Alton Street Surgery

Quality Report

Alton Street
Ross-on-Wye
Herefordshire
HR9 5AB
Tel: 01989 563646
Website: www.altonstreet.nhs.uk

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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	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Good ●
Are services caring?	Good ●
Are services responsive to people's needs?	Outstanding ☆
Are services well-led?	Outstanding ☆

Key findings

Contents

Letter from the Chief Inspector of General Practice

This practice is rated as Outstanding overall.
(Previous inspection October 2014 – Good)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Outstanding

Are services well-led? - Outstanding

As part of our inspection process, we also look at the quality of care for specific population groups. The population groups are rated as:

Older People – Good

People with long-term conditions – Good

Families, children and young people – Good

Working age people (including those retired and students – Good

People whose circumstances may make them vulnerable – Outstanding

People experiencing poor mental health (including people with dementia) - Outstanding

We carried out an announced comprehensive inspection at Alton Street Surgery on 21 March 2018 as part of our inspection programme.

At this inspection we found:

- The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. Care and treatment was delivered according to evidence-based guidelines.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Patients said that they found the appointment system straightforward to use and reported that they were able to access care when they needed it. Routine appointments were always available on the same day.
- The GP partners and management team were forward thinking. There was a strong commitment towards development and integrated care.
- The practice was presented with a highly commended award by the Herefordshire Carers' Association in 2017 in recognition of their work for carers.
- The practice was a hub for community health groups. For example, Herefordshire Carers' Support and Dementia Action Alliance.
- A self-care station in reception offered practical advice on managing conditions. It enabled patients to be more actively involved in their own self-care programme.

Summary of findings

- The practice implemented suggestions for improvements and made changes as a consequence of feedback from patients and from the patient participation group.
- The practice placed a great deal of emphasis on training for trainee GPs, medical students as well as for their own staff.
- The practice was accredited with the Primary Care Clinical Research Network at Warwick University.

We saw an area of outstanding practice:

- The practice took an holistic person centred care approach to people living with mental health issues. For example, a GP chaired the Ross Mental Health and Wellbeing Steering Group, which was instrumental in setting up initiatives such as the Ross Dementia Centre and the GP had developed a poetry support group. Feedback from people using the services identified positive outcomes.

The area where the provider **should** make improvements is:

- Continue to encourage the uptake of cervical screening.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

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
People with long term conditions	Good
Families, children and young people	Good
Working age people (including those recently retired and students)	Good
People whose circumstances may make them vulnerable	Outstanding
People experiencing poor mental health (including people with dementia)	Outstanding

Alton Street Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector and included a GP specialist advisor.

Background to Alton Street Surgery

Alton Street Surgery is registered with the Care Quality Commission (CQC) as a partnership provider. It is located in the market town of Ross-on-Wye in Herefordshire. The practice holds a General Medical Services (GMS) contract with NHS England. The GMS contract is a contract between general practices and NHS England for delivering primary care services to local communities. At the time of our inspection Alton Street Surgery was providing medical care to 10,630 patients who live within an area of approximately five miles radius from the practice. The practice has a low level of deprivation. The practice has a website which details services and gives information to patients: www.altonstreet.nhs.uk.

The practice provides additional GP services commissioned by Herefordshire Clinical Commissioning Group (CCG). For example, minor surgery. A CCG is an organisation that brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services.

Limited parking is available on site and there is ample parking in the Ross Community Hospital Pay and Display car park nearby. Bus stops are situated on the street outside the practice. There are three parking spaces for disabled patients at the rear of the building and disabled patients can be brought by car to the 'pull-in' adjacent to the front entrance. The practice has facilities for disabled patients.

The practice team consists of three GP partners (two male, one female), four salaried GPs (one male, three female), and a female retainer GP. They are supported by a practice manager, two advanced nurse practitioners, three practice nurses, two health care assistants, a clinical assistant and a reception and administrative team.

Alton Street Surgery is an approved training practice for doctors who wish to become GPs. A trainee GP 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 trainee GPs and the practice must have at least one approved GP trainer. At the time of our inspection, there were two trainee GPs. There was also a foundation year two doctor (a doctor in their second year of clinical experience after qualifying as a doctor).

Alton Street Surgery is a teaching practice and provides placements for medical students who have not yet qualified as doctors. There were no medical students at the time of our inspection.

Alton Street Surgery is open from 8am until 6pm on every weekday. Extended hours appointments are provided between 6.30pm and 7.30pm on Mondays, Tuesdays and Wednesdays. The practice is closed at weekends.

Patients can access the out of hours service by using the NHS 111 service. If patients need to see a GP, they are given an appointment at a Primary Care Centre either locally or in Hereford. Home visits are arranged for those patients who are too ill to travel to a Primary Care Centre. Patients can also book appointments with Taurus Healthcare, which provides extended access from 6pm until 8pm during the week and from 8am until 8pm at weekends.

Detailed findings

Patients can attend the Minor Injuries Unit at Ross Community Hospital for minor accidents and injuries.

Good

Are services safe?

Our findings

We rated the practice, and all of the population groups, as good for providing safe services.

Safety systems and processes

The practice had clear systems to keep patients safe and safeguarded from abuse.

- The practice conducted a range of safety risk assessments. It had a suite of safety policies which were regularly reviewed and readily available to staff on the practice intranet. The policies clearly outlined who to go to for further guidance. We saw that staff received safety information for the practice as part of their induction and refresher training. The practice had systems to safeguard children and vulnerable adults from abuse. There was a lead GP for safeguarding and all staff had received training at a level appropriate to their role.
- The practice worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks 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). We saw that risk assessments were carried out for non-clinical members of staff to determine whether or not they required a DBS check.
- Staff we interviewed were able to tell us how they would identify and report concerns. It was practice policy that only clinical staff acted as chaperones. They were trained for the role and had received a DBS check.
- There was an effective system to manage infection prevention and control (IPC). A practice nurse was the IPC lead and they received updates from the IPC lead at the Herefordshire Clinical Commissioning Group. Regular audits were carried out with review dates to check on the progress of any recommended action points. For example, we saw a recommendation that all posters in consulting rooms should be laminated. This action, highlighted in June 2017, had a review date of October 2017 and we noted that it had been actioned.
- The practice ensured that facilities and equipment were safe and that equipment was regularly maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed. The practice used a software programme to assess demand and capacity for clinicians and they used this to plan the clinicians' rotas.
- There was an effective induction system for temporary staff tailored to their role. We viewed the locum policy and a completed locum induction checklist. We saw that a record was maintained of all necessary pre-employment checks for locum GPs.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. We were told that a salaried GP had organised a session on dealing with medical emergencies: staff were divided into teams and given one of four scenarios to discuss and present to the whole team.
- Clinicians knew how to identify and manage patients with severe infections, for example, sepsis. Sepsis guidance was available in each consulting room and a sepsis checklist had been developed for clinicians to take on every home visit.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Referral letters included all of the necessary information.

Good

Are services safe?

Safe and appropriate use of medicines

The practice had reliable systems for appropriate and safe handling of medicines.

- The systems for managing medicines, including vaccines, medical gases, and emergency medicines and equipment minimised risks. The practice kept prescription stationery securely and monitored its use.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance.
- We checked that the monitoring of patients on high risk medicines was in line with national guidelines. We saw that the GP issuing the repeat prescription always checked that monitoring blood tests had been done before the prescription was issued. An audit on patients who were prescribed a high risk medicine found that 100% had had monitoring blood tests within the recommended timeframe.
- There was evidence of actions taken to support good antimicrobial stewardship. The practice had audited antimicrobial prescribing and found that nine out of 41 patients had received antibiotics outside of the guidelines. An educational update was added to the next prescribing newsletter as a result of the audit findings.
- Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately. The practice involved patients in regular reviews of their medicines.

Track record on safety

The practice had a good safety record.

- There were comprehensive risk assessments in relation to safety issues.
- The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a comprehensive system for recording and acting on significant events and incidents. All significant events were recorded on a spreadsheet which included details of actions taken and minutes of meetings at which the events were discussed. Staff understood their duty to raise concerns and report incidents and near misses. They knew that the GP partners and management team would support them when they did so.
- There were systems for reviewing and investigating when things went wrong. Staff were able to tell us where they could find the reporting form and we were told that the minutes of meetings where incidents were discussed were emailed to all staff. Relevant staff were also tasked individually if they had to take action. High risk significant events were dealt with weekly. Discussion of incidents was a standing item on the agenda of the quarterly clinical governance meetings, so that lessons could be shared and learned across the practice teams. For example, the procedure regarding the electronic distribution of documents to GPs was changed after documents went unchecked for a couple of days as a result of a GP's unforeseen absence. No urgent documents were missed, but each GP's list was now checked daily and re-distributed if necessary.
- There was a comprehensive system for receiving and acting on patient safety alerts and medicines updates. There was a link on all staff desktops to the online spreadsheet which listed all alerts and medicines updates. The spreadsheet contained hyperlinks to each alert, together with the response and any associated communications. The practice learned from external safety events as well as patient and medicine safety alerts.

Good

Are services effective?

(for example, treatment is effective)

Our findings

We rated the practice as good for providing effective services overall.

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We did not see any evidence of discrimination when making care and treatment decisions.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- Older patients who were frail or might be vulnerable received a full assessment of their physical, mental and social needs. Those identified as being frail had a clinical review including a review of medication.
- Patients aged over 75 were invited for a health check. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan.
- The practice provided daily cover and supervision for patients in 32 beds at Ross Community Hospital, which meant that the practice had quick access to 'step up' nursing care and that discharges were facilitated. ('Step up' beds provide short term nursing care for patients who have a care need that cannot be managed within their own home or who cannot be left safely at home.)
- The beds at Ross Community Hospital could be used for day case transfusions if appropriate.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any additional or changed needs.
- The practice held regular Gold Standard Framework meetings to discuss patients deemed to be severely frail and nearing the end of life with multi-disciplinary teams, including a Macmillan nurse.
- Alerts were placed on the medical records of patients considered to be frail to prompt a GP assessment within 24 hours of discharge from hospital.
- Practice nurses and health care assistants went out to nursing homes to do foot checks, blood tests and flu vaccinations.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check that their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- Nurse-led clinics were held for patients with long term conditions. For example, asthma, diabetes, chronic lung disease and heart conditions. We saw that personal care plans were in place for patients.
- A diabetes dietician saw patients at the practice twice a month.
- A diabetes specialist nurse held a joint clinic with the lead practice nurse for diabetes once a month.
- A handbook called 'My Diabetes Handbook' was given to diabetic patients. The handbook contained comprehensive information and a self-management plan.
- Patients with asthma were given a personalised asthma management plan.
- The practice carried out an annual review of all cancer diagnoses to look for factors that might have enabled earlier diagnosis. In addition, six monthly reviews of patient deaths were carried out in order to check for quality of care.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were above the target percentage of 90%.
- Priority was given to children under the age of five years.
- Patients could attend minor illness clinics instead of seeing a GP, if this was appropriate for their needs.
- Patients could register to book routine appointments online as well as receive text messages for appointment reminders and order repeat prescriptions.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines.

Good

Are services effective?

(for example, treatment is effective)

- There was a family health section on the practice website as well as minor illness advice.

Working age people (including those recently retired and students):

- The practice's uptake for cervical screening was 75%, which was slightly below the 80% coverage target for the national screening programme. The practice acknowledged that the uptake was lower than the national target. We were told that one nurse had been on maternity leave and one had been on long term sick leave, so these absences had affected the capacity to carry out smear tests. The practice had submitted an article to a local newspaper to be published in April 2018 in order to raise awareness of the importance of screening. Non-responders were contacted by the practice or booked in opportunistically when they attended the practice.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Extended hours appointments were provided on three evenings during the week, which was convenient for patients who could not attend during core opening hours.
- Evening and weekend appointments were available via Taurus Healthcare hubs.
- Timed callbacks could be arranged to suit patients' working patterns.
- Patients who lived out of the area were able to register at the practice if that was more convenient for them, although they were asked to sign that they understood that home visits would not be provided.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. All patients who were eligible for the health checks had been included in the call and recall programme. We saw that there was a 38% uptake. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- The practice had piloted a scheme whereby an employment advisor attended the practice to offer support. This had now ended, but the practice hoped that funding would be allocated to allow it to restart.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- There was a GP buddy system for end of life care, which took into account the patient's preference in order to promote continuity of care.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice had 74 patients on the learning disability register, which was higher than average. We saw that 60 of these had received health checks since April 2017.
- The practice had responsibility for patients with learning disabilities in six local care homes.
- The practice was working with the learning disability consultant to develop a deprescribing protocol.
- A GP sat on the Substance Misuse Deaths review panel with Public Health England (PHE), which meant that they could update PHE about the substance misuse issues in the local community, in particular which drugs were currently circulating and the circumstances around the deaths.

People experiencing poor mental health (including people with dementia):

- 87% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This is slightly above the national average of 84%.
- 96% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This is 6% above the national average.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example the percentage of patients experiencing poor mental health who had received discussion and advice about alcohol consumption (practice 90%; CCG 92%; national 91%).
- A GP chaired the Ross Mental Health and Wellbeing Steering Group. The main function of the group was to act as a link between health services and the local community. It has also allowed connections between third sector and statutory providers. For example, staff

Good

Are services effective?

(for example, treatment is effective)

from social care and the Mental Health trust attended the meetings. The GP was able to feed back to the Herefordshire Clinical Commissioning Group, which helped to inform commissioning decisions.
- The same GP was the Mental Health lead for the herefordshire Climnical Commissioning Group.
- The practice had input into the countywide suicide prevention plan, the self-harm protocol for schools and dementia shared care prescribing protocols.

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. Where appropriate, clinicians took part in local and national improvement initiatives.

The most recent published Quality Outcome Framework (QOF) results were 99.7% of the total number of points available compared with the Clinical Commissioning Group (CCG) average of 98.8% and national average of 95.6%. The overall exception reporting rate was 10.5% compared with a national average of 9.9%. (QOF is a system intended to improve the quality of general practice and reward good practice. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.)

- We noted that the exception reporting rates for mental health and depression were higher than local and national averages. The practice explained that this was due to incorrect coding. The practice carried out an audit of the patients who had been exception reported for depression. Out of 10 patients, six exception codes were appropriate, but four were inappropriate and could have been avoided by using a symptom code at first presentation. The practice planned to raise the importance of good coding at their next team meeting.
- The practice was actively involved in quality improvement activity, which included audits. We viewed audits and found evidence of improved care as a result. For example, an audit had been carried out to check whether the prescribing of two medicines commonly used to treat urinary tract infections was in line with primary care antibiotic guidelines. Nine out of 214 prescriptions were found to have been issued inappropriately. GPs were reminded of the current guidelines and an information sheet was circulated.
- Where appropriate, clinicians took part in local and national improvement initiatives. For example, the practice was piloting a capacity and demand tool for the Herefordshire Clinical Commissioning Group.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.

- The practice understood the learning needs of staff and provided protected time and training to meet them. We viewed the detailed training matrices held by the practice manager and reception manager, which listed records of skills, qualifications and training. Staff were encouraged and given opportunities to develop.
- We noted that each desk in the reception office had a designated task allocated to it and that each staff member rotated between desks, which ensured multi skilling and provided variety.
- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. We viewed the new recruit welcome checklist which was supplemented by a timetable for the first week and a role specific training checklist. Staff told us that six monthly informal reviews were carried out as well as their annual appraisals.
- The practice ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing.
- There was a clear approach for supporting and managing staff when their performance was below standard.
- A GP was the lead for mental health in the Herefordshire Clinical Commissioning Group. The same GP was the locality champion for the Primary Care@Home initiative, which aimed to promote more integrated working relationships between health professionals, local organisations and the local community, which would enable them to develop more effective services and support.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

Good

Are services effective?

(for example, treatment is effective)

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who might be vulnerable because of their circumstances.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their health. A self-care section was provided in reception, which included a computer for patients to download relevant information to enable them to manage their health condition.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately.

Guidance for the provisions of the Mental Capacity Act (MCA) and Deprivation of Liberty were available in each consulting room. A GP had delivered a training session to practice staff on safeguarding adults, the MCA, Deprivation of Liberty safeguards and power of attorney.

Good

Are services caring?

Our findings

We rated the practice, and all of the population groups, as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- The lead GP had recorded the opening message on the telephone.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- All of the 40 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients wrote that GPs were caring and reassuring and always took time to listen. The practice was said to be well-organised and staff were thought to be polite, friendly and helpful. This was in line with other feedback received by the practice.
- Results from the Friends and Family Test conducted in January 2018 showed that 96% of the respondents would be extremely likely or likely to recommend the practice (there were 46 respondents).

Results from the July 2017 annual national GP patient survey showed that patients felt that they were treated with compassion, dignity and respect. 232 surveys were sent out and 122 were returned. This represented about 1% of the practice population. The practice was in line with local and national averages for its satisfaction scores on consultations with GPs and nurses. For example:

- 91% of patients who responded said the GP was good at listening to them compared with the Clinical Commissioning Group (CCG) average of 92% and the national average of 89%.
- 87% of patients who responded said the GP gave them enough time; CCG - 89%; national average - 86%.
- 96% of patients who responded said they had confidence and trust in the last GP they saw; CCG - 97%; national average - 95%.
- 86% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG– 89%; national average – 86%.
- 88% of patients who responded said the nurse was good at listening to them; CCG - 93%; national average - 91%.
- 87% of patients who responded said the nurse gave them enough time; CCG - 93%; national average - 92%.
- 97% of patients who responded said they had confidence and trust in the last nurse they saw; CCG - 98%; national average - 97%.
- 88% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG - 92%; national average - 91%.
- 95% of patients who responded said they found the receptionists at the practice helpful; CCG - 91%; national average - 87%.

Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care and were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given):

- Approximately 5% of the practice population were from Eastern Europe. Interpretation services were available for patients who did not have English as a first language. Laminated information cards in different languages were available in the reception office.
- Staff communicated with patients in a way that they could understand, for example, communication aids and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.

The practice proactively identified patients who were carers. There was a carers' noticeboard in the reception area and a question on the new patient questionnaire. There was section for carers on the practice's website, which had links to support services available. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 228 patients as carers (2% of the practice list).

Good

Are services caring?

- A member of staff acted as a carers' lead to help ensure that the various services supporting carers were coordinated and effective. The carers' lead attended the quarterly meetings of the local Carers' Association, which were held at the practice.
- The Carers' Association attended the annual flu clinics at the practice.
- The practice was presented with a highly commended award by the Herefordshire Carers' Association in 2017 in recognition of their work for carers.
- The practice hosted meetings of the Ross Carers' group.

When families experienced bereavement, their usual GP would contact them and offer advice on the various support services available. This call was followed up by the GP two months and 12 months after bereavement in order to check whether further support was needed.

Results from the National GP Patient Survey showed patients' responses to questions about their involvement in planning and making decisions about their care and treatment. Results were slightly below local and national averages:

- 83% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the Clinical Commissioning Group (CCG) average of 90% and the national average of 86%.
- 78% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG - 86%; national average - 82%.
- 87% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG - 91%; national average - 90%.
- 81% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG - 88%; national average - 85%.

The practice told us that they were disappointed with these results, which contrasted with the comment cards and with the patient feedback received on the day. The practice explained that they have doctors at different stages in their training who have different consultation skill levels. In future, the trainee GPs would have joint tutorials incorporated into their training to enable them to improve on involving patients in decision making. The practice had used locum nursing staff during a period of staff sickness and thought that this might have contributed to the lower than average results for the nurses, because patients had already complained about one locum nurse whom the practice no longer employed.

In addition the practice said that they would organise specific training through consultation role play, targeted at the management and decision making during a consultation for all clinical staff. They were also going to organise a training session during a clinical governance meeting to look specifically at these skills.

The practice said that they would discuss these areas with the patient participation group (PPG), and their opinion sought. The practice planned to follow up specific training with a survey of the Virtual PPG to ensure that improvements had been made.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The practice complied with the Data Protection Act 1998.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We rated the practice as outstanding for providing responsive services.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs. For example extended opening hours, online services such as repeat prescription requests, advanced booking of appointments, advice services for common ailments.
- The practice improved services where possible in response to unmet needs.
- The facilities and premises were appropriate for the services delivered.
- A separate children's area, decorated with a bright mural, was provided with two play tables.
- A self-care section promoted information for patients. A computer was provided to enable patients to download relevant information.
- The practice made reasonable adjustments when patients found it hard to access services. For example, signs were available in Braille.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice had responsibility for patients who lived in 10 care homes in the local area, six of which were homes for people with learning disabilities. We were told that GPs provided an excellent standard of care to their patients who lived in the care homes. GPs were said to have a good understanding and rapport with patients and to be respectful.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GP and practice nurse also accommodated home visits for those who had difficulties getting to the practice.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- Carers' support group meetings were held at the practice.
- The practice held regular meetings with multi-disciplinary teams to discuss and manage the needs of patients with complex medical issues.

Families, children and young people:

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child under the age of five were offered a same day appointment when necessary.
- A wide range of contraceptive methods was provided.

Working age people (including those recently retired and students):

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, extended opening hours were provided on three weekday evenings between 6.30pm and 7.30pm and a heath care assistant provided appointments starting at 8am once a fortnight.
- Patients were able to register to book routine appointments online and receive text message reminders.
- Telephone GP consultations were available which supported patients who were unable to attend the practice during normal working hours.
- Well person checks were available by arrangement.

People whose circumstances make them vulnerable:

This population group was rated outstanding because:

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- Walk in attendances were provided for those with chaotic lifestyles.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

- Addaction drug services held regular clinics at the practice (at least fortnightly), which were attended by about 10 patients each time. Addaction is a charity which provides support to people to help them make positive behavioural changes, particularly with substance misuse and mental health. One of the advantages of hosting the clinics at the practice was that clinics were held in familiar premises, which in turn encouraged attendance and meant that patients did not have to find the money to travel further afield in the county. We were told that GPs were alerted to patients who had prescription or physical health needs each time a clinic was held and that these patients could be seen by a GP straight away. GPs said that they had been able to talk with Addaction workers about ensuring that an emergency medicine which reverses overdoses was available to all who wanted it, and added that it was useful to be able to remind patients and their carers that this option was available.
- There was a close working relationship with the Outreach group, who supported homeless and vulnerable people.
- The practice had close links with community support groups, for example, Ross Community Garden and the Ross Meeting Centre, so patients could be signposted to the services.
- Close liaison with the Ross Baptist Church enabled patients with vulnerable housing or homelessness issues to be signposted there and also meant that people could be signposted to the practice if they were in need of medical help.
- The Ross Mental Health and Wellbeing Steering Group, which was chaired by a GP at the practice, had links with local groups such as Alcoholics Anonymous and the Samaritans, so patients could easily be signposted to these services.
- Patients could be offered support from GPs with completing benefits claims. We were told that the practice had been offering this support for a number of years in order to help their most vulnerable patients, especially those with functional illiteracy. One GP said that he helped to complete two a week on average.
- A social prescribing project was scheduled to start in the summer of 2018. (Social prescribing is a way of linking patients in primary care with sources of support in the community.)
- Information about domestic abuse was discreetly displayed.

People experiencing poor mental health (including people with dementia):

This population group was rated outstanding because:

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- Care home managers spoke highly of the GPs, who were said to be compassionate and understanding.
- Early or late appointments were provided for patients who might find it challenging to sit in the reception area. We were told that GPs would see patients in cars if they found it difficult to come into the practice and they would make it easy for patients to get to consulting rooms by blocking off corridors.
- A GP who was the mental health lead for the Herefordshire Clinical Commissioning Group actively championed improvements to the provision of care for patients with mental health issues in the area. The GP helped to set up and support the Ross Dementia Centre (DMC) at a local church. The DMC provided the opportunity for patients and their carers to socialise and take part in activities.
- The practice had organised two dementia friendly awareness sessions at the practice, which were attended by nurses from Ross Community Hospital, the local Alzheimer's Society and staff from local practices.
- The GP had also set up a poetry group, which met every fortnight at the practice. The practice had not carried out a formal evaluation of the effects of the group, but patients commented that attendance helped with providing alternative strategies for dealing with many of their health issues, as well as helping with isolation issues. The group was also open to patients with other chronic conditions and loneliness.
- We were told that MIND, a mental health charity, was shortly going to use the practice's meeting room for ArtSpace (an arts-based project which offered a safe space for people with mental health issues to work towards recovery and good wellbeing through art activities and peer support).
- The GP chaired the Dementia Leadership Programme Board which was held to encourage the improvement of support services for patients with dementia in the county.
- The practice was a founder member of Ross Dementia Action Alliance. This group used a meeting room in the practice.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

- The practice was working towards achieving Dementia Friendly Practice status.
- The practice hosted weekly mental health clinics which were run by staff from the 2gether NHS Foundation Trust.
- The practice also hosted meetings held by a Mindfulness Group.
- The practice was a pilot site for improving access to primary care mental health support.

Timely access to the service

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- The triage system for appointments was easy to use and had proved popular with patients once it had become embedded. We heard how it had improved access to the most appropriate clinician.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was comparable to local and national averages. This was supported by observations on the day of inspection and completed comment cards. 232 surveys were sent out and 122 were returned. This represented a 53% completion rate and about 1% of the practice population.

- 78% of patients who responded were satisfied with the practice's opening hours compared with the Clinical Commissioning Group (CCG) average of 78% and the national average of 76%.
- 89% of patients who responded said they could get through easily to the practice by telephone; CCG – 81%; national average - 71%.
- 96% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment; CCG - 87%; national average - 84%.
- 94% of patients who responded said their last appointment was convenient; CCG - 86%; national average - 81%.
- 89% of patients who responded described their experience of making an appointment as good; CCG - 80%; national average - 73%.
- 72% of patients who responded said they did not normally have to wait too long to be seen; CCG - 63%; national average - 58%.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available in reception and on the practice website. There was a GP lead for complaints, but the day to day responsibility was devolved to the practice manager. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. We saw that 11 formal and four informal complaints were received in the last year. We reviewed the comprehensive complaints log and found that complaints were satisfactorily handled in a timely way in accordance with the practice's complaints procedure. The practice also kept a log of informal complaints and suggestions.
- The practice learned lessons from individual concerns and complaints and also from analysis of trends. Complaints were dealt with at the time and discussed annually at a partners' meeting. It acted as a result to improve the quality of care. For example, average waiting times for secondary care appointments were given to GPs and displayed in reception following a complaint that waiting times had not been explained.

Are services well-led?

Outstanding ☆

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

Our findings

We rated the practice, and all of the population groups, as outstanding for providing a well-led service.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders had the experience, capacity and skills to deliver the practice strategy and address risks to it.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Staff commented on the open door policy in the practice and said that the GP partners and management team were very approachable and supportive.
- We saw the organisation improvement plan with time frames attached to action points and progress documented against the timeframes.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice. For example, the practice had planned for the maternity leave of the practice manager.

Vision and strategy

The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients.

- There was a clear vision and set of values. The practice had a strategy to achieve priorities.
- The practice developed its vision, values and strategy jointly with patients, staff and external partners. The practice had a mission statement and the reception team had come in on a Saturday morning in order to devise their own, which was displayed in the reception office.
- The strategy was in line with health and social priorities across the region. The practice planned its services to meet the needs of the practice population.
- The practice was keen to evolve and adapt to new challenges. The GP partners and management team recognised the importance of continual development to improve patient outcomes and provide resilience for the future.
- The practice encouraged multi-skilling of staff and was exploring new roles in order to meet demand. For example, a clinical assistant role was being developed to provide extra capacity in the nursing team.
- The practice monitored progress against delivery of the strategy.

Culture

The practice had a culture of high-quality sustainable care.

- Staff told us that they felt respected, supported and valued. They were proud to work in the practice.
- There was a high level of commitment and loyalty across both clinical and non-clinical teams.
- The practice focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. We saw that GPs or the practice manager contacted patients promptly by telephone or by letter to explain what had happened.
- The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us that they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed. A feedback and suggestion box was available for staff to use.
- There were processes for providing all staff with the development they needed. This included appraisal and career development conversations. Staff we spoke with confirmed that they received formal annual appraisals and six monthly reviews. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff, including nurses, knew that they were considered to be valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff.
- Equality and diversity were promoted in the practice. Staff received equality and diversity training. We viewed the equal opportunities policy and staff felt they were treated equally.
- The positive relationships between staff and teams were evident. Staff appreciated the social events that were

Are services well-led?

Outstanding ☆

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

arranged so that they had the opportunity to mix outside of the working environment. Staff told us how much they enjoyed the 10,000 pedometer challenge, which reinforced the team working ethos in the practice.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- The strong focus on the importance of good communication methods was evident within the teams. We saw that meetings were held regularly and that meeting discussions were minuted. There was easy access to information for all staff.
- Informal 'huddles' took place during coffee breaks, which gave clinical staff the opportunity to have brief discussions in addition to the full multi-disciplinary meetings. External staff such as health visitors knew that this was a good time to talk to GPs.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control.
- Practice leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. The GP partners and management team had oversight of MHRA alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.
- The practice had plans in place and had trained staff for major incidents. The business continuity plan included a communication cascade for staff, as well as instructions for dealing with events such as the loss of the computer system or utilities. All risks associated with the loss of a system were rated for impact on the service.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The practice used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were effective arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high-quality sustainable services.

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. For example, a member of staff had suggested that a board be set up in the reception office so that meeting decisions could be written on there as a reminder and for the benefit of those who could not attend. We saw that the board was used for this purpose.
- There was an active patient participation group (PPG), which met quarterly. A PPG is a group of patients registered with the practice who worked with the practice team to improve services and the quality of

Are services well-led?

Outstanding ☆

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

care. The PPG was affiliated to the National Association for Patient Participation (NAPP), which promotes and supports patient participation in primary care. NAPP bulletins were discussed at every PPG meeting. Minutes were kept of all meetings, which were attended by a GP and the practice manager. There was also a virtual PPG, whose members could be contacted for opinions on issues affecting patients.

- The practice took action as a result of suggestions made by the patients and PPG. For example, the touch screen was going to be moved from inside the main entrance into the reception area to improve patient confidentiality.
- We saw that the practice had carried out an in-house survey in 2016 and produced a detailed action plan as a result. For example, a PPG noticeboard was now in reception and a patient newsletter was produced on a quarterly basis in order to keep patients informed about events.
- The service was transparent, collaborative and open with stakeholders about performance.
- The practice worked with other local organisations to set up services to meet patient needs and benefit the local community. For example, a GP had been instrumental in setting up the Ross Dementia Centre.
- The flu clinic was attended by members of local organisations. For example, Herefordshire Carers, Wellbeing Information Signposting Herefordshire (WISH), the local fire brigade and the Ross Community Hospital League of Friends.
- We saw that the practice submitted health information articles to the local paper on a regular basis.
- The practice had social media accounts, which broadened their channels of communication with patients.
- The practice had started work on helping to develop a caring communities scheme, which looked into ways of tapping into wider community resources promoted via a website to aid people in need of extra support, thereby promoting a stronger sense of community and potentially reducing health care use.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

- There was a strong focus on continuous learning to drive through improvement at all levels within the practice.
- The practice manager had started as an apprentice at the practice and the practice still supported a receptionist apprentice scheme. In addition, a GP always attended the careers' fair at the local high school and the practice hosted work experience placements for eligible students.
- A GP was a GP training course organiser, a GP appraiser and an examiner for the Royal College of General Practitioners. Another GP was also a GP appraiser. The quality of the training provided and the supportive culture was evidenced by the fact that three of the four salaried GPs had been registrars at the practice and that another registrar was due to start as a salaried GP in August 2018.
- The practice actively engaged in local initiatives. For example, the practice was one of three local practices to pilot a capacity and demand tool which analysed appointment data from the previous 12 weeks and used it to predict demand for the next four weeks. The tool was found to be so useful that the Clinical Commissioning Group agreed to fund it for all their practices.
- The practice was proactive in its support for initiatives within the wider community. For example, a social prescribing scheme was due to start in summer 2018. The scheme was at the interview stage when we visited. (Social prescribing is a way of linking patients in primary care with sources of support in the community.)
- Staff knew about improvement methods and had the skills to use them.
- The practice took part in research in order to expand knowledge for their staff and others. For example, the practice participated in the Cambridge University research into telephone triage in general practice. The practice was accredited with the Primary Care Clinical Research Network at Warwick University.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.