Moorfield 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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection of this practice on 15 October 2014.

The practice has a main surgery and two branch surgeries. We did not include the branch surgeries in this inspection.

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

Our key findings were as follows:

- The practice had clear and thorough systems to monitor safety. They ensured that any information arising from complaints or significant events was shared so that staff could learn them and improve the service for patients.
- The systems in place at the practice to manage medicines and to ensure infection control were clear, robust and thorough.
- Patients were positive about the care and treatment they received.
- The practice team understood the needs of their patient population. They offered appointments at times which were convenient to patients and they worked flexibly as a team to ensure patients' health needs were met.
- The practice had created a 'learning culture' which involved all members of the practice team and ensured that patients continually benefitted from high levels of care and treatment.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep 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. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. People's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and planned for. The practice could identify all appraisals and the personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they could make an appointment with a named GP and that when they needed urgent care, same day appointments were available.

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. There was clear evidence that all staff discussed complaints and learned from them.

Summary of findings

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and provided a range of services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with complex needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. Longer appointments and home visits were available when patients needed them. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. Immunisation rates were relatively high for all standard childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies. There were good examples of joint working with health visitors. Emergency processes were in place and referrals were made for children and pregnant women whose health deteriorated suddenly.

Working age people (including those recently retired and students)

Good

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

Summary of findings

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients who needed end of life care and offered these patients a caring and compassionate service. The practice held a register of patients with a learning disability. It had set up systems for carrying out annual health checks for this group and was about to start these checks.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It provided information about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health, including people with dementia. The practice regularly worked with multi-disciplinary teams to support patients experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia and provided appropriate information for them or referred them to other teams. The GPs referred to themselves as 'advocates' for their most vulnerable patients.

Summary of findings

What people who use the service say

During our inspection, we spoke with thirteen patients. Each one told us they were happy with the care they received at the practice. They told us that all staff were kind, help and treated them with respect.

The patients we spoke with said they found it easy to get an appointment. We found that reception staff were knowledgeable about supporting patients who did not speak English and knew how to arrange an interpreter to support them. Patients we spoke with said that the GPs and nurses gave them clear information and explanations about their health concerns and involved them fully in decisions about the management of their health conditions.

We had left a box for patients to post comments to us. Seven patients had made comments on the cards we had left. They told us that every member of the practice team was kind, courteous and helpful. One patient told us a follow-up appointment was made to fit in with their work commitments. One patient commented that it could be difficult to get through to the practice by telephone during the mornings. Others told us they appreciated being able to access the surgery on-line.

Moorfield House Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

The inspection team was made up of an Expert by Experience, a GP specialist advisor and a CQC inspector who led the inspection.

Background to Moorfield House Surgery

Moorfield House Surgery provides a primary medical service to patients who live within the city of Hereford. The practice has estimated that that majority of its patients speak English.

The practice has five GP partners and four salaried GPs. It is a training practice and when we visited, a GP registrar was undertaking their specialist training to become a GP there. The practice employed five nurses and two healthcare assistants. Overall there was a balance in the gender of the clinicians. A practice manager and a deputy practice manager led the team of ten reception and administrative staff.

We visited Moorfield House Surgery at 35 Edgar Street, Hereford. The practice also has two branch surgeries at: 15 Aylestone Hill, Hereford and at Ross Road, Hereford. No concerns had been raised with us about the branch surgeries and we did not go to them during our inspection.

The practice does not provide out of hours services for its patients. Full information was available for patients on-line and in the practice leaflet and if patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances.

The GPs at Moorfield House Surgery together with other GPs across the Herefordshire CCG area owned and managed an extended hours service. Patients were able to book appointments with this service from the practice.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

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

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

How we carried out this inspection

Before inspecting, we reviewed a range of information we hold about the practice and asked other organisations, including the Clinical Commissioning Group (CCG) for Herefordshire, to share what they knew. We carried out an announced visit on 15 October 2013. During our visit we spoke with a range of staff at the practice including four GPs, the practice manager, the deputy practice manager and other staff. We spoke with 13 patients, including a

Detailed findings

representative of the patient participation group (PPG). We spoke with a health visitor and a physiotherapist who were employed by other parts of the NHS and were attached to the practice to work with its patients.

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 whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety; including reported incidents, national patient safety alerts and comments and complaints received from patients. We saw that clinicians routinely treated potential risks that they identified as a significant event and followed the analysis process to minimise the risk of the event ever actually happening. We looked at one particular instance where this had been done. A GP had identified a particular risk attached to a clinical procedure, had followed the potential risk though the significant event analysis process and as a result the practice policy around this procedure had been changed to make sure this risk did not materialise into an actual event.

The staff we spoke with were aware of their responsibilities to raise concerns and knew how to report incidents. Records showed that staff from each team at the practice had raised matters which concerned them. We saw that every complaint made by a patient was managed as a significant event and was investigated and analysed thoroughly.

When we reviewed reports of incidents and significant events we found that the practice had a robust system to manage these and demonstrate the outcomes. The system showed us how the outcomes of investigations had generated improvements in safe patient care, for example changes to the way new patient records were handled and stored and the development of a specific consent form for a particular procedure. We saw that the practice had a consistent approach to reviewing and making improvements in patient care over time.

Information we reviewed from NHS England, who commission primary medical care practices to provide services, indicated that there had been no reported risk factors in respect of patient safety during the last reporting period.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We saw incident forms were available on the practice intranet. Once completed these were sent to the practice manager who showed us the system they used to oversee how these were managed and monitored. Records had been kept of all significant events and safety incidents and we selected a sample to track from the initial report, through to the investigation stage and on to minutes of staff meetings where incidents and the learning from them were discussed.

Evidence of action taken as a result of incidents was shown to us. For example we saw that a risk to patient confidentiality had been recognised and a system used by reception staff was changed to prevent a similar event from recurring.

GPs and nurses held weekly clinical meetings to review their own practice and national guidance. We saw that safety incidents were discussed at these meetings and in meetings dedicated to significant events. In addition, all staff had protected time every quarter to review and learn from incidents. We saw that all these meetings had been logged in the practice diary. A member of the reception team we spoke with confirmed that they were encouraged to raise any concerns or areas for improvement they might have. They confirmed that the administrative and reception staff attended the training sessions in 'protected time' when learning from any concerns which had been raised was shared. They told us that learning from events was also reviewed in their own team meetings. Minutes from meetings confirmed this.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to children, young people and vulnerable adults. They used the expertise of the lead nurse with responsibility for safeguarding within the local Clinical Commissioning Group (CCG) to provide training and for consultation. They received information about domestic violence through the CCG. They had formed strong links with local health visitors and community nurses and discussed patients about whom they had safeguarding concerns with them. GPs and other practice staff were clear about the reporting structure when patients were at risk of harm. Contact details were easily accessible to all staff.

We looked at training records which showed that most staff had received role specific training on safeguarding children and vulnerable adults. The GPs had attended safeguarding training at the appropriate level for clinicians. We found that they had updated their safeguarding training every three years, most recently in 2013. We asked non-clinical members of the practice team about their understanding of

safeguarding procedures. They were aware of their responsibilities in respect of vulnerable adults and children. They knew how to share information, record safeguarding concerns appropriately and how to contact the relevant agencies in working hours and out of normal hours.

The practice had appointed a GP lead for safeguarding vulnerable adults and children. All staff we spoke knew who the lead was and who to speak to in the practice if they had a safeguarding concern.

The practice manager confirmed that there was a system to highlight vulnerable patients on the practice's electronic records. This alerted clinical staff to any relevant issues when patients attended appointments; for example children subject to protection plans; child 'in need' plans or families where there had been an incident of domestic violence. The system had safeguards to ensure that only appropriate staff could access all information in order to protect patients' rights to confidentiality. A chaperone policy was in place and visible on the waiting room noticeboard and in consulting rooms.

The GPs and other staff described positive working relationships with other health professionals in respect of vulnerable patients. We met with one health visitor who confirmed that staff at Moorfield House Surgery were pro-active in ensuring that risks to their patients were recorded and acted upon. They confirmed that practice staff welcomed their input and were pro-active in contacting the health visiting team when they had concerns about children and families. They worked together to review risks to identify and follow up disadvantaged children, including children who missed routine immunisation appointments. We saw that the practice had achieved child immunisation rates which reflected the average rate for practices across Herefordshire. The health visitor confirmed that the GPs provided information when requested for meetings about children at risk convened by local authority Children's Services.

GPs told us about their support for their patients in care homes. Two GPs made weekly visits to patients in care homes and followed them up during a subsequent weekly telephone call. They monitored their health and medication needs. They ensured that their older patients received care to keep them safe and if a decision of 'Do Not Attempt Resuscitation' was appropriate for a patient, this was made lawfully.

The electronic patient information system, EMIS, which is used by all the health service providers across Herefordshire, supported communication between health teams and promoted patient safety.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring medicines were kept at the required temperatures. The action to take in the event of a potential power failure was described. This was being followed by the practice staff.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance.

All prescriptions were reviewed and signed by a GP before they were given to the patient. We saw records of a series of audits that reviewed a particular area of prescribing. We saw that clear guidance was issued for GPs, nurses and healthcare assistants to follow when they were involved in either prescribing or monitoring patients with a particular disease.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. For example, how staff who generate prescriptions were trained and how changes to patients' repeat medicines were managed. This helped to ensure that patients' repeat prescriptions were still appropriate and necessary.

There was a system in place for the management of high risk medicines which included regular monitoring in line with national guidance.

Good

Are services safe?

Cleanliness and infection control

We found that all areas of the practice were visibly clean. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The deputy practice manager took responsibility for infection control in the practice. We saw that cleaning standards were clearly defined and cleaning schedules were in place for every room. The schedules described what needed cleaning and how it should be done. Schedules were signed off by cleaners and inspected by the deputy practice manager.

Nurses cleaned all equipment. Most instruments were packaged for single use. We saw that a safe system was in place to dispose of sharp items. We saw that protocols for 'sharps' injuries or spillage of body fluids were prominently displayed in all clinical areas.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use.

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

The practice had 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 that Legionella assessment had been carried out in 2013. The practice had been found clear of contamination.

We saw that infection control was included in induction training for all staff and that this was followed up in annual mandatory training for all staff. Comprehensive checks of infection control were made by the practice and when the CCG completed an audit for infection control at Moorfield House Surgery in October 2013, we saw that the practice had achieved a very high score.

Equipment

GPs and the practice manager told us they had the equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly.

We saw that equipment was sterile, appropriately calibrated where necessary and ready for use. We saw records that confirmed that appropriate maintenance checks were made.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employing new staff. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the staff groups to ensure there were enough staff on duty.

Staff told us there were always enough staff to maintain the smooth running of the practice and to ensure patient safety. They achieved this by asking part-time staff to work additional hours on occasions and by encouraging flexibility within the administrative and reception staff teams. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice 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.

Identified risks were included on a risk log. Each risk was assessed and discussed at clinical meetings and within team meetings. For example, we were able to track an incident regarding patient information. The practice manager had acted to prevent the risk of breach of patient confidentiality and ensured all staff were aware of the change in protocol. We were able to confirm this when we looked at records of staff meetings.

We looked at one of the audits completed by the practice which identified risks for patients with rheumatoid arthritis.

Good

Are services safe?

Medicines which had been initially prescribed by hospital doctors required a repeat prescription but evidence of blood tests had not been routinely made available to the practice. We saw that the GPs had completed the audit and had developed a system to ensure robust checks were made of patients' blood analysis records before prescriptions were signed off.

The GPs were alert to the risks of their older patients experiencing a rapid deterioration in their health and monitored patients who lived in care homes during weekly visits and patients in the community when they attended the practice or when alerted by other healthcare professionals.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. A business continuity plan was in place and contained details of water, power and other service organisations. Copies of the plan could be accessed away from the building.

We saw records showing all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). All staff asked knew the location of this equipment and records we saw confirmed these were checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Practice staff told us that when patients requested an urgent appointment the GPs provided an initial assessment or 'triage' to establish needs. Patients who needed to be seen that day were always seen either at one of the surgeries or at home. We found from our discussions with the GPs that staff completed thorough assessments of patients' needs and these were reviewed when appropriate.

The GPs we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed.

The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs that staff completed thorough assessments of patients' needs in line with NICE guidelines and these were reviewed when appropriate. For example, we were told that patients who had complex health needs had enhanced care plans. Within this group were many older patients who lived in care homes. We saw that GPs referred patients who needed secondary care promptly and followed up their care afterwards with appropriate treatment.

The GPs told us they had developed specialist clinical areas of interest such as diabetes, heart disease and asthma. The practice nurses supported this work which allowed the practice to focus on specific conditions. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support.

The practice's performance for antibiotic prescribing was better than average for the Clinical Commissioning Group (CCG) of Herefordshire. National data showed the practice was in line with referral rates to secondary and other community care services for all conditions.

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

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was collated by the practice manager and deputy practice manager to support the practice to carry out clinical audits. The practice had a system in place for completing clinical audit cycles. Examples of completed clinical audits included reviews of blood monitoring and prescribing for patients with rheumatoid arthritis.

The practice also used the information collected for the quality and outcomes framework (QOF), which is a national performance measurement tool, to monitor outcomes for patients. For example, most patients with diabetes had had an annual medication review and the practice met all the minimum standards for QOF in diabetes and respiratory diseases. This practice did not fall outside the expected range for any QOF (or other national) clinical targets.

We were shown that the practice used a range of specialist computer programmes to manage patients' treatment. For example, patients who had a risk of blood clotting could be initiated on a programme of medicine to prevent the risk of clotting, with an accurate dosage calculated electronically.

There was a protocol for repeat prescribing which was in line with national guidance. Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The patient management system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving alerts, the GPs had reviewed the use of a medicine where there was no evidence that patients' blood analysis had been checked. The evidence we saw confirmed that the GPs had oversight and a thorough understanding of best treatment for each patient's needs.

Good

Are services effective?

(for example, treatment is effective)

To improve outcomes for older patients, the practice allocated a named GP for each patient. When patients presented with symptoms of dementia, these were documented and the patient information system, EMIS would generate an alert for the GP to offer a short question based check to see whether further testing was indicated. The practice could refer patients to a local 'memory' clinic where this would be appropriate. The practice had systems in place to ensure that patients who were nearing the end of their life received the best possible care. They had a register of patients who needed palliative care and held regular internal as well as multidisciplinary meetings to discuss the treatment and support needs of patients and their families.

Effective staffing

The practice staff team included medical, nursing, managerial and administrative staff. Staff records were well organised and included comprehensive training records for all groups. We reviewed staff training records and saw that all staff were up to date with attending essential courses such as annual basic life support. We saw that where training was due, arrangements had been made for staff to attend training or for trainers to come into the practice during the 'protected time' training days.

We saw that all new staff completed a comprehensive induction relevant to their role in the practice. We saw that there was a rolling programme of annual appraisals for all staff and that these were up to date. We saw that appraisals were structured and thorough. There was a focus on development and objectives were set for every member of staff.

A member of the administrative and reception team described their recent training at the practice in safeguarding vulnerable adults; on-line training in 'Skills for health' and 'Understanding Policies and Procedures' and focussed training in respect of the flu clinics that were imminent. They told us their progress was monitored through all their training by the reception manager or one of the practice managers. They confirmed they had an annual appraisal. They told us that the support they received was a positive contribution to enjoying their job and the development of an effective team.

Nurses were expected to perform defined duties and had received appropriate training to fulfil these duties. For example, a nurse practitioner had completed training to take cervical smears. There was a specialist trained respiratory nurse and a specialist trained nurse for diabetes. The healthcare assistants and nurses provided smoking cessation advice as well as general nursing clinics.

We noted a good skill mix among the doctors; for example one GP had a particular interest in muscular-skeletal disorders and worked closely with the physiotherapist attached to the practice. GPs used a British Medical Association (BMA) template for their annual appraisals. The practice training records showed that GPs had completed all the elements of essential training including resuscitation training. GMC now requires all doctors to be revalidated every five years. We saw that the GP partners had been revalidated and that a date had been set for the revalidation process for all the GPs. (Only when revalidation has been confirmed by the GMC can the GP continue to practise and remain on the performers list with the NHS England.)

The practice was a training practice and doctors who were training to qualify as GPs had longer appointment times with patients and access to a senior GP throughout the day for support and advice. We received positive feedback from the trainee we spoke with.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and support patients with more complex needs. They told us that within the Herefordshire CCG area they had access to a 'virtual ward' led by local GPs and a Hospital at Home team which was led by a consultant and enabled their patients who required intravenous medicines to receive this care in their own homes. Patient information we saw in the surgery indicated that GPs and nurses could signpost their patients to a support group for carers.

We found that all the GPs provided care and support for patients with a mental illness or in mental distress. They told us they worked closely with the Community Mental Health Team who provided support for their patients. A community psychiatric nurse (CPN) was attached to the practice and offered a counselling service either at one of the surgeries or in other settings. They told us they could sign post the people who cared for their patients to a carers' group within Hereford and said that one of their staff attended the meetings to support the group and the carers who attended it.

Good

Are services effective?

(for example, treatment is effective)

GPs told us they worked closely with a local breast cancer charity, a hospice team and Macmillan nurses to ensure patients received appropriate clinical support and counselling when they needed it.

Information sharing

Within the Herefordshire Clinical Commissioning Group (CCG) area, medical teams used a patient information system, EMIS, to share information. This was particularly helpful when the practice worked with other service providers to meet people's needs and manage complex cases. The practice 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 through EMIS and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. GPs told us there were no instances within the last year of any results or discharge summaries that were not followed up appropriately.

The practice team communicated with other health and social care professionals, including palliative care nurses, community nurses and social workers to discuss patients with complex needs. Some decisions about health care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the meetings or telephone communication as a means of sharing important information.

Consent to care and treatment

The GPs we spoke with understood the importance of documenting patients' consent to interventions and referred to the practice policy in respect of obtaining patients' consent. We saw that the practice had set up specific patient consent forms for some procedures, for example for fitting contraceptive devices.

GPs had clear knowledge of the Mental Capacity Act 2005 and how it applied to their practice. They told us they had used one of their clinical meetings for training in this. They discussed working with others when patients did not have capacity to give informed consent and required a review of their 'best interests'. They told us about their patients who lived in care homes and their involvement in 'do not attempt resuscitation' decisions which they made with regard to the law. They told us about their understanding of 'Gillick' principles when determining whether children under the age of 16 were able to give consent to treatment.

Health promotion and prevention

It was practice policy to offer a health check to all new patients registering with the practice. The practice identified patients who needed additional support. Any health concerns were followed up, including offering smoking cessation advice for patients who might benefit from this.

The practice identified patients who needed additional support. The practice kept a register of all patients with a learning disability and had set up templates to begin providing annual checks for patients in this group. They had undertaken specialist training to enable them to provide appropriate and effective care to patients with a learning disability. The practice identified the smoking status of patients over the age of 16 and actively offered nurse-led smoking cessation clinics to these patients. They had developed a register of patients who needed end of life care. These groups were offered further support in line with their needs.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was at the average for the CCG; there was a clear policy for following up patients who did not attend.

The practice offered contraceptive advice and services and invited patients for cervical smear testing in line with the national recall system. Information we reviewed showed that the take up rate for cervical smear testing was in line with the national average.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

The patients we spoke with told us they were treated with consideration and respect by all staff. Their dignity was maintained at all times. They said that GPs and nurses were compassionate and understood their concerns. Some patients emphasised that they considered the care provided at Moorfield House Surgery was of the highest standard. Some patients had completed comment cards to tell us about their care. We reviewed their comments and found that patients were positive about the care they received.

We observed how patients were treated by receptionists. We saw that the reception staff were pleasant and welcoming to patients and spoke with them in a discrete manner. The practice manager told us that the reception task was an important one and that staff were highly motivated to provide an excellent service for patients. This was confirmed by other staff we spoke with. The practice manager told us that any concerns about the approach to patients would be discussed in supervisory sessions or team meetings.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the 2014 national patient survey and a survey of 473 patients (which is greater than a 2.5% sample) undertaken by the practice in conjunction with their patient participation group (PPG). The main aim of a PPG is to ensure that patients are involved in decisions about the range and quality of services provided by the practice.

The evidence from all these sources showed patients were satisfied with how they were treated. For example, data from the national patient survey showed the practice achieved an score comparable to the national average for patients reporting that the GP they last saw was 'good' or 'very good' at treating them with care and concern; and an above average score for patients reporting that the nurse they last saw was 'good' or 'very good' at treating them with care and concern. Of the patients who responded to the practice's annual survey, 87% said the GP gave them enough time and had treated them with care and concern. More than 98% of patients reported that they received excellent or good care from staff at the practice.

Care planning and involvement in decisions about care and treatment

Patients we spoke with on the day of our inspection told us that the GPs and nurses gave them clear information about their health and involved them in decisions and care plans in respect of any treatment they needed. They told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive.

The practice had estimated that between 2% and 3% of their patients did not speak English. We found that reception staff had the knowledge and understanding to support patients who did not speak English and to locate an interpreter for them. We saw that that information about translating and interpreting was available for patients.

The patient survey information we reviewed showed that nearly all patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. They reported that both GPs and nurses listened to them, explained tests and treatment and involved them in decisions about their care. This confirmed what patients told us.

Patient/carer support to cope emotionally with care and treatment

Patients told us that staff at the practice were supportive and that they appreciated this.

Notices in the patient waiting room, patient website and in the practice leaflets and newsletters signposted people to a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We saw that there was a carers' support group in Hereford and staff told us that one member of the practice team always attended their meetings to support the group and individual patients and carers.

The GPs told us they were aware of the need to provide support for all vulnerable patients. We saw that the practice had a register of all their patients who required palliative care and that the practice team worked closely with Macmillan nurses and the local hospice to ensure their patients who were nearing the end of their lives and their families received the help and support they needed. Staff

Good

Are services caring?

told us families who had suffered bereavement were called by their usual GP. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or signposting to a support service.

The GPs told us they worked closely with specialist services and the community mental health services on behalf of patients who needed help to manage alcohol and other substances and patients who experienced emotional concerns or mental ill health,. They referred to themselves as 'advocates' for their most vulnerable patients and sought to improve their circumstances in a holistic way by giving them longer appointments when they needed them and referring them on to other services as appropriate.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to the needs of the practice population. Practice staff engaged with other staff in practices within the Clinical Commissioning Group (CCG) to discuss local needs and work in partnership to meet them. For example GPs working in the Herefordshire CCG had formed a federation to provide extended hours care for their patients. Staff at Moorfield House Surgery could book appointments for their patients with the extended hours service. The federation had recently made a successful bid to provide out of hours care for patients in Herefordshire. We found that the GPs from Moorfield House Surgery were enthusiastic about the possibilities of this for their patients.

The practice had an active patient participation group (PPG). The main aim of a PPG is to ensure that patients are involved in decisions about the range and quality of services provided by the practice. We spoke with a representative of the PPG who told us the group had previously raised issues about appointments and about parking with the practice team. They said that practice staff had listened and made changes which led to improvements in both these areas.

Tackling inequity and promoting equality

When we spoke with practice staff they demonstrated that they understood their patient population. They had recognised the needs of different groups in the planning of its services. For example, the practice building was an older building, without lifts to the upper floors. We saw that the practice used consulting rooms on the ground floor for disabled or frail patients. The waiting area was large enough to accommodate patients with wheelchairs and prams. Accessible toilet facilities were available for all patients attending the practice.

People who did not have a permanent address were able to register with the practice care of the practice address. Mentally ill patients and patients who had difficulties in managing alcohol and other substances were offered flexible appointments to encourage their attendance. The GPs told us they recognised the range of health and social care problems these vulnerable patients faced. They referred them to appropriate services where these were available and followed them up to ensure their needs were met. They described themselves as 'advocates' for patients who did not have other support.

The practice training record showed that all staff had attended a training session about equality and diversity. This reflected a particular interest within the practice. The practice team had recognised the needs of different groups in the planning of its services. They told us that between 2% and 3% of their patients did not speak English and used a variety of other languages. They used an interpreting service to ensure they were able to communicate with these patients. They were able to pre-book the service or arrange telephone interpreting when the patient needed it.

Access to the service

Appointments were available at Moorfield House Surgery from 8.30am to 11am; 2pm to 3pm and 4pm to 6pm on weekdays. On two Tuesdays each month, this surgery was open from 7pm to 9pm. On one Saturday each month the surgery was open from 8am to 1pm. Patients who worked told us they appreciated the later appointment times. GPs emphasised they did not leave the building until every patient had received the care they needed.

Weekday appointments were also available from 8.30am to 11am and 4pm to 6pm at both branch surgeries. These additional surgeries increased choice and flexibility for patients. Patients could make appointments in person, by telephone and on-line. The practice offered pre-bookable appointments up to six weeks in advance. Full information about appointments was available to patients on the practice website and in practice leaflets. Other information available included details about specific clinics for diabetes, asthma, smoking cessation, family planning, child health and ante natal clinics; repeat prescriptions and urgent care.

Longer appointments were available for people who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to three local care homes on a specific day each week by a named GP and to those patients who needed one.

When we reviewed information from NHS England about patient satisfaction with making surgery appointments in England, we saw that the practice had scored lower than average, although not so low that this had been seen as a risk. Some patients who had left cards for us commented that it could be difficult to get through to the practice by telephone during the early mornings. We saw that the practice had responded to earlier feedback. There had

Good

Are services responsive to people's needs?

(for example, to feedback?)

been a staff meeting earlier this year to examine how the practice could resolve this issue. We saw that a range of ideas had been reviewed, including how to support more patients to book their appointments on-line.

The patients we spoke with confirmed that they were always able to see a GP or nurse when they needed to. One patient of working age told us that a follow up appointment had been made for them to fit in with their work pattern. One GP offered urgent appointments each day as the 'duty doctor'. They provided telephone assessment (triage) when appropriate so that patients were seen when they needed face-to-face appointment. Home visits were made following clinical triage.

The GPs at Moorfield House Surgery together with other GPs across the Herefordshire CCG area owned and managed the extended hours service. Patients were able to book appointments with this service from the practice. This increased flexibility and choice for all patients.

There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person, the practice manager, who handled all complaints in the practice. Information about making a complaint was available in the practice leaflet and on the website. One patient who had previously made a minor complaint told us it had been resolved to their satisfaction.

The practice manager had developed a clear system which enabled us to review how complaints had been managed. We saw that all complaints were treated as significant events. We reviewed all complaints made during 2014. We saw that all complaints were investigated and analysed thoroughly and followed up with appropriate actions to prevent recurrence of the issue. Responses to patients or other people who had made complaints were appropriate, informative and timely. Appropriate apologies were made.

Staff told us that in each case learning points were highlighted and discussed with the practice team in staff meetings. We reviewed a selection of staff meeting minutes which confirmed this.

Are services well-led?

Good

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

Our findings

Vision and Strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. Their Statement of Purpose outlined their commitment to high standards in primary medical care, continuous improvement and robust governance systems. These were reflected in high scores on the Quality Outcomes Framework (QOF) which is used by NHS England and local Clinical Commissioning groups to measure the performance of primary medical care practices. The aim to deliver high quality care was reflected too in the discussions about patient care we held with members of the practice team. All the staff we spoke with articulated the same message that they were there to support patients achieve positive health outcomes.

The practice had an on-going plan of improvements to support their vision. The plan identified and prioritised tasks for staff to complete. We saw that reporting on the progress of the plan was completed regularly: clinical matters were discussed in clinical meetings and other support processes were reviewed by the administrative and reception teams during their meetings.

Governance arrangements

The practice had a governance structure to provide assurance to patients and the local Clinical Commissioning Group (CCG) that the service was operating appropriately. There were identified lead roles for areas such as infection control, complaints and incident management, and safeguarding. The responsibilities were shared between the practice manager, the GP partners and senior nurses. The staff we spoke with were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

When we looked at the practice diary, we saw that the practice held regular governance meetings. The practice had policies and procedures in place to govern activities and these were available to staff via computer terminals and in paper format within files.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes. The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken.

Leadership, openness and transparency

The GP partners led by example. They were open about their own work and the need to review and challenge their practice. They had developed a learning culture which extended through the practice. There was an emphasis on learning from mistakes and a no blame culture.

The senior members of the practice team told us they took their leadership responsibilities very seriously. They said they always ensured that no member of staff worked alone in the building, particularly in the evenings.

Other staff told us that the GP partners and other managers were very approachable. Staff confirmed that there was an open culture within the practice and that they had opportunities to raise issues at team meetings. They said that they met regularly with their own staff group and that staff training meetings for the whole practice team were held every two or three months. The minutes of meetings we reviewed confirmed this.

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

The practice obtained feedback from patients through annual surveys, comments and complaints. They viewed the information as opportunities to learn and improve their services for patients.

The practice had an active patient participation group (PPG). The main aim of a PPG is to ensure that patients are involved in decisions about the range and quality of services provided by the practice. We saw that the group included female and male patients from across the age spectrum plus members of the staff team. A representative from the PPG told us that the patient representatives in the group felt that their contribution was valued by the practice. They told us the group advised on the content of the annual surveys undertaken by the practice and followed up actions arising. They confirmed that concerns arising from surveys in previous years had been acted upon and that the appointments system and car parking were examples of improvements made because patients had requested this.

In respect of feedback from staff, we followed through two items on the practice action plan which related to

Are services well-led?

Good

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

administrative and reception staff. We saw that there was a development task to train more staff to produce letters from templates and to take responsibility for chairing their team meetings. We saw evidence of progress in respect of both plans. The deputy practice manager told us that through this process, administrative and reception staff had increased their engagement. The deputy practice manager told us that staff had expressed that they felt empowered by taking on greater responsibilities and having their voices heard.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five staff files relating to staff from each team and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had protected time for learning every three months.

The practice was a GP training practice which meant that qualified doctors who wished to complete specialist training to become GPs could work at the practice as a registrar under supervision. We saw that a recent registrar had taken up a permanent contract at the practice on completion of their specialist training. They confirmed that their training at the practice had been a positive experience and shared their view that the practice provided excellent care for patients.