot and cold water temperatures to help minimise the risk of legionella developing. The legionella risk assessment identified some improvements that were needed. The practice manager informed us that the practice had obtained quotations for this work and were due to decide which company to give the work to at a meeting the following day.

The staff training records showed that most staff had completed training about infection prevention and control during 2014. Some had last done this in 2013 and they were identified as needing to do the training again during 2015. Staff told us that everyone at the practice was expected to complete on line IPC training. In addition a recent practice meeting had been used to provide additional training about hand washing, wearing jewellery and to reinforce the practice's 'bare below the elbow' policy.

General cleaning of the premises was done by an external contractor. Staff told us this worked well and that the cleaning company supervisor and manager monitored standards regularly including doing spot checks. The cleaning staff kept records using cleaning schedules the practice had provided. Cleaning equipment and products were kept securely and information about safe use of cleaning materials was readily available. Staff told us that clinical equipment was cleaned by the nurses and health care assistants who were responsible for making sure equipment in their rooms was clean.

Specific equipment and products were available to deal with any bodily fluids that might need to be cleaned and staff knew where these were kept. The practice had a plentiful supply of personal protective equipment, such as disposable gloves and aprons, for staff to use. We saw that suitable foot operated bins were provided for general and clinical waste. There were disposable privacy curtains in treatment rooms and staff had recorded the date these had been changed on the labels provided for this.

Staff told us that the practice had an annual cleaning day when they checked every room, removed out of date information and made sure information displayed was clean, up to date and still relevant.

The practice had carried out IPC related audits. These included specific topics such as for Clostridium Difficile (C Diff) and prescribing rates for antibiotics. Both of these audits had been completed two years in succession and had shown low levels of C Diff and of antibiotic prescribing.

There was a sharps injury policy and procedure so staff had information about the action to take if they accidentally injured themselves with a needle or other sharp medical device. The practice had written confirmation that all staff were protected against Hepatitis B and expected all new staff to have this checked when they started work at the practice.

The practice had a contract with a specialist company for the collection of clinical waste and had suitable locked storage for this and 'sharps' awaiting collection.

Equipment

Good

Are services safe?

In our discussions with staff we established that the practice had the equipment they needed for the care and treatment they provided. We saw evidence that equipment was maintained and re-calibrated as required. This work was carried out by a specialist company and we saw that they were due to visit the practice to do the 2014 checks the week after our inspection.

Portable electrical equipment was tested and there was a fire safety folder. The fire safety folder contained a fire risk assessment by a specialist company in April 2014, routine tests and checks including fire alarm tests and fire drills. We saw that the practice had an action plan in respect of the fire risk assessment. Work to complete improvements to the automatic fire detection system was due to be completed by April 2015 and other items on the risk assessment had already been dealt with.

Staffing & Recruitment

The practice had an experienced and skilled staff team with clear responsibilities and lines of accountability. The overall staffing levels and skill mix at the practice ensured that they had sufficient staff to maintain a safe level of service to patients. The practice used a traffic light system to monitor GP patient numbers so these could be adjusted and maintained at safe levels. GPs confirmed that although the practice was very busy and demand was high, the team routinely monitored workload and stress levels.

We met a new member of the practice team. They confirmed that they had been though a thorough recruitment procedure and a structured induction period which they had not yet completed. Whilst they had been at the practice only a short time they had already completed a range of mandatory training and had a review with their line manager. They were able to tell us with confidence about the practice's arrangements for patient consent, health and safety, infection prevention, fire safety, safeguarding and several other topics.

The practice had a recruitment policy. This did not contain specific details of the policy and procedure at the practice for carrying out checks through the Disclosure and Barring Service (DBS). DBS checks identify whether a person has a criminal record or is on an official list of persons barred from working in roles where they will have contact with children or adults who may be vulnerable. We found that a member of clinical staff had started work before their DBS check was sent for and would have contact with patients before it arrived. Whilst they would only do this when other staff were present to supervise them the practice did not have a risk assessment setting out the factors they considered in deciding this would be safe. The policy did not specify how the practice satisfied itself of the conduct of job applicants in previous employment involving the care of children or vulnerable adults. However, staff told us that no one was allowed to start work at the practice until references had been received.

Monitoring Safety & Responding to Risk

The practice carried out a comprehensive annual health and safety audit. We saw that this included every room in the practice. The audit included a list of any issues identified and action plans for dealing with these. The practice had a rolling programme for the refurbishment of the building.

The practice had robust arrangements for identifying those patients who may be at risk and to help ensure the safety of staff when working alone. There were practice registers in place for patients in high risk groups such as those with long term conditions, mental health needs, dementia or learning disabilities. The practice computer system was used to inform staff of individual patients who might be particularly vulnerable. Staff working in reception and answering the telephones also had this information to help them prioritise potentially urgent cases.

The practice had their own handyman and we saw that the premises were well maintained. Staff had access to a maintenance log where anyone could record repairs or maintenance that needed to be carried out.

The three managers had a rota system for one of them to be deployed as a duty manager each day. They spent the day in the reception area where they were able to provide support to the team of reception and telephone staff. This system also meant that a senior member of staff was readily available to respond in the event of a difficult situation, concern or emergency.

Arrangements to deal with emergencies and major incidents

All staff at the practice had completed Cardiopulmonary Resuscitation (CPR) training and the practice had a system for monitoring when refresher training was due. All but two of the clinicians had completed their CPR training during 2014 and all of the non-clinical staff were up to date with

their training. Staff told us that additional discussions about medical emergencies took place during some of the practice meetings each year. Staff told us there was an emergency call bell in every room which staff could access in an emergency and that everyone knew what to do. When the call bell was used the room number was displayed in the corridor so that staff knew which room they needed to go to provide assistance.

The practice had oxygen, a defibrillator (equipment used to attempt to restart a patient's heart) and emergency medicines available for use in a medical emergency at the practice. We saw evidence that staff checked these regularly to make sure they were available and ready for use when needed. Staff told us that the nursing team were responsible for checking the contents and that the nurse manager monitored this. The practice had made a decision that GPs would not have their own bags for visits. This was to make sure that GPs on home visits always had a bag containing all of the required equipment and medicines. The practice also judged this to be less wasteful because medicines were less likely to pass their expiry date. The practice had a full spare set of supplies in case these were needed while a GP was out and had the main bag with them.

We saw evidence of fire safety checks and tests including fire alarms and drills. Staff we asked confirmed that they had taken part in fire safety training and drills. The staff records included records of fire safety training. Most staff had completed fire training in 2013 and 2014. A small number of the team were due to have updates and this was highlighted in the training records.

Some of the GPs had 4 x 4 vehicles and/or snow chains to help ensure patients could be reached at home if it snowed. In very cold weather the handyman came to the practice to grit the car park.

The practice had a business continuity plan covering a range of situations and emergencies that may affect the daily operation of the practice. The plan was available to all staff on the practice's computer system and paper copies were kept in the practice. All of the GP partners and management team had copies at home so that it was available all of the time. The areas covered included computer failure, loss of power, heating or water, adverse weather, unplanned sickness and access to the building. The plan also included information in the event of widespread illness such as a flu outbreak and details of precautions regarding Ebola. The document also contained relevant contact details for staff to refer to.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Our discussions with the GPs and nurses showed that that they were aware of and worked to guidelines from local commissioners and the National Institute for Heath and Care Excellence (NICE) about best practice in care and treatment. The practice had a lead GP for clinical governance and they made sure that information such as NICE guidance was circulated to all the GPs and nurses. Data available to us showed that the practice had high achievement levels or the Quality and Outcomes Framework (QOF). QOF is a scheme which rewards practices for providing quality care and helps to fund further improvements.

GPs told us they regularly discussed NICE guidelines and care pathways at the various meetings they held. They told us that when guidelines changed they also updated in-house information such as practice policies.

Several patients described situations when their GP took decisive actions which resulted in them receiving a prompt diagnosis and treatment. During our inspection we learned of three situations where GPs took prompt action which resulted in patients receiving the treatment they needed. Some patients also gave us examples of GPs' careful assessment of their health.

Management, monitoring and improving outcomes for people

The practice had nine nurses. Three of these were nurse practitioners who were also nurse prescribers. A nurse practitioner is a registered nurse who has acquired the knowledge base, decision-making skills, and clinical competencies for expanded practice beyond that of a registered nurse. Nurse prescribers have received additional training to allow them to prescribe medicines for patients in specific circumstances.

The practice also had two healthcare assistants and a phlebotomist (a person trained to take blood). The size and range of the practice nursing team and their collective range of experience, knowledge and skills enabled the practice to provide a range of services to their patients. These included long term condition management for conditions such as diabetes, COPD, heart conditions, women's health, family planning and immunisations. Other nurse led services available at the practice were ECGs, ear syringing, ear syringing, dressings and travel clinics. Patients could have blood taken at the practice and the nursing team provided monitoring for patients taking medicines used to prevent blood clotting. The practice nurses described working closely with a member of the practice administrative team to make sure patients with long term conditions were called for their regular checks. One of the nurses was trained to carry out procedures to remove warts using a technique where these are frozen with liquid nitrogen.

One of the practice nurses specialised in diabetes and told us the practice had about 500 patients with diabetes. They had completed extended training for this role including an insulin initiation course. This enabled them to commence insulin treatment for patients when they were first diagnosed with the condition so that patients did not necessarily have to be referred for secondary care. They had also completed a course to enable them to prescribe a medicine which can prevent patients needing to take insulin. One of the GPs had also completed this training. The nurse told us that they had seen good outcomes for patients including improvement in the control of their diabetes. They gave us an example of a patient where they had identified a concern and referred them for specialised testing. This had confirmed that they needed specific treatment due to a rare element to their condition. This had resulted in their health improving. We spoke with the local NHS Trust specialist diabetes nurse following our inspection. They confirmed that the experience and training of the practice nurse had enabled them to identify something unusual which might have otherwise have been missed.

When new patients join a practice their previous GP records need to be summarised into the new practice's systems. At this practice this task was always carried out by the GPs. New patients were invited to come to the practice for a health check with one of the healthcare assistants. New patients with a known long term condition were seen by a GP.

People living at a nearby care home were registered as patients with the practice. This was part of a local enhanced service (LES) in partnership with the clinical commissioning group (CCG). A GP visited the home twice a week and also carried out full health reviews of all patients every six months. The practice described a positive working

Good

Are services effective?

(for example, treatment is effective)

partnership with staff at the home. We spoke with the registered manager of the home. They told us that the service provided by the practice was excellent and said that the practice provided a caring service. They said that as well as the twice weekly visits the GPs willingly visited patients at other times as and when the need arose.

The practice provided medical care to older patients in a local community hospital where they did a daily ward round and took part in a virtual ward scheme aimed at reducing hospital admissions and discharge delays. Virtual wards enable healthcare professionals to provide medical care and monitoring to patients in their own homes rather than in a hospital setting. The practice used the gold standards framework for end of life care. They had a register of patients who needed care and support though this stage of their lives and took part in meetings with other professionals involved in their care.

Clinical audits are a process by which practices can demonstrate ongoing quality improvement and effective care. A GP gave an example of an audit, policy and care pathway based on NICE guidelines for atrial fibrillation (a type of heart condition). This showed the work done for the first cycle of the audit and identified the practice's intentions for a repeated audit. We also saw evidence that the practice followed NICE guidelines for other conditions including respiratory conditions and diabetes. GPs told us that the practice nurses supported them in this by making effective use of specialised forms for following care and treatment pathways. GPs told us about an audit relating to the care of their patients who lived at the care home they provided medical care to. The practice provided details of a completed clinical audit cycle in respect of a medicine which had resulted in improvements in prescribing patterns, patient records and GP awareness. We also saw evidence of audits in respect of antibiotic prescribing and infection prevention and control. Although the practice carried out minor surgery they had not completed any clinical audits for this.

A GP gave us an example of a situation where they had used their knowledge and experience to make an effective diagnosis of a serious condition. They had done this based on minimal information and vague symptoms when a patient became unwell at the practice. We also learned of other effective diagnoses including a situation when a GP had referred a child to a specialist when neither they nor doctors at the local hospital had been able to find what was causing their symptoms. The specialist provided immediate guidance and the child was referred to a consultant for treatment.

Some of the patients we spoke with or had filled in comment cards indicated that they had long tem health conditions. Several gave us examples of the treatment and support the practice had provided to help them manage their health. Others described their GP or other members of the practice team working with them and other professionals to monitor their health.

Effective staffing

The GPs and nurses at the practice had a wide range of knowledge and skills. Their knowledge and skills were updated with ongoing accredited training and in-house training. The nurses and healthcare team gave us numerous examples of training they had done. In many cases the practice had funded them to do this training. For example, we met a practice nurse who specialised in respiratory diseases. They had completed diploma level extended training in respect of asthma, children's asthma and chronic obstructive airways disease (COPD) and a specialist course for spirometry (a spirometer measures the volume and speed of air that can be exhaled and inhaled and is a method of assessing lung function). They told us the practice had paid for the courses and been flexible about the time they needed to take part in these.

The GPs told us that their annual external appraisals and requirements for revalidation were up to date. Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by General Medical Council can the GP continue to practice and remain on the performers list with the NHS England.

The practice's specialist diabetes nurse was due to retire during 2015. The practice had planned ahead to ensure that there was no interruption or reduction in the quality of the care and treatment they gave to patients with diabetes. They had appointed a replacement nurse two years ago. This nurse was receiving relevant training including a diploma level course and an insulin initiation course. They were working alongside the current nurse to get to know patients and become familiar with the practice's arrangements for their treatment. The current diabetes nurse told us that the practice team had supported them

well in their role. As well as a range of specialist training they took part in diabetes link nurse meetings twice a year and attended relevant meetings and conferences. The current nurse, the new nurse, a GP and one of the other practice nurses had regular meetings about diabetes care at the practice. They said that from January 2015 time had been allowed in the staffing rota to enable them to complete the handover of their work before they retired.

We saw information that showed that the practice reviewed their staffing arrangements to consider patient need and the available staffing levels. For example, the practice had looked at how the hours for the nurses, healthcare assistants and reception staff could be re-allocated or increased. Alongside this the team had reviewed the use of treatment rooms in the practice. This was to make sure any changes they decided to make took into account available time, staff and space. The overall aims of this were to increase patient contact time, develop the phlebotomy (taking blood) service and the time available for smoking cessation and other health promotion services.

Staff told us that the GPs and management team supported them well and that they were encouraged to develop their knowledge and skills. For example, one of the team told us they had received 90 hours clinical supervision to support them with a training course.

Working with colleagues and other services

Several patients mentioned that GPs at the practice worked closely together and with staff from other health services to ensure they received the care and treatment they needed to have. They gave us examples of situations where they had received the correct care quickly as a result of this.

Health visitors, district nurses, midwives and mental health workers were able to use rooms at the practice to see patients and a physiotherapist was based there. Staff told us this assisted communication with colleagues. They recognised the importance and value of this, particularly for patients with long term conditions or needing end of life or palliative care.

The practice's diabetes nurse described a positive working relationship with the local NHS Trust specialist diabetes nurse. They explained that together they held a joint clinic every six weeks. This enabled a joined up approach to monitoring and providing the right level of care and treatment for each patient. We spoke with the specialist diabetes nurse following our inspection. They confirmed that until recently this had been the only practice in the Bromsgrove area working with them this proactively. They agreed that the relationship with the practice was positive and resulted in good outcomes for patients. They gave us an example of a patient where the close working relationship had helped to establish their treatment and self-care when they were first diagnosed.

The practice worked closely with a link worker from the local NHS community mental health team. This worker visited the practice twice a week and GPs were able to discuss patients' mental health care and treatment needs with them. The practice also provided in-house counselling services from a Relate counsellor, and when necessary referred patients to NHS psychology services.

We learned that the practice worked in partnership with Pathways Worcestershire a joint venture provided by a voluntary organisation, the Crime Reduction Initiative (CRI). This was part of a Local Enhanced Service supported by Worcestershire County Council which the practice took part in although the numbers of patients involved were low. CRI provided support workers (both nurses) to support patients in the process of detox from drugs and/or alcohol. They visited twice a week to see patients and two of the GPs worked with them to provide medical support and prescriptions for those patients. The GPs and support workers undertook joint medical reviews with these patients every three months. The Community Alcohol Team also supported patients at the practice with the GPs providing medical and prescribing support for this too. The practice made facilities available for CRI to hold regular group support sessions for patients at the practice.

The practice engaged fully with the Redditch and Bromsgrove clinical commissioning group (CCG). The GPs took part in monthly GP forum meetings organised by the CCG and in other meetings with a CCG representative and three other practices. The practice was also represented at annual CCG meetings to discuss the setting of priorities. GPs in Bromsgrove held regular peer clinical meetings. GPs at New Road Surgery had identified that they wanted to attend these meetings more regularly than they had been.

Information Sharing

Good

Are services effective?

(for example, treatment is effective)

Information was available for all staff to access on the shared drive of the practice's computer system. All of the staff we spoke with knew this and gave us examples of information they might look for such as safeguarding information or consent forms.

The practice had a system for making sure test results and other important communications about patients were dealt with. The system ensured that if the relevant GP was not at work when results arrived these were checked by the duty GP so that action could be taken promptly if urgent action was needed. The nurse manager also monitored the arrangements to make sure that all abnormal and urgent results were dealt with as soon as possible. The practice told us that some test results could be confusing and were looking at ways to improve their systems further.

The practice had systems for making information available to the out of hours service about patients with complex care needs, such as those receiving end of life care.

The practice used the Choose and Book system and the GPs supported patients with this process themselves and did not delegate it to other members of the team. The Choose and Book system enables patients to choose which hospital they will be seen in and to book outpatients appointments in discussion with their chosen hospital.

The practice recognised the importance of confidentiality and of complying with data protection legislation. Staff were required to sign to confirm they had read and understood the confidentiality and data protection policies. The practice had a poster in the waiting room and information on their website to inform patients about their rights regarding how their information was managed. The practice had very secure fire resistant storage for historical paper patient records and we saw that the records were filed in a well organised way.

Consent to care and treatment

The practice had a comprehensive policy to support staff in fulfilling the requirements of the Mental Capacity Act 2005. The MCA provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves. This reflected national and local guidance and provided links to government and voluntary organisation information to support best practice. The policy included information about how patients who did not speak English as a first language might need additional support to be able to give consent.

GPs and nurses with duties involving children and young people under 16 were aware of the need to consider Gillick competence. The Gillick Test helps clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment.

Staff we spoke with understood the importance of gaining informed consent. All of them described the principles and processes involved in a knowledgeable way and knew where the practices' consent forms were stored if they needed to use one. Members of the team gave us several examples when they had needed to consult colleagues and consider whether or not a person had capacity to give consent to a procedure or treatment.

Several patients gave us examples of staff ensuring they had consent. For example, one told us that they had been asked for their consent to a student nurse being present during their appointment. Information about consent was displayed in reception.

The manager of a local care home where the practice provided GP services told us that the GPs were respectful towards their patients and dealt with issues such as consent and decisions about end of life care in a sensitive way. The confirmed that they involved the right people in making decisions in patients best interests when they were too ill to be involved themselves. However, whenever possible they spoke direct with the patient to gain their views and wishes.

Health Promotion & Prevention

The practice nurses, healthcare assistants and phlebotomist provided 13 different weekly clinics for a range of health checks and conditions. These ranged from health checks and baby clinics to specialist clinics for patients with long term conditions such as diabetes or respiratory problems. Information about these was provided on the practice website. A member of staff told us that the practice was planning to re-start a smoking cessation clinic and that they had been asked to become involved in this. They told us they were enrolled on a two day training course due to begin in December 2014 and that they had already started an on-line training course.

Good

Are services effective?

(for example, treatment is effective)

The practice had an informative website which had a facility to display the information provided in numerous other languages. The website provided information about various health and care topics. These included information about long term conditions such as diabetes, chronic obstructive airways disease (COPD) and asthma. There was also information about osteoporosis, heart disease, cancer and stroke. There were also links to information and guidance about mental health needs. Individual sections of the website related to women's, men's and children's health. Printed leaflets were available at the practice and the GPs and nurses could print information for patients direct from the NHS computer system. This helped to ensure patients always received the most up to date information which could be printed in languages other than English if needed.

The practice held baby clinics every week and the health visitor team based in the building held clinics twice a week. Childhood immunisations were provided and the GPs carried out six week checks for babies. The practice provided Meningitis C vaccinations for young people. The nurse manager explained that due to high university uptake in the area this was very popular.

One of the practice nurses was responsible for the practice's cervical screening programme and patients were called for these tests every three to five years or more frequently if their individual needs made this desirable. This nurse held a women's clinic every week for cervical screening and other women's health issues.

Staff told us about the flu clinic they held in October 2014. They explained that the whole team took part in this and that it was very well organised including supervision of the car park. They said that the healthcare assistants acted as 'runners' to make sure all the GPs and nurses had what they needed and that patients were happy. National data showed that the practice had achieved higher than the national average figures for providing flu vaccinations to patients aged 65 or over and were in line with the national average for patients of all ages who might be a specific risk if they developed flu.

A healthcare assistant had completed training about high blood pressure and ran a weekly clinic for patients who needed regular blood pressure checks. They told us a specialist nurse had been to the practice to talk to the team about atrial fibrillation, a type of heart condition. Following this talk they had identified some patients during their blood pressure checks who might have this condition and arranged for them to be seen by one of the practice nurses or GPs for this to be fully checked.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We gathered the views of patients from the practice by looking at the 27 Care Quality Commission (CQC) comment cards that patients had filled. We spoke with four patients on the day of the inspection as well as with a member of the patient participation group (PPG). A PPG is made up of a group of patients registered with a practice who work with the practice to improve services and the quality of care. All of the information we gained from patients about their care and treatment was positive. Data available from Public Health England and the NHS England GP patient survey showed that the patients had reported positive views about the practice. The practice had higher than average scores in respect of overall satisfaction with the care they received, the opening hours and the numbers of patients who would recommend the practice.

We received considerable positive feedback from patients about the practice. Patients told us that the staff placed high importance on their privacy and dignity and treated them with compassion and sensitivity. Patients described the GPs and other members of the team as kind, approachable and dedicated. Several remarked that members of the practice team took their concerns seriously and treated them as an individual.

Patients were confident that their privacy was respected. Some commented that treatment room doors were always closed, staff knocked on doors before coming into a room and they did not overhear conversations about other patients. There was a poster displayed in reception information patients to ask if they wished to speak with a receptionist privately. The practice had a dedicated team of staff to answer the telephones. This team worked in an area of the reception which was separate from the reception desk. This helped to make sure that conversations with patients on the telephone could not be overheard by those waiting at the reception desk.

Patients and staff told us that patients could ask to be seen by either a male or female GP and staff told us that they could usually accommodate this.

Care planning and involvement in decisions about care and treatment

In many of the comment cards patients mentioned that their GP listened to them and treated them as individuals. Patients said they did not feel rushed and had confidence in the care and treatment they received. Several patients described situations when the decisive actions their GP had taken had resulted in them receiving a prompt diagnosis and treatment. Patients told us that their GP gave them clear information and involved them in decisions about their care. One GP told us that they reviewed a patient's care because the patient had shown them information about their condition that they had obtained on the internet. They said they were open to listening to information from patients in this way

Some patients told us they had one or more long term conditions and confirmed that the practice responded to their needs and treated them with respect. Others commented that their GP listened to them properly and said this gave them confidence. Several patients gave us examples of a GP or nurse describing their treatment options so they could decide which course of action suited them best. One described how a GP had explained something to them in a way that was easy for them to understand. One person told us they had not been given clear guidance about how to change a dressing but this was the only negative comment about care that anyone made.

Patient/carer support to cope emotionally with care and treatment

The information contained in the comment cards showed that patients felt supported by the practice. One patient gave us an example of how the practice team supported them and their partner during and after an acute period of ill health. A patient who was also a carer remarked on the care and attention provided when their older relative was unwell. They added that their relative was treated with respect and that nothing was too much trouble.

The practice had a written protocol for staff to follow when a patient died and a system to make sure that bereaved patients received the support they might needed. Staff in reception and in the telephone room had clear information available to make them aware of patients nearing the end of their lives where a rapid response may be needed to provide the necessary care or emotional support.

Good

Are services caring?

The practice sent sympathy cards to families when patients died. We saw notes in staff meeting minutes passing on patients' thanks for the support given by GPs and nurses following the death of family members.

Information about sources of support and guidance was available on the practice website and at the practice. This included details of various support groups and organisations for carers and families. There was also information about specific topics such as Alzheimer's Disease, stroke, cancer and Ebola precautions. Patients who were carers were given information about Worcestershire Association of Carers a voluntary organisation which provides advice and support.

The practice had a Relate counsellor based at the practice who was available to provide support to patients either with concerns about relationships or other difficulties. The practice also had an attached social worker who worked in partnership with the practice to help provide support to older patients.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Patients and staff were positive about their experience of the practice. They portrayed a service that they found to be efficient and welcoming. All of the GPs specialised in one or more health care areas. This enabled the practice to offer a range of services to patients of all ages and across all population groups.

The practice was aware of the needs of the practice population and was able to provide us with detailed information about the numbers of patients they had with long term conditions, mental health needs, learning disabilities or dementia. They also knew how many patients they were supporting who were receiving palliative care.

Information we obtained before the inspection from the NHS England Area team and Redditch and Bromsgrove Clinical Commissioning Group (CCG) provided a picture of GPs who engaged positively with these organisations and of a well organised practice.

The practice had a register of people with mental health support and care needs. Each person on the register was invited for an annual review of their overall health. A link worker from the NHS community mental health team was at the practice twice a week to support the team to identify patients' needs and to provide advice and information about treatment options.

The team were alert to the complex needs of people who were living with dementia and had a dementia register. GPs told us that they reviewed these patients' needs at least annually.

The practice provided GP care to older people living in a local care home. Some of those patients were living with dementia but most needed significant levels of care due to their physical care needs. This service reflected a local enhanced service (LES) arrangement between the CCG and GP practices in the area to provide responsive service to older people living in care homes and nursing homes. A GP visited the home twice a week and reviewed each patient's medicines and health every six months. The manager of the nursing home told us that the practice provided a supportive and caring service. They confirmed that a GP visited twice a week and avoided mealtimes so that patients could have their meals uninterrupted. In addition to the two routine visits each week, the GPs visited at other times when they were needed. They told us the practice worked closely with them and with patients' families.

The practice used the gold standard framework for end of life care and had a register of patients receiving palliative care. The practice took part in monthly meetings with other professionals involved in caring for patients in these circumstances. They had a clear system for making sure members of the team, including reception staff and those who staffed the phone lines, were aware of patients who were at the end of their lives and might need an urgent response from the team.

Three GPs at the practice specialised in the care and treatment of patients who misused alcohol and illegal substances. Two of these GPs were trained to provide specialist prescriptions for patients in recovery from drug misuse and worked in partnership with Pathways Worcestershire a joint venture provided by a voluntary organisation, the Crime Reduction Initiative (CRI). This was part of a Local Enhanced Service supported by Worcestershire County Council which the practice took part in although the numbers of patients involved were low. CRI provided support workers (both nurses) to support patients in the process of detoxification from drugs and/or alcohol. They visited twice a week to see patients and two of the GPs worked with them to provide medical support and prescriptions for those patients. The GPs and support workers undertook joint medical reviews with these patients every three months. The Community Alcohol Team also supported patients at the practice with the GPs providing medical and prescribing support for this too. The practice made facilities available for CRI to hold regular group support sessions for patients at the practice.

Staff at the practice assured us that any patient in need would be seen by a GP on the same day. Patients whose health prevented them from being able to attend the surgery were visited by the GPs or practice nurses at home so that they were not disadvantaged by this.

Tackling inequity and promoting equality

The GPs rooms were on the ground floor and there was a ramp with a handrail into the building from the car park. The nurses' treatment rooms were on the lower ground floor. Staff showed us that patients unable to use the stairs could reach these by coming into the building through a

Good

Are services responsive to people's needs?

(for example, to feedback?)

door on that level. The car park provided disabled parking spaces near to the main entrance. One patient commented that they felt the practice needed to increase the number of these. Parking was also available at the back of the building for anyone needing to use the lower ground floor entrance.

Staff told us that the practice did not have any homeless patients or traveller families registered with them but would respond as needed as when necessary.

The practice used a telephone interpreting service for any patients who were unable to converse in English and some information at the practice was available in languages other than English. The practice website had a translation service which patients could use to translate all of the content into their preferred language. GPs also had the facility to print up to date NHS patient information leaflets during consultations with patients and it was possible to select other languages for this. However, staff told us that the practice population was not culturally diverse and so whilst these facilities were available they did not need to use them often.

The practice had an induction loop to assist people who use hearing aids.

One of the GPs had delivered equality and diversity training to the whole staff team. We did not identify any suggestion of discrimination on any grounds during the inspection.

Access to the service

The practice's main opening hours were 8.30am to 6.30pm Monday to Friday. Additional appointment hours were available for patients unable to visit the practice during those times. The practice called these 'Commuter Clinics'. These extended hours appointments were 6.30pm to 7.45pm on Monday and 7.20am to 8.30am on Tuesday. The practice also had appointments available one Saturday morning a month from 8.30 am to 11.30am.

The practice had an information leaflet and practice website providing a wide range of information about the team at the practice, opening times, the appointment system and internet booking.

The practice had a dedicated team of staff who took all the telephone calls so that reception staff could focus on patients needing attention in person at reception. The practice told us that their ability to answer calls more quickly had improved due to this system. We met some of the reception team and staff who answered the telephones. They showed that they understood the appointment arrangements at the practice well.

Patients could book appointments by telephone or on the internet. Appointments could be made for the same day or in advance. Patients could also book a telephone appointment with a GP if they did not need to see them face to face. The practice had a duty GP every day who spoke with patients requesting an appointment on the same day. This enabled an initial clinical assessment to decide whether patients needed to be seen the same day and to give advice to patients.

A few patients told us that they could not use the internet to make an appointment and found it difficult to get through to the practice first thing in the morning to ask for an appointment that day. Reception staff told us that if patients telephoned later in the day needing an urgent appointment and there were none remaining that day they asked the duty GP to call the patient back. The duty GP then called patients to assess the situation and decide what care or treatment was required including whether they needed to see the patient. Staff told us this was especially important for older or vulnerable patients.

Some patients said it could be difficult to get an appointment on the same day but qualified this by saying they always received a telephone call and were then seen by a GP if necessary. One patient remarked that it was not possible to get an appointment for the next day if they telephoned after midday. The only other negative comment was that it took longer to get an appointment if a patient wished to see a specific GP. The practice had recognised that the volume of patients telephoning the practice first thing in the morning made it difficult for some patients, especially older patients and families with school age children who needed to leave the house at that time. They were keeping the arrangements under review but felt that on the whole the system worked well.

Some patients told us they were seen on time but a few said they sometimes had to wait. However, one person commented that they did not mind this because they knew it was because their GP always gave people the time they needed.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice provided information about out of hours arrangements on their website and in a leaflet available in the practice.

Listening and learning from concerns & complaints

The practice had a system for handling complaints and concerns including a comprehensive complaints procedure to provide guidance to help staff deal with all concerns and complaints in a helpful and constructive way. There was a GP with lead responsibility complaints handling. The complaints policy was in line with recognised guidance and contractual obligations for GPs in England. The practice website and a patient information leaflet included initial information about the process for this. A more detailed complaints leaflet was also available for patients. This set out the steps the practice took to deal with their concerns and other organisations they could contact if they were dissatisfied with how the practice had dealt with these.

Patients we heard from said they had not needed to make a complaint but would speak to staff if they did have any concerns.

We saw evidence to show that the practice discussed concerns and complaints at team meetings and used these to help them improve the service. The minutes of meetings contained information about the reasons for any complaints and indicted whether verbal or written explanations and apologies had been provided to patients. Examples of this included apologies for misunderstanding about appointments and repeat prescriptions and delays with prescriptions being ready at the pharmacy. Information we looked at in the complaints file and the practice's complaints log showed that the practice responded to patients promptly and appropriately and made changes to practice where this was needed. For example, following an error with a prescription the practice had produced additional written guidance to prevent this happening again.

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 whole team at New Road Surgery showed a strong commitment to providing patients with a safe, high quality and caring service.

The practice leadership team were aware of the importance of forward planning to ensure that the quality of the service they provided could continue to develop. When the team considered developments these were discussed and costed to enable the whole picture to be considered. For example, the team had looked at extending the service provided by the nurses, healthcare assistants and phlebotomist (a person trained to take blood). We saw that their discussions had taken into account the practice's contract obligations to NHS England, a comparison of staff costs and the available treatment room space at the practice.

The practice appointed a new diabetes nurse two years before the current nurse's planned retirement in 2015. This showed a strategic approach to planning and outstanding commitment to the continuity of care and treatment of patients with diabetes.

Governance Arrangements

The GP partners all had lead roles and specific areas of interest and expertise. During the inspection we found that all members of the team understood their roles and responsibilities. There was an atmosphere of teamwork, support and open communication.

The practice had policies and procedures to support the team in the effective management of the practice. Responsibility for each of these was delegated to named GPs and we saw that the policies were reviewed regularly.

The practice held a variety of regular meetings and events to provide opportunities for communication, team building and shared education and learning. These included team meetings for the practice nursing team and for the reception and office staff and partners' meetings which they held every two months with the management team. Meetings for the whole team to discuss complaints and significant events took place every two to three months. In addition the GPs had an informal meeting over coffee every morning. The GPs told us that the appointments were scheduled to make sure all of them could take part. The GPs valued these meetings and considered they played an important part in making sure the practice had an open culture. The practice also arranged two or three whole practice meetings each year and had an annual 'away day'. This was used for discussions about the future of the practice away from day to day pressures.

An example of a decision made following an 'away day' was the work that the practice had done to ensure they had a succession plan in place for the retirement of the practice's specialist diabetes nurse.

The practice used information from a range of sources including their Quality and Outcomes Framework (QOF) results and the Clinical Commissioning Group to help them assess and monitor their performance. Each of the GP partners was a lead for a specific aspect of QOF. We saw one completed clinical audit cycle and other audits demonstrating that the practice reviewed and evaluated the care and treatment patients received. However, the arrangements for completed clinical audit cycles were not fully embedded in the practice culture.

Leadership, openness and transparency

The practice had a robust and structured management structure to support the GP partners in the management of all aspects of the running of the practice. The GP partners formed the executive team and each of them had a lead role. One partner was the chair, another was the executive lead and the other two were the leads for nursing and finance. GPs also had other lead roles such as complaints, clinical governance and prescribing.

The executive team were supported by the practice manager who was line managed by the executive lead GP. The management team also included a nursing manager and a finance manager who were line managed by the relevant GP leads.

Each member of the management team were responsible for the relevant teams within the practice. The practice manager was responsible for the reception team, the nurse manager managed the team of nurses, healthcare assistants and the phlebotomist and the finance manager managed the medical secretaries and the managers' assistant.

Line management responsibilities and duties were clearly defined and included practice policies, staff recruitment, induction and training, staff appraisals and team meetings.

Are services well-led?

Good

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

Staff described feeling well supported and confirmed that there was an open and co-operative culture at the practice. Members of the team remarked that it was easy and enjoyable to come to work and that it was always alright to ask questions or make suggestions.

The practice deployed one of the three managers as a dedicated duty manager every day. The GPs and management team viewed this as a key daily responsibility and the time for this was therefore protected. The role of the duty manager was to deal with day to day issues that arose and to support the reception team and other support staff so that the rest of the management and executive team were free to deal with their core work. This ensured that a senior member of staff was always readily available to support members of the team when unforeseen situations occurred.

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

The practice had a patient participation group (PPG) which had been established for four years. A PPG is made up of a group of patients registered with a practice who work with the practice team to improve services and the quality of care. The PPG carried out a patient survey very year. Information about the PPG, its constitution and how to get involved was included on the practice website. Membership was open to anyone and information on the website encouraged patients to get involved. There was also information about the PPG on a notice board at the practice. The PPG and the practice recognised that the number of members was low in proportion to the number of patients registered with the practice and hoped to increase the numbers. The practice hoped this would also make the PPG more representative of the practice population.

Recent improvements made by the practice following the last survey included changing the practice phone number from a lo-call number to a local number to reduce call costs for patients and improving signage within the building. A patient told us they had appreciated the change of telephone number which had made contacting the practice easier for them. The practice had also introduced a coffee morning for patients with diabetes.

The PPG also told us about work they had done to organise fundraising for the practice. This had been successful and the money raised was used to buy equipment for the GPs.

Whilst the PPG felt this was worthwhile they also commented that they would like the practice to become more proactive in their involvement with the PPG. They believed this would help the group to be more effective in supporting improvements at the practice. The chair of the PPG told us that the group particularly valued the input of the nurse manager who played a key role in communication between the PPG and the GPs.

Throughout the inspection we heard that all members of the practice team were fully involved in discussions about the running of the practice. Staff told us that the partners and management team were approachable and that they could raise anything they needed to either one to one or in the appropriate team meetings. Teamwork was encouraged and the practice had a peer reward scheme to encourage individual contributions. This involved a monthly staff award with the winner chosen by their colleagues. A member of staff told us that the GPs would always support developments if they put forward a business case that showed the benefits. They gave us the example of recognising they could increase the practice's capacity for taking blood by appointing a phlebotomist (a person trained to take blood) when a healthcare assistant left.

Management lead through learning & improvement

We saw evidence that the practice valued the importance of quality, improvement and learning. There was a well-established staff development programme for all staff within the practice, whatever their role. This included a process for monitoring the training each member of the team and highlighting those staff who needed to do updates during the year ahead.

The practice held half day team meetings two or three times a year. These were used for training and to give staff the opportunity to learn in a team environment. Cover for the practice was provided by a locum during this time. The practice had invited a specialist learning disability nurse to provide training at the most recent of these training days. The partners and management team had an annual 'away day' to review progress and discuss future developments away from the day to day pressures of the practice. This took place on a Saturday so that the service to patients was not affected.

Are services well-led?

Good

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

Staff were supported to complete extended training for lead roles within the practice and had opportunities to develop awareness of other healthcare settings. For example, one of the practice nurses told us they took part in an exchange with a nurse from a prison healthcare setting. This had also provided an opportunity for the prison healthcare team to learn more about the management of diabetes and in particular how to encourage patients to improve their participation in their care.

The staff we spoke with confirmed that they received structured support and supervision and an annual appraisal. The practice nurses appraisal included discussions relevant to the scope of their role including where relevant prescribing arrangements. A nurse told us their appraisals normally included NICE guidance, a case history, a clinical audit and plans for their continued professional development as well as topics related to the running of the practice. Staff said that they could ask senior members of the team for support, guidance and clinical supervision at any time.

The practice held regular meetings for all staff to discuss significant events, complaints and compliments. Staff told us that whichever member of staff had reported or dealt with an incident or complaint presented the information to the team at the meetings. They explained that at the meetings all staff were equal and the aim was to build an atmosphere where no one was afraid to say if something went wrong. A healthcare assistant told us they had presented a significant event at one of these meetings. They had felt safe and confident that no one would criticise them or make them feel upset.

We saw that the practice also used staff meetings to pass on compliments and praise from patients and their families.

New Road Surgery was a training practice providing GP training places for up to three GP registrars. Only approved training practices can employ GP registrars and the practice must have at least one approved GP trainer. We met three GP registrars during the inspection. They were all positive about the support and experience they were gaining during their placement. They described the GPs as enthusiastic and said that the team actively considered ideas and ways to make things work.