Albany House Surgery

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of Albany House 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 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:

- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.
- The practice was proactive in helping people with long term conditions to manage their health and had arrangements in place to make sure their health was monitored regularly.
- The practice had comprehensive systems for monitoring and maintaining the safety of the practice and the care and treatment they provided to their patients.
- The practice was clean and hygienic and had arrangements in place for reducing the risks from healthcare associated infections.
- The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand.
- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.

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 fully understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. The practice disseminated information about significant events to all staff to enable them to learn from incidents and was committed to providing a safe service. Information about safety was recorded, monitored, appropriately reviewed and addressed. The practice assessed risks to patients and managed these well. There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Patients' care and treatment was provided based on guidelines issued by the National Institute for Care and Health Excellence (NICE). Patients' needs were assessed and care was planned and delivered in line with current legislation. The practice was proactive in the care and treatment provided for patients with long term conditions and regularly audited areas of clinical practice. We saw evidence of how the practice worked in partnership with other health professionals. Staff received appropriate training for their roles and the practice supported and encouraged their continued learning and development.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients told us they were treated with compassion, dignity and respect and they were involved in decisions related to their care and treatment.

Accessible information was provided to help patients understand the care available to them. We saw patients were treated respectfully by staff who were aware of the importance of confidentiality. The practice provided advice, support and information to patients, particularly those with long term conditions and to families following bereavement. Carers were actively identified by the practice and provided with appropriate support.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice was aware of the needs of their local population and engaged with the NHS Area Team and South Worcestershire Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients told us they had good access to the practice and we saw urgent appointments were available the same

Summary of findings

day. The practice had good facilities and was well equipped to treat patients and meet their needs. There was a clear complaints system and we saw 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 being well-led. The practice had a clear vision with quality and safety highly prioritised. Governance and performance management arrangements had been introduced and dates set for them to be reviewed. They took account of current models of best practice. Staff received comprehensive inductions, regular performance reviews and attended staff meetings and events. The practice proactively sought feedback from patients and had an active patient participation group (PPG).

Summary of findings

The six population groups and what we found

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

Older people

Good

This practice is rated as good for the care of older patients. Patients over the age of 75 had a named GP and were included on the practice's avoiding unplanned admissions list to alert the team to patients who may be more vulnerable. Hospital admissions and discharges were reviewed on a daily basis. Care plans were in place for the most vulnerable patients to avoid hospital admission when possible. The practice ensured older people had appropriate support and medicines in place when discharged from hospital and would liaise with professional agencies and the patient's pharmacy when appropriate. GPs carried out visits to patients' homes if they were unable to travel to the practice for appointments.

People with long term conditions

Good

This practice is rated as good for the care of patients with long term conditions, for example asthma, arthritis and diabetes. The practice had effective arrangements for making sure that patients with long term conditions were invited to attend the practice for annual reviews of their health. Clinics were held for a range of long term conditions, including diabetes, arthritis and chronic obstructive pulmonary disease (COPD). Patients with these conditions had care plans in place. Each member of clinical staff had specialist training in a different long term medical condition. It was the practice policy to promote care in the community rather than have patients attend hospital clinics and a range of services was offered to facilitate this, for example, minor surgery, 24 hour blood pressure monitoring and electrocardiograms (ECGs).

Families, children and young people

Good

This practice is rated as good for the care of families, children and young people. The practice held weekly childhood vaccination clinics and its rates of immunisation for children was above average for the South Worcestershire Clinical Commissioning Group (CCG). Priority was given to children who needed emergency same day appointments. Weekly antenatal and baby and children's clinics were held. Within the practice building there were baby changing facilities and a dedicated room for patients to use for breast feeding. There was also a child-friendly area within the patient waiting room equipped with toys (with appropriate infection control procedures in place) and artwork. The practice provided cervical screening and a family planning service.

Summary of findings

Working age people (including those recently retired and students)

Good

This practice is rated as good for the care of working age patients, recently retired people and students. The practice provided extended opening hours to enable patients who worked during the day to access appointments. There were available with GPs until 7pm or 8pm on three evenings every week with practice nurse appointments available until 7pm weekly. On-line services included appointment booking and repeat prescription request. NHS health checks were carried out for patients aged 40-75. The practice also provided smoking cessation clinics.

People whose circumstances may make them vulnerable

Good

This practice is rated as good for the care of patients living in vulnerable circumstances. Regular reviews were carried out in conjunction with community nurses and matrons. One of the GPs was the lead for learning disability (LD) care at the practice and the practice had an LD register. All patients with learning disabilities were invited to attend for an annual health check and were given additional time for clinical appointments (up to 20 minutes). Staff were aware of safeguarding procedures and GPs told us how alerts were placed on the records of potentially vulnerable patients.

People experiencing poor mental health (including people with dementia)

Good

This practice is rated as good for the care of patients experiencing poor mental health (including people with dementia). The practice carried out dementia screening. There was a register of patients at the practice with mental health support and care needs. Care plans were also in place. All patients with poor mental health were invited to attend for an annual health check and were given additional time for clinical appointments (up to 20 minutes). We saw evidence of close working relationships between the practice and the community mental health team and the local social services department. These teams worked with the practice to identify patients' needs and to provide patients with counselling, support and information.

Summary of findings

What people who use the service say

We gathered the views of patients from the practice by looking at 39 CQC comment cards patients had filled in and by speaking in person with nine patients. Four patients we spoke with were involved with the Patient Participation Group (PPG). 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 were highly positive about Albany House Surgery. They said GPs and nurses treated them with respect, were caring and gave them the time they needed. A total of 24 patients specifically told us the practice was excellent or good. Seven patients told us how clean and tidy the practice was. Two patients told us they sometimes had to wait to obtain a routine appointment with a GP. We spoke with management in two care homes served by the practice and were told the practice offered an excellent and reliable service.

Data available from the 2014 GP National Patient Survey demonstrated the practice was broadly average or above average within the South Worcestershire Clinical Commissioning Group (CCG). For example, 74% of patients with a preferred GP said they usually got to see or speak to that GP. This was against an average of 62% for the CCG. A total of 90% of patients described their experience of making an appointment as good. The average for the CCG was 78%. One area below average was that 51% of patients said they usually waited 15 minutes or less after their appointment time to be seen. The average for the CCG was 64%.

Most patients also said they were usually able to obtain appointments with ease and could usually get through to the practice on the telephone without difficulty. One patient told us they sometimes had to wait to have an appointment with their preferred GP.

In line with all GP practices in England, the practice is currently carrying out the NHS Friends and Family Test. Currently, 94% of patients would recommend Albany House Surgery to friends and family.

Albany House Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Albany House Surgery

Albany House Surgery is located approximately a mile to the north of Worcester city centre. The practice was established 50 years ago and has been at its current location for 20 years. At the time of our inspection, the practice had 6667 patients registered. The practice has a General Medical Services (GMS) contract with NHS England. This is a contract between NHS England and general practices for delivering general medical services.

The practice is situated in an area with a higher than average elderly population and in addition to elderly patients who live independently, cares for patients exclusively within two local care homes and has other patients in a total of 16 care homes. This includes patients with dementia. Locally, the rate of unemployment is in line with the national average and there are localised areas of deprivation.

Albany House Surgery offers a range of NHS services including family planning, smoking cessation, minor surgery and a baby clinic. It is also a training practice and regularly hosts trainee and foundation year GPs. The practice has three GP partners and a salaried GP (two male and two female GPs), two practice nurses, and a health care assistant who is also a trained phlebotomist, so able to carry out blood tests. The clinical team is supported by a practice manager, and a team of administrative and reception staff. A chaperone service is available for patients who request the service. This is advertised throughout the practice.

The practice is located in a listed building. As a result, there are severe restrictions on changes that can be made to the exterior and interior of the building. There are also a limited number of car parking spaces as the parking area is surrounded by trees that have a tree preservation order and therefore cannot be removed. The GP partners have sought to have this restriction removed to enable more parking spaces to be provided, however have been unsuccessful to date.

Based on information we gathered as part of our intelligent monitoring systems we had no concerns about the practice. Data we reviewed showed that the practice was achieving results that were average or in some areas slightly above average with the South Worcestershire Clinical Commissioning Group in most areas.

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

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. This provider was previously inspected in August 2013 under the Care Quality Commission's (CQC) previous method of 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

Detailed findings

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

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

How we carried out this inspection

Before this inspection, we reviewed a range of information we held about Albany House Surgery and asked other organisations to share what they knew. These organisations included South Worcestershire Clinical Commissioning Group (CCG), NHS England local area team and Healthwatch. We carried out an announced inspection on 9 July 2015. During the inspection we spoke with a range of staff (GPs, nurses, practice manager, reception and administrative staff). We spoke with nine patients who used the service, four of which were members of the Patient Participation Group (PPG).

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

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

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

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

Good

Are services safe?

Our findings

Safe track record

During our inspection, we examined the range of information used by Albany House Surgery to identify potential risks to patients and improve patient safety. This included reported incidents and national patient safety alerts. We also looked at comments and complaints received from patients. We discovered staff had an awareness of their responsibility to raise concerns and how to report incidents and near misses.

We looked at safety records, incident reports and minutes of meetings where these had been discussed, for the last two years. This showed the practice had managed these consistently over time and could show evidence of a safe track record over the longer term. When incidents occurred we were satisfied they were identified, dealt with, recorded and staff informed. One such incident we examined concerned blood samples having been incorrectly labelled at the practice before they were sent to the laboratory, where the error was identified. The error had been made by a locum member of staff who had not worked at the practice before. All patients affected were contacted, given an apology and blood tests were re-taken. Following the incident, the procedure was incorporated into the induction training for new members of clinical staff and it was ensured all existing staff were fully aware of the correct procedures to follow.

Learning and improvement from safety incidents

There was an appropriate system in place at the practice for handling significant events, incidents and accidents. This included the way they were identified, reported, recorded and monitored. We were shown the system used to manage and monitor incidents. We tracked three incidents and saw records were completed in a comprehensive and timely manner. When patients had been affected by something that had gone wrong, they were given an apology and informed of the actions taken, in accordance with practice policy.

One example was a patient who failed to attend for an urgent blood test requested by the practice. The blood test had to be taken before a repeat prescription for medicines was issued. The patient failed to attend and requested a repeat prescription which the practice refused to issue. The patient then complained. When the practice investigated the incident it was discovered the patient had been unaware how urgent the blood test was and that it needed to be carried out before a repeat prescription could be issued. As a result, the practice changed the wording used in its letters sent to patients when urgent blood tests were needed to include relevant facts and ensured it was included on patients' notes.

We saw this incident and others we examined had been correctly recorded on the 'significant events record sheet' used by the practice. We saw that they were discussed by the clinical team at the end of each working day, then at the weekly meeting of GP partners and finally at a later full practice meeting. When appropriate, points for action were set for staff members to carry out. These were reviewed at later meetings. Clinical and administrative staff we spoke with knew how to raise an issue for discussion at the meetings. National patient safety alerts were also discussed in staff meetings with practice staff.

Reliable safety systems and processes including safeguarding

Albany House Surgery had policies and procedures in place to manage and review risks to vulnerable children, young people and adults. We examined training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about this training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also able to describe different types of abuse. We were satisfied staff were aware of their responsibilities and knew how to share information, record safeguarding concerns and contact the relevant agencies in working hours and out of normal hours. Contact details for relevant agencies were easily available to staff and were kept updated. We saw how safeguarding concerns were discussed regularly at the multi-disciplinary team meetings and clinical staff told us how safeguarding alerts were placed on the records of vulnerable patients.

The lead GP partner was the practice safeguarding lead for vulnerable adults and children. There was a deputy appointed to act in their absence. They had received appropriate training. All staff we spoke with were aware who the lead was and who to speak to in the practice if they had a safeguarding concern. The lead safeguarding GP was aware of vulnerable children and adults who were registered at the practice and records demonstrated good liaison with partner agencies such as the local authority.

Good

Are services safe?

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

Systems were in place to identify potential areas of concern. For example, for clinical staff to identify vulnerable adults with a high number of accident and emergency attendances and the follow up of children who failed to attend for immunisations.

Measures were also in place to ensure practice staff had a safe working environment. For example, an emergency alarm had been installed in the examination rooms for staff to use if they were in danger. This sounded an alert in the administrative area of the practice and staff knew what to do if this happened.

Medicines management

During our inspection, we checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and only accessible to authorised staff. There was a policy in place to ensure medicines were kept at the required temperatures, which also described the action to take in the event of a potential failure. We saw that practice staff followed this policy and fridge temperatures were checked daily. Processes were in place to check medicines were within their expiry date and suitable for use. All medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

We saw there were Patient Group Directions (PGD) in place to support the nursing staff in the administration of vaccines. These are written instructions for how medicines should be supplied and administered. There was also a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance.

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

Cleanliness and infection control

We noted the practice was visibly clean and tidy. There were cleaning schedules in place and records of cleaning were kept. Guidance was available and this included information for the Control of Substances Hazardous to Health (COSHH).

There was an infection control lead for the practice who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role. Staff we spoke with confirmed this. Regular infection control audits were carried out. The latest audit was dated June 2015 and following this 'de-cluttering' was carried out in some of the practice rooms. It was also noted that worn flooring needed to be changed in two rooms within the building. We saw quotes had been obtained and a decision was shortly to be made to choose the most appropriate contractor to carry out the work. We were satisfied that when actions were identified in infection control audits, they were quickly carried out and reviewed in a subsequent staff meeting.

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

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

There was a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). We saw records that confirmed the practice carried out annual checks in line with this policy to reduce the risk of infection to staff and patients. The latest legionella risk assessment had been carried out in January 2015.

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

Good

Are services safe?

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. We saw equipment was tested and maintained regularly. Maintenance logs and other records confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date, October 2014 and there was a testing schedule in place.

Staffing & Recruitment

During our inspection, we saw how the practice ensured there were sufficient numbers of suitably qualified, skilled and experienced staff on duty each day. There was a staff rota to demonstrate which staff were on duty throughout the week. This was devised to ensure sufficient staff were available to meet the needs of patients. This was regularly reviewed to take into account changes in patient demand, seasonal variations and changes in staff availability, for example, sickness. Some administrative staff had part time contracts and were able to work additional hours to provide staff cover if a staff member was unexpectedly absent. We saw guidance was in place to cover staff sickness, and planned absences.

We examined the business continuity plan which had been devised by the practice to advise what to do if there was a shortage of GPs and practice staff due to sickness for example. This included arrangements for using locum GPs and service level agreements were in place for this. This would help to ensure sufficient availability of GPs to continue provision of the primary care service to patients.

Albany House Surgery had a comprehensive and up-to-date recruitment policy. This detailed all the pre-employment checks to be undertaken for a successful applicant before that person could start work in the service. This included identification, references and a criminal record check with the Disclosure and Barring Service (DBS). These were checks 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. When DBS checks were not required, for example, for administrative staff who did not work alone with patients, a risk assessment had been carried out to confirm this. We looked at a sample of recruitment files for GPs, administrative staff and nurses. These demonstrated that the recruitment procedure had been followed.

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

Monitoring safety and responding to risk

There were 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, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative who had received appropriate training for the role.

Identified risks were included on a risk log. Each risk was assessed and rated and actions recorded to reduce and manage the risk. We saw that any risks were discussed during staff meetings. For example, quotes had been obtained for worn flooring that needed to be replaced in two rooms and work was expected to start soon after our inspection.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. GPs explained how patients with long term medical conditions were monitored and appropriate alerts were placed on patients' medical records.

Arrangements to deal with emergencies and major incidents

There were arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available, this included oxygen and an automated external defibrillator (AED). This is a portable electronic device that analysed life threatening irregularities of the heart including ventricular fibrillation and was able to deliver an electrical shock to attempt to restore a normal heart rhythm. When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest and anaphylaxis (an allergic reaction). Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

Good

Are services safe?

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. This had been reviewed in February 2015. Management confirmed copies of this were kept at the homes of GPs and practice management. Risks identified included power failure, adverse weather including flooding and access to the building. If the practice building became unusable, arrangements had been made to use alternative premises and procedures were in place to advise how staff and patients should be informed. The practice had carried out a fire risk assessment in June 2015 and all staff received regular fire safety training. A fire evacuation drill had last been carried out in November 2014 and another was planned for the near future.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care & treatment in line with standards

Albany House Surgery assessed patient needs and planned and delivered its care in line with their individual needs and preferences. All patients we spoke with and all patients who had completed comment cards were happy with the care they received and any follow-up that was needed. They said GPs and practice staff provided excellent care.

Clinical staff managed the care and treatment of patients with long term conditions, such as diabetes, asthma and chronic obstructive pulmonary disease (COPD), 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. All patients with asthma and COPD had care plans in place to assist with the monitoring and management of their medical conditions. Over the last 12 months, 75% of patients with COPD had been reviewed. GPs had recognised this was low and employed a practice nurse with specialist knowledge of the condition. At the time of our inspection, the practice was working to catch-up with COPD reviews.

We found there were appropriate systems in place to ensure patients with long term conditions were seen on a regular basis. We saw 98% of patients with dementia, 62% of patients with depression and 74% of patients with a learning disability had been reviewed within the last 12 months. Each member of the clinical team had a specialist interest in a number of long term conditions and this detailed knowledge was shared throughout the team. Feedback obtained from patients said they preferred community care, rather than hospital care. To facilitate this, the practice had introduced a range of procedures. This included 24 hour blood pressure monitoring, and the initiation of insulin and monitoring for patients who received blood thinning medicines.

Patients who required palliative care (palliative care is a holistic approach to care for patients with incurable illnesses and their families) were regularly reviewed. We saw all patients who required palliative care had been reviewed within the last 12 months. Their details were passed to the out of hours practice each weekend to ensure care would continue when the practice was closed. A palliative care meeting was held quarterly, this included GPs, the practice manager, district nurses and a nurse from the local hospice.

GPs we spoke with told us how they used the National Institute for Health and Care Excellence (NICE) templates for processes involving diagnosis and treatments of illnesses. NICE guidance supported the surgery to ensure the care they provided was based on latest evidence and of the best possible quality. Patients received up to date tests and treatments for their disorders.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. Examples of completed clinical audits included audits of certain types of pain relief and infection prevention during minor surgical procedures. Some of this monitoring was carried out as part of the Improving Quality Supporting Practices scheme (IQSP), which is a voluntary quality improvement exercise.

The practice's overall performance for the Quality and Outcomes Framework (QOF) was 96.5%, 0.2% below the average for the South Worcestershire Clinical Commissioning Group (CCG) for QOF. This placed the practice within the top 10% of practices within the CCG. 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 such as diabetes and implementing preventative measures. The results are published annually. The practice had a number of results above the average for the CCG. For example, monitoring of chronic kidney disease (the practice scored 100%, above the average of 95.9% of the CCG) and monitoring of dementia (the practice scored 98.5%, above the average of 95% for the CCG).

The practice was able to identify and take appropriate action on areas of concern. For example, when patients complained about being unable to make appointments or had difficulty using the on-line system to make appointments, they were invited to the practice for assistance.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending courses

Good

Are services effective?

(for example, treatment is effective)

such as annual basic life support and safeguarding. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff had annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. As the practice was a training practice, the trainee GP based at the practice had access to a senior GP for support when needed.

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

Working with colleagues and other services

We saw how the practice worked with other service providers to meet people's needs and manage complex cases. It received blood test results, x-ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post.

The practice held regular integrated team meetings to discuss concerns. For example, the needs of complex patients, those with end of life care needs or children who were at risk of harm. These meetings were attended by district nurses, social workers, palliative care nurses as appropriate and decisions about care planning were documented. Additionally, GPs met at the end of each day to briefly discuss any concerns that had arisen during the course of the day. Clinical staff and the GP partners met regularly outside practice opening times. We saw evidence that clinical updates, difficult cases, significant events and emergency admissions to hospital were discussed and actions identified.

We saw records that confirmed the practice worked closely with the local community midwife service, health visitors, the community mental health team and community drug teams. Clinics were held for blood testing, hypertension (high blood pressure), diabetes and minor surgery amongst others, to which patients were referred when appropriate.

There was a large range of information leaflets about local services in the waiting room. Most of this information was in English, but could be provided in other languages if required.

Information sharing

The practice used electronic systems to communicate with other healthcare providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made most of its referrals through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patient care. All staff were fully trained on the system.

Consent to care and treatment

There were processes in place to seek, record and review consent decisions. We saw there were consent forms for patients to sign agreeing to minor surgery procedures. We saw that the reason for the surgery and the risks involved had been clearly explained to patients. We also saw evidence that audits of consent for minor surgery were carried out. This demonstrated consent had been obtained from patients at all times.

We saw the process in place to obtain signed consent forms for children who had received immunisations. The practice nurse was aware of the need for parental consent and what action to follow if a parent was unavailable. There was information available for parents informing them of potential side effects of the immunisations. Clinical staff we spoke with demonstrated a clear understanding of the importance of determining if a child was Gillick competent especially when providing contraceptive advice and treatment. A Gillick competent child is a child under 16 who

Good

Are services effective?

(for example, treatment is effective)

has the legal capacity to consent to care and treatment. They are capable of understanding the implications of the proposed treatment, including the risks and alternative options.

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

The practice used an interpretation service to ensure patients understood procedures if their first language was not English.

Health Promotion & Prevention

We saw all new patients were offered a consultation with the practice nurse when they first registered with the practice. If any medical concerns were found, the patient was referred to the GP or another healthcare professional if more appropriate. The practice also offered NHS health checks to all its patients aged 40-75. Within the last 12 months, the practice had carried out cervical screening on 77% of its patients who were eligible for the procedure.

We were shown work the practice had carried out to identify and promote particular health needs within the area. For example, flu vaccinations had been given to 67% of patients aged over 65 during the 2014-2015 programme and over the last 12 months, an increase of over 10% from the previous year. A total of 76% of patients who smoked had been given smoking cessation advice. As a result 2.2% had stopped smoking. The practice computer system recorded the number of patients who received flu vaccinations as very low. A GP told us there had been a problem with the way they had been recorded within the computer system and this data was being analysed.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

All patients we spoke with and patient comment cards we received were complimentary about the care given by the practice and any follow-up that was needed. All patients felt they were always treated with respect and dignity by all members of staff. Patients commented on how professional, friendly and helpful GPs and staff were. Thirteen patients specifically comment on how caring staff at the practice were.

During our inspection we observed within the reception area how staff and patients interacted with each other, in person and over the telephone. Staff were helpful, polite and understanding towards patients. Staff we spoke with told us excellent patient care was crucial and their behaviour displayed this at all times. We saw curtains could be drawn around treatment couches in consultation rooms. This would ensure patients' privacy and dignity in the event of anyone else entering the room during treatment.

The 2014 GP National Patient Survey revealed that 91% of patients felt the last GP they saw or spoke with was good at giving them enough time. This was above the average of 90% for South Worcestershire Clinical Commissioning Group (CCG) and a national average of 87%. A total of 91% of patients said the last GP they saw or spoke with was good at explaining tests and treatments. This compared with 90% for the CCG and 86% nationally. We saw patients with learning disabilities were given 20 minutes for their reviews.

Care planning and involvement in decisions about care and treatment

As part of our inspection, we looked at patient choice and involvement. GPs explained how patients were informed before their treatment started and how they determined what support was required for patients' individual needs. Clinical staff told us they discussed any proposed changes to a patient's treatment or medicine with them. Some patients we spoke with confirmed this. GPs described treating patients with consideration and respect and said they kept patients fully informed during their consultations and subsequent investigations. Patients we spoke with confirmed this and told us decisions were clearly explained and options discussed when available. Patients had the information and support available to them to enable them to make an informed decision about their care and treatment needs. Some patients we spoke with had long term conditions and they told us they were seen regularly.

The 2014 GP National Patient Survey revealed that 88% of patients felt the last GP they saw or spoke with was good at involving them in decisions about their care. This was above the average of 86% for the CCG and a national average of 81%.

Patient/carer support to cope emotionally with care and treatment

We did not speak with or receive any comment cards from patients who were also carers. However the GP and staff described the support they provided for carers (a total of approximately 1.5% of the patient list) and how they referred patients to appropriate organisations such as a carer's support service and a counselling service for professional support. The practice provided advice, support and information to patients, particularly those with long term conditions and to families following bereavement. The practice contacted the families of bereaved patients to offer condolences and discuss appropriate support, for example, signposting to a service which offered specialist bereavement support.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found that Albany House Surgery was responsive to the needs of patients. There were appropriate systems in place to maintain the level of service provided. The practice understood the needs of its patients, particularly within the context of the local area and systems were in place to address identified needs in the way services were delivered. We saw the practice had good connections with voluntary services who were best placed to meet additional needs patients had. Patients were signposted to Asthma UK, Diabetes UK, Age UK and local counselling and advice services when appropriate. This included support for patients with alcohol abuse. The practice also allowed travellers and homeless people to register as patients to enable them to access the full range of NHS services.

The practice planned its services carefully to meet the demand of the local population. We saw minutes of meetings that demonstrated regular meetings were held to discuss capacity and demand. As a result of this, changes were made to staffing and clinic times when required. As a result of patient feedback to say practice nurse appointments could be difficult to obtain, appointments were made available during the evenings when the practice opened. GPs and practice management were also aware of developments within the wider health sector locally

GPs provided examples of how the practice responded to the needs of the local community. For example, historically the practice had low numbers of patients who requested the flu vaccination, which concerned GPs. During the 2014-2015 flu vaccination programme, the practice heavily promoted this and launched vaccination clinics on Saturday mornings. As a result, the volume of vaccinations completed had increased by over 10% from the previous year. GPs told us they planned a similar approach for the 2015-2016 vaccination programme.

There was an established Patient Participation Group (PPG) in place at the practice. This was a group of patients registered with the practice who worked with the practice to improve services and the quality of care. This ensured that patients' views were included in the design and delivery of the service. We saw how the PPG played an active role and was a key part of the organisation. Regular meetings were held. We saw how the PPG had been involved with discussions to improve patient care, promote on-line services, including the booking of patient appointments and examined ways to improve access for disabled patients within the restrictions imposed by the listed building.

Tackling inequity and promoting equality

Most of the patients registered at the practice spoke English as a first language. Staff had access to a translation service if this was needed and information could be provided in other languages when required.

The practice had an induction loop to assist people who used hearing aids and staff could also take patients into a quieter private room to aid the discussion if required. The ground floor of the practice was fully wheelchair accessible. The practice ensured that patients who were unable to use the stairs were seen in ground floor consultation rooms.

Access to the service

The practice opened from 8.30am to 6.30pm. Appointments were available during these times. Three evenings each week, the practice offered extended hours to either 7pm or 8pm. The precise days varied from week to week. Practice nurse appointments were also available until 7pm on Wednesdays. If all appointment slots were taken, patients who required an emergency appointment were telephoned by a GP and asked to come in if they needed to be seen. The practice had a policy of seeing all children the same day, regardless of appointment availability and all adults the same day in an emergency. 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, within two weeks or further ahead. Patients could make appointments and order repeat prescriptions through an on-line service. Text message reminders were also available. Home visits were available for patients who were unable to go to the practice.

The 2014 GP National Patient Survey revealed that 84% of patients found it easy to get through to the practice by phone, compared to an average for the South Worcestershire Clinical Commissioning Group (CCG) of 76%; 90% of patients described their experience of making an appointment as good, compared to a CCG average of 78% and 93% of patients said the last appointment they

Good

Are services responsive to people's needs?

(for example, to feedback?)

were given was convenient, compared to a CCG average of 92%. One area below average was that 51% of patients said they usually waited 15 minutes or less after their appointment time to be seen. The average for the CCG was 64%. The practice had taken steps to reduce this waiting time and kept it under review.

Data available from the 2014 GP National Patient Survey demonstrated the practice was broadly average or above average within the South Worcestershire Clinical Commissioning Group (CCG). For example, 74% of patients with a preferred GP said they usually got to see or speak to that GP. This was against an average of 62% for the CCG. A total of 90% of patients described their experience of making an appointment as good. The average for the CCG was 78%.

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

Listening and learning from concerns & complaints

Albany House Surgery had an appropriate system 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 a complaints summary which summarised the complaints for each year. This was used to identify any trends.

During our inspection, we looked to see whether the practice adhered to its complaints policy. Within the last 12 months, the practice had received two formal complaints. We examined one which related to treatment given to a family member. We saw the complaint had been resolved in a satisfactory way and in accordance with the practice complaints procedure. The other complaint related to secondary healthcare and was not therefore directly related to the practice. The patient had been signposted to the appropriate organisation.

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

GPs we spoke with told us the practice aimed to provide a traditional family general practice which offered a personal service. This was displayed in literature produced by the practice, on the practice website and the same values were mentioned by other staff we spoke with. One patient we spoke with told us the practice used the latest treatment but treated patients with traditional values. GPs explained how the practice kept up to date with research and governance recommendations and communicated these accordingly. We also saw how the GP partners investigated and reviewed significant events and initiated and reviewed clinical audits.

Staff we spoke with clearly demonstrated knowledge of the need to give patients a safe and caring service and to treat them with dignity and respect at all times. Staff also told us how these values extended to the way they as staff were treated by GPs and practice management.

The GP partners held regular partner's meetings outside of surgery opening times, to discuss important issues such as forward planning, succession planning, practice objectives and future direction and vision. In addition, they met briefly at the end of each working day to discuss the events of that day and make any key decisions that needed to be made.

GPs openly discussed with us the demands imposed by a growing patient list and the limitations they had with a listed building. They discussed ways they had made their use of the building as flexible as possible under the circumstances. However, due to the listed status of the building they could not install a lift, could not install fibre optic broadband or provide more car parking spaces because of the preservation orders placed on the trees that surrounded the practice car park.

Governance Arrangements

Each GP partner at Albany House Surgery had a lead role and a specific area of clinical interest and expertise. Lead management roles, including governance were clearly defined. Staff we spoke with fully understood these lead roles and responsibilities. We saw that policies were in place to support and guide this.

There was an atmosphere of openness, teamwork and management support within the practice. GPs and staff we spoke with confirmed this and five patients specifically mentioned how good the staff team were.

The practice held a regular meeting of clinical staff which included discussions about any significant event analyses (SEAs) that had been done. All of the clinical staff attended these meetings and where relevant, other staff also took part in the discussions about SEAs. This helped to make sure that learning was shared with appropriate members of the team. GPs also met regularly to discuss clinical and governance issues.

The practice used information from a range of sources including their Quality and Outcomes Framework (QOF) results and the Clinical Commissioning Group (CCG) to help them assess and monitor their performance. 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's performance was average or above average in some areas for the South Worcestershire Clinical Commissioning Group (CCG) for QOF. This placed Albany House Surgery within the top 10% of practices within the CCG. We saw examples of completed clinical audit cycles, such as a cervical screening audit. This demonstrated the practice reviewed and evaluated the care and treatment patients received.

Leadership, openness and transparency

The practice had a team of partners, some of whom had worked together over a number of years to provide stable leadership. They were supported by a practice manager who was described by other staff as being highly approachable, very supportive and fulfilling a key role within the practice. Staff told us they felt very well supported at all times by management and GPs.

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

The practice had an established Patient Participation Group (PPG) in place. This was a group of patients registered with the practice who worked with the practice to improve services and the quality of care.

This ensured patient views were included in the design and delivery of the service. We saw minutes of previous PPG

Are services well-led?

Good

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

meetings and saw how the PPG had been fully involved in initiatives such as promoting on line patient services and examining the results from the GP National Patient Survey and NHS Friends and Family Test.

All staff were fully involved in the running of the practice. We saw there were documented regular staff meetings. This included meetings for clinical staff and meetings that included all staff. This ensured staff were given opportunities to discuss practice issues with each other.

The practice asked patients who used the service for their views on their care and treatment and they were acted on. This included the use of surveys to gather views of patients who used the service. We saw that there were systems in place for the practice to analyse the results of the survey so that any issues identified were addressed and discussed with all staff members. The 2014 GP National Patient Survey revealed that 94% of patients would recommend the practice to someone new to the area. This was above the South Worcestershire Clinical Commissioning Group (CCG) average of 84%

We saw records of discussions within the minutes of staff meetings. All the patients we spoke with on the day of our inspection told us they received a high quality service from the practice. It was clear patients experienced the quality of service that met their needs.

Management lead through learning & improvement

We saw evidence that the practice was focussed on quality, improvement and learning. We examined training records that demonstrated staff were up to date with training such as safeguarding and first aid. Staff also had 'protected learning' times. This was used for training and to give staff the opportunity to spend time together. We also saw how training courses had been funded for staff, for example, health and safety awareness and cancer diagnosis.