Moorfield House Surgery

Inspection report

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Garforth
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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 location	Good
Are services safe?	Good
Are services effective?	Outstanding
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Overall summary

This practice is rated as Good overall. (A previous inspection undertaken on 28 October 2014 had rated the practice as Good overall.)

The key questions at this inspection are rated as:

Are services safe? – Good

Are services effective? – Outstanding

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Good

As part of our inspection programme, we carried out an announced comprehensive inspection at Moorfield House Surgery on 14 June 2018.

At this inspection we found:

- The practice had clear governance policies and protocols, which were accessible to all staff. There were clear systems in place 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. For example, in relation to their recall system regarding high-risk medicines. This system had subsequently been shared with other local practices as best practice.
- Patient care and treatment was delivered in line with up to date best practice guidance. There was evidence of quality improvement within the practice. Clinicians knew how to identify and manage patients with severe infections including sepsis.
- The practice was proactive in engaging with patients to encourage and support them to attend for reviews of their care needs and treatment.
- The practice had achieved 100% (559) of the total Quality and Outcomes Framework indicators. This was higher than local and national figures (530 and 539 respectively).
- The practice offered patients a range of access to appointments, such as telephone consultations and extended hours. Patients also had access to Saturday morning appointments via a local 'hub'.
- Uptake rates for cancer screening programmes were higher than local and national averages.
- The practice were engaged with innovative schemes to support quality patient care and service delivery.
- Patients where overwhelmingly positive about the service, care and treatment they received at the practice.
- The practice had been acknowledged as the second highest practice in Leeds for patient satisfaction (using the national GP patient survey results).
- There was evidence of a cohesive team with a strong focus on continuous learning and improvement at all levels of the organisation.

We saw areas of outstanding practice:

- As a result of a significant incident, a template had been developed regarding the review of patients who were prescribed high risk medicines. This template had subsequently been shared with, and in the process of being adopted by, other local practices.
- The practice were proactive in identifying and supporting patients who were experiencing domestic abuse. They worked with the local police to raise awareness and support patients in disclosing their experiences of being abused. This had resulted in an increase in patients feeling able to discuss their experiences. Their work in this area had been presented both at a local and national level.

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

Please refer to the detailed report and the evidence tables for further information.

Population group ratings

Older people	Good
People with long-term conditions	Outstanding
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)	Good

Our inspection team

Our inspection team was led by a Care Quality Commission (CQC) lead inspector and included a GP specialist adviser.

Background to Moorfield House Surgery

Moorfield House Surgery is the provider of the practice which is located at 11 Wakefield Road, Garforth, Leeds LS25 1AN. It is based within a semi-rural area in the South East of Leeds. The premises are owned by one of the the GP partners.

The provider is contracted to provide Personal Medical Services to a registered population of approximately 4,515 patients. There are some variables to the practice patient profile compared to national figures. For example, the percentage of patients whose working status is classed as being unemployed is 3% (5% nationally) and the percentage of patients aged 65 years and over is 35% (27% nationally).

The ethnicity of the practice patient population is approximately 98% white British with the remaining 2% from mixed ethnic groups. The National General Practice Profile shows the level of deprivation within the practice demographics being rated as nine. (This is based on a scale of one to ten, with one representing the highest level of deprivation and ten the lowest.)

The provider is registered with the Care Quality Commission to provide the following regulated activities: diagnostic and screening procedures; treatment of disease, disorder or injury; maternity and midwifery services; family planning and surgical procedures.

The practice clinical team is made up of two GP partners and one salaried GP (all female), one practice nurse, two healthcare assistants and a clinical pharmacist. The practice team consists of a practice manager and a range of administration and reception staff. There were arrangements in place should a patient wish to specifically consult with a male GP.

Opening times for Moorfield House Surgery are 7.30am to 6pm Monday to Friday, with the exception of Tuesday when they open at 8am. Patients also had access to Saturday morning appointments which were run alternatively at two local practices.

Routine and urgent appointments are available, along with telephone consultations as appropriate. Patients can also make appointments via the practice's online portal on their website. When the practice is closed out-of-hours serviced are provided by Local Care Direct, which can be accessed by calling the NHS 111 service.

We saw that the ratings from the previous inspection were displayed both in the practice and on the website.

Good

Are services safe?

We rated the practice as good for providing safe services.

Safety systems and processes

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

- The practice had appropriate systems to safeguard children and vulnerable adults from abuse. All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Staff gave us several examples where they had addressed safeguarding concerns. Learning from safeguarding incidents were available to staff.
- All staff who acted in the capacity of a chaperone had been trained and had received a Disclosure and Barring Service (DBS) check. (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.)
- Staff took steps, including working with other agencies, to protect patients from abuse, neglect, discrimination and breaches of their dignity and respect.
- The practice carried out appropriate staff checks at the time of recruitment and on an ongoing basis.
- There was an effective system to manage infection prevention and control. There were up to date audits and evidence of completed actions.
- The practice had arrangements to ensure that facilities and equipment were safe, regularly maintained and in good working order.
- Arrangements for managing waste and clinical specimens kept people safe.

Risks to patients

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

- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness, busy periods and epidemics.
- There was an effective induction system for temporary staff tailored to their role.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections including sepsis.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

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

- The care records we saw showed that information needed to deliver safe care and treatment was available to staff.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. Regular multidisciplinary meetings were held with other community staff, such as the district nurse, palliative care team and health visitors. Patients' records were updated with relevant information arising from those meetings.
- Clinicians made timely referrals in line with protocols.

Appropriate and safe use of medicines

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

- The systems for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment, minimised risks.
- Medicines were prescribed, administered or supplied to patients in line with current national guidance. The practice had reviewed its antibiotic prescribing and taken action to support good antimicrobial management in line with local and national guidance.
- There was a patient centred approach regarding how their health and prescribed medicines were reviewed and monitored.
- Those patients who were prescribed high risk medicines received regular reviews in line with national guidance.
- As a result of a significant event the practice had reviewed their recall system regarding high-risk medicines. They had engaged with local Clinical Commissioning Group (CCG) medicines management team regarding their templates to ensure that patients were not missed for their monitoring. This system had subsequently been shared with, and in the process of being adopted by, other local practices as best practice.

Good

Are services safe?

Track record on safety

The practice had a good track record on safety.

- There were comprehensive risk assessments in relation to safety issues.
- The practice monitored and reviewed safety using information from a range of sources.
- There was a comprehensive system in place to manage patient safety alerts. These were cascaded to staff, discussed in clinical meetings and actioned as appropriate. We saw the practice had taken action in response to Medicines and Healthcare products Regulatory Agency (MHRA) drug safety alerts. This included an alert in April 2018, regarding the appropriate management of women of child bearing age taking a specific anti-epiletic medicine.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a system for reporting and recording any areas of concerns. Staff understood their duty to raise concerns and report incidents and near misses and were encouraged to do so.
- There were systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice.
- The local CCG supported the practice to positively report any incidents to support shared learning across the Leeds areas.

Please refer to the evidence table for further information.

Outstanding ☆

Are services effective?

We rated the practice and population groups of people with long-term conditions and p eople whose circumstances make them vulnerable, as outstanding for providing effective services overall.

(Any Quality and Outcomes Framework (QOF) data relates to 2016/17. QOF is a system intended to improve the quality of general practice and reward good practice.)

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice.

- Patients' immediate and ongoing needs, including their physical and mental wellbeing, were fully assessed by clinicians. Care and treatment were delivered in line with current legislation, standards and guidance, supported by clear clinical pathways and protocols. There was no evidence of discrimination when clinicians made care and treatment decisions.
- Clinical templates were used, where appropriate, to support decision maing and ensure best practice guidance was followed.
- Practice staff were aware of social prescribing and signposted patients to other avenues of support as appropriate or if their condition should deteriorate.
- The practice had achieved 100% (559) of the total Quality and Outcomes Framework indicators. This was higher than local and national figures (530 and 539 respectively). This was reflected in the higher than average percentage of reviews of patient care and treatment.
- The practice was proactive in engaging with patients to encourage and support them to attend for reviews of their care needs and treatment. They had invested in an effective recall system, which triggered relevant pre-consultation information in a letter to be sent to the patient.

Older people:

- An appropriate tool was used to identify patients aged 65 years and over who were living with moderate or severe frailty. Those identified as being frail received a holistic review of their care and treatment needs.
- The practice followed up on older patients discharged from hospital. They ensured that patients' care plans and prescriptions were updated to reflect any extra or changed needs.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- GPs attended the local residential homes where registered patients resided. Weekly 'ward rounds' were undertaken, patients had annual health checks and were reviewed as needed and after a hospital discharge.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check 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.
- The practice provided care and treatment for adult patients who were newly diagnosed with cardiovascular disease, which included the offer of high-intensity statins for secondary prevention. Patients with atrial fibrillation were assessed for stroke risk and treated as appropriate. Any patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- The practice was able to demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice's performance on quality indicators for long-term conditions was above local and national averages. For example, 96% of patients diagnosed with COPD had been reviewed, compared to 88% locally and 90% nationally.

Families, children and young people:

- Childhood immunisation uptake rates were in line with the target percentage of 90% or above.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation.
- Clinicians liaised regularly with the health visiting team, to support appropriate care was available for children and families.

Outstanding ☆

Are services effective?

- Contraception services were available, which included coil and implant fittings and removals. Chlamydia screening kits were easily accessible for patients.

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

- The practice's uptake for cervical screening (2016/17 data) was 86%, which was above the 80% coverage target for the national screening programme.
- At 80% and 67% respectively, the practice's uptake for breast and bowel cancer screening was also higher than the national average (70% and 55%).
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

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.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- Annual health checks were offered to patients who had a learning disability. These patients were also signposted to other appropriate services for additional support.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice was proactive in identifying and supporting patients who were experiencing domestic violence or historical sexual abuse. They worked with the local police to raise awareness and support patients to disclose they were experiencing abuse. Consequently, in a two year period the number of patients who felt able to disclose issues to the practice had increased from zero to 132; these included both male and female patients. The rate of self-reporting to police had also increased by 47%. We saw several examples of positive comments from patients.
- The practice had been a finalist in 2017 for Primary Care Team of the Year, in respect of their work regarding domestic violence. They had also been awarded a "domestic violence quality mark" by a local City Council.

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

- Patients who had complex mental health needs or dementia had their care reviewed in a face-to-face consultation with a clinician.
- Patients had access to health checks and interventions for obesity, diabetes, heart disease, cancer and access to 'stop smoking' and physical activity services.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- Those patients who were on long-term or high risk medication were reviewed in line with guidance.
- The practice had access to a memory worker, who supported patients as appropriate, to minimise the risk of instances of 'crisis'.
- The practice's performance on quality indicators for mental health and dementia was above local and national averages, with lower than average exception reporting. (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.) For example, 97% of patients with a severe and complex mental health condition had an agreed care plan in place with 0% exception reporting (compared to the national average of 90% and 13% exception reporting).

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.

- The QOF results for 2016/17 showed the practice was performing higher than local CCG and national averages in the majority of areas, with lower than average exception rates. This supported patients receiving effective care and treatment in line with best practice.

Outstanding ☆

Are services effective?

- The practice was actively involved in quality improvement activity. Where appropriate, clinicians took part in local and national improvement initiatives, such as medicines optimisation. They also used information provided by the CCG to identify and address any areas for improvement.
- A programme of audit was used to drive quality improvements in clinical care and service delivery. We reviewed several audits, which included full cycle audits on coeliac disease and discharge summary action. These all showed quality improvement.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

- Staff had appropriate knowledge for their role, for example to carry out reviews for patients with long-term conditions.
- 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. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with ongoing support. There was an induction programme for new staff. This included one to one meetings, appraisals, coaching and mentoring, clinical supervision and revalidation.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.
- Training and equipment had been provided to the local residential home staff to support them in providing care and support for patients who resided there. For example, urine testing sticks, thermometers and pulse oximeters.

Coordinating care and treatment

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

- We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.
- The practice shared clear and accurate information with relevant professionals when discussing care delivery for people with long-term conditions and when coordinating healthcare for care home residents. They shared information and liaised with community services, social services and carers for housebound patients and with health visitors and community services for children who have relocated into the local area.
- Care was coordinated between services and those patients who received 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 may be vulnerable because of their circumstances.
- Discussion of safeguarding and vulnerable patients was a standing agenda item at the monthly clinical meetings.

Helping patients to live healthier lives

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

- All newly registered patients, including children, with the practice were offered a health check.
- Staff encouraged and supported patients to be involved in monitoring and managing their own health. Healthy lifestyle information and interventions, such as smoking cessation, alcohol misuse and social prescribing, were available for patients.
- 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, frailty and falls prevention.
- 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 who were at risk of developing a long-term condition and carers.
- We were informed about the knowledge of patients that clinicians had, particularly regarding those patients who

had mental health issues, dementia or experienced domestic violence. This enabled clinicians to support patients and provide interventions early to prevent a crisis or admission to secondary care services.

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.

Please refer to the evidence table for further information.

Good

Are services caring?

We rated the practice 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 NHS Friends and Family Test is a survey which asks patients if they would recommend the practice to their friends and family, based on the quality of care they have received. The results in the preceding quarter showed that out of 824 responses, between the period January to May 2018, 100% of patients were happy with the practice. The results were collated and reviewed on a monthly basis and any comments responded to. We saw that some of the responses commented positively about specifically named staff.
- Feedback from patients we received via CQC comment cards was positive about the way staff treat people.
- The most recently published national GP patient survey results (January to March 2017), showed the practice was higher than the national averages, for the percentage of patients who said they thought the GP and nurse were good at listening to them and at treating them with care and concern.

Involvement in decisions about care and treatment

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

- Staff communicated with people in a way that they could understand and had access to communication aids such as easy read materials and translation services.
- The practice identified patients who were a carer for another person and support was provided at an individual level.
- Patients and carers were signposted to advocacy services that could support them in making decisions about their care and treatment if needed.
- The most recently published national GP patient survey results (January to March 2017), showed the practice was higher than the national averages for the percentage of patients who said they thought the GP and nurse was good at involving them in decisions about their care.

Privacy and dignity

The practice respected patients' privacy and dignity.

- Staff recognised the importance of people's dignity and respect. Patients' comments we received and observations on the day supported this.
- 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.

Please refer to the evidence table for further information.

Good

Are services responsive to people's needs?

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

Responding to and meeting people's needs

The practice understood the needs of its population and organised and delivered services to meet those needs.

- The facilities and premises were appropriate for the services delivered. The practice made reasonable adjustments when patients found it hard to access services.
- The practice provided effective care coordination for patients who were more vulnerable or who had complex needs. They supported them to access services both within and outside the practice.
- Longer appointments were available for patients as appropriate.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.
- The practice supported a weekly social prescribing clinic, which was facilitated by a qualified professional from Connect for Health.

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 was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. Six monthly visits were offered to housebound patients, to enable medication and general health to be reviewed.
- The practice made use of a frailty register which enabled them to identify those patients who were at a higher risk of illness or injury and supported them to respond quickly to areas of concern.
- Registered patients who were resident in care homes were visited on a minimum weekly basis with additional visits as needed.

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.
- Care was co-ordinated with other health care professionals, such as district nurses, to support patients who were housebound. Multidisciplinary meetings were held to discuss and manage these patients.

Families, children and young people:

- 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.
- There was access to emergency appointments or telephone consultations for those parents who had concerns regarding their child's health.
- Weekly ante-natal clinics were held by a midwife and supported by the GPs. Post-natal checks were undertaken by the GPs.
- Patients had access to contraception services, which included coil and implant fitting and removal.
- A letter of congratulations was sent to the mothers of all new births. This included a registration form for the baby and provisional appointments for a post-natal check of the mother and six to eight week baby check.

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.
- The practice offered telephone consultations and extended hours appointments. Appointments were available on Saturdays via a local 'hub' of GP practices.
- Patients were encouraged and supported to access online services, such as booking appointments and ordering prescriptions.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including those patients who had a learning disability.
- Longer appointments were available for those patients who had complex needs.
- Carers were identified and supported as needed.

Good

Are services responsive to people's needs?

- Staff had received training on how to approach the issue of domestic violence with patients appropriately. The practice responded in a timely and supportive way to patients who disclosed an issue.

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

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice held a register of patients who lived with dementia and utilised appropriate tools to identify early signs of dementia.
- Patients who had difficulties relating to their memory were referred to a memory worker for additional support. This worker had good links with the local psychiatry team and could identify early onset dementia, ensuring the patient had access to treatment and support in a timely manner.

Timely access to care and treatment

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.
- A domiciliary phlebotomy service was provided to those residential homes and for housebound patients.
- Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- Patients reported that the appointment system was easy to use.
- The most recently published national GP patient survey results (January to March 2017), showed the practice was considerably higher than the national averages for patient satisfaction relating to access. For example, 96% said they generally found it easy to get through to the practice via telephone (compared to 66% locally and 76% nationally).

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. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. The practice learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care. However, it was noted that the practice received very few complaints and utilised other forms of patient feedback to support any appropriate learning or changes.

Please refer to the evidence table for further information.

Good

Are services well-led?

We rated the practice as good for providing a well-led service.

Leadership capacity and capability

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

- Leaders were knowledgeable about issues, challenges and priorities relating to the quality and future of services. The practice had undertaken SWOT analysis to identify their areas of strength and weakness, threats and opportunities. They had used information from this to inform their strategy and future planning.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.
- We were informed of some of the challenges the practice had faced regarding the loss of some clinical staff. However, they assured us they had managed to maintain good patient care and service delivery through this period. This was reflected in the QOF and patient satisfaction results.

Vision and strategy

The practice had a clear vision, a realistic strategy and supporting business plans to deliver high quality, sustainable care.

- All staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social care priorities across the region. The practice planned its services to meet the needs of the practice population.
- The practice monitored progress against delivery of the strategy.
- The practice engaged the support of staff and their patient participation group (PPG) in delivering their vision and strategy.

Culture

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

- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. 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 they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary. Any behaviour and performance issues were acted upon.
- The practice actively promoted equality and diversity and staff had received training in this area.
- The practice focused on the needs of patients. There was a strong emphasis on the safety and well-being of all staff and patients.
- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- It had been recently reported in the media that Moorfield House Surgery had been voted second best GP practice in Leeds, out of more than 140 practices. This was based on the most recently published national GP patient survey question relating to “how likely a patient is to recommend the surgery to a friend”. We saw the patient survey results which supported they were second relating to the question identified.

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 co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control
- Practice leaders had established policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Good

Are services well-led?

- There were a range of meetings where governance was on the agenda and staff were kept informed.

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. Practice leaders had oversight of safety 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 practice considered and understood the impact on the quality of care of service changes or developments.

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 robust 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 the public, staff and external partners to support high-quality sustainable services.

- The service was transparent, collaborative and open with stakeholders about performance.
- 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. There was an active patient participation group.
- The practice worked collaboratively with other local practices to improve the quality of and access to patient care.

Continuous improvement and innovation

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

- There was a focus on continuous learning and improvement. Staff were enthusiastic and passionate about continuing to provide quality patient care.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- The practice was involved in Royal College of General Practitioners accredited research activities, looking at how advances in medicine can improve patient care.
- One of the GPs had recently delivered a presentation to Leeds practices citywide regarding the domestic abuse work they had undertaken. We received information from the CCG informing us of the usefulness in sharing this work. As a result of the presentation, it has been agreed to fund training in domestic violence for all Leeds practices.

Please refer to the evidence table for further information.