Drs Knight, Hargraves & Flores (also known as Quay House)

Quality Report

100 Westfaling Street
Hereford, HR4 OJF
Tel: 01432 352600
Website: http://www.quayhousemedical.nhs.uk

Date of inspection visit: 10 October 2014
Date of publication: 08/01/2015

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

Summary of this inspection

Page

Overall summary 2

The five questions we ask and what we found 3

The six population groups and what we found 5

What people who use the service say 7

Areas for improvement 7

Detailed findings from this inspection

Our inspection team 8

Background to Drs Knight, Hargraves & Flores (also known as Quay House) 8

Why we carried out this inspection 8

How we carried out this inspection 8

Detailed findings 10

Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of Drs Knight, Hargraves and Flores (also known as Quay House) on 10 October 2014. The practice has a branch surgery in the village of Credenhill which we did not inspect on this occasion. The inspection team was led by a CQC inspector and included a GP specialist advisor, and a second CQC inspector. We found that Quay House provided a good service to patients in all of the five key areas we look at. This applied to patients across all age ranges and to patients with varied needs due to their health or social circumstances.

Our key findings were as follows:

- The practice had comprehensive systems for monitoring and maintaining the safety of the practice and the care and treatment they provided to their patients.
- The practice was proactive in helping patients with long term conditions to manage their health and had arrangements in place to make sure their health was monitored regularly.
- The practice was clean and hygienic and had robust arrangements for reducing the risks from healthcare associated infections.
- Patients felt that they were treated with dignity and respect. They felt that their GP listened to them and treated them as individuals.
- The practice had a well-established and well trained team with expertise and experience in a wide range of health conditions.
- There were areas where the practice needs to make improvements.

The practice should:

- Review the dispensing training and monitoring of staff employed to work at the branch surgery.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. The practice provided opportunities for the staff team to learn from significant events and was committed to providing a safe service. Information about safety was recorded, monitored, appropriately reviewed and addressed. The practice assessed risks to patients and managed these well.

Are services effective?

Good

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

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed patients rated the practice higher than others for several aspects of care. Patients told us they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Information was provided to help patients understand the care available to them. We saw that staff treated patients with kindness and respect and were aware of the importance of confidentiality. The practice provided advice, support and information to patients, particularly those with caring responsibilities, long term conditions, and to families following bereavement.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice was aware of the needs of their local population and engaged with the NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) to secure service improvements where these are identified. Patients reported good access to the practice and said that urgent appointments were available the same day. The practice had good facilities and was well equipped to treat

Summary of findings

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

Are services well-led?

Good

The practice is rated as good for providing well-led services. The practice had an open and supportive leadership and a clear vision to continue to improve the service they provided. There was a clear leadership structure and staff felt supported by management. The practice had well organised management systems and met regularly with staff to review all aspects of the delivery of care and the management of the practice. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and this was acted upon. The practice had a developing patient participation group (PPG). There was evidence that the practice had a culture of learning, development and improvement.

Summary of findings

The six population groups and what we found

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

Older people

Good

This practice is rated as good for the care of older people. Patients over the age of 75 had a named GP and GPs carried out visits to patients' homes if they were unable to travel to the practice for appointments. The practice was in the process of delivering its 'flu' vaccination programme. The practice provided a responsive service to patients living in a local care home.

People with long term conditions

Good

This practice is rated as good for the care of people with long term conditions. The practice had effective arrangements for making sure that people with long term conditions received regular health checks and had plans in place in the event of their condition deteriorating. The practice included patients in those groups in their 'preventing unplanned admissions' patient register.

Patients whose health prevented them from being able to attend the surgery for appointments were visited at home. Patients told us they were pleased with the support they or their family members received to help them manage their health.

The practice worked with various local specialist services such as specialist nurses and physiotherapists. A physiotherapist visited the practice two days a week to provide ease of access to physiotherapy treatment.

Families, children and young people

Good

This practice is rated as good for the care of families, children and young people. The practice held weekly childhood vaccination clinics for babies and children. Childhood 'flu' vaccinations were also provided. A midwife came to the practice every week to see pregnant women. The practice provided a family planning service. The GPs and nurses worked with other professionals where this was necessary, particularly in respect of children who may be at risk.

Working age people (including those recently retired and students)

Good

This practice is rated as good for the care of working age people, recently retired people and students. The practice provided extended opening hours until 6pm for people unable to visit the practice during the day and also had arrangements for people to have telephone consultations with a GP. They were also able to book evening and weekend appointments for patients with a local

Summary of findings

GP extended hours 'hub'. The practice was in the process of inviting patients between the ages of 40 and 74 for NHS health checks. Students were offered Meningitis C vaccinations before they started at college or university.

People whose circumstances may make them vulnerable

Good

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

People experiencing poor mental health (including people with dementia)

Good

This practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice had a register of people at the practice with mental health support and care needs and invited them to attend for an annual health check. Staff described close working relationships with the local NHS mental health trust which worked with the practice to identify patients' needs and to provide patients with counselling, support and information.

The practice was alert to the complex needs of people who were living with dementia. They worked in partnership with a designated dementia nurse from the local NHS mental health trust to provide the care and treatment patients needed.

Summary of findings

What people who use the service say

We gathered the views of patients from the practice by looking at 50 Care Quality Commission (CQC) comment cards patients had filled in and by speaking with member of the Quay House Patient Participation Group (PPG). A PPG is usually made up of a group of patient volunteers and members of a GP practice team. The purpose of a PPG is to discuss the services offered and how improvements can be made to benefit the practice and its patients. Data available from the NHS England GP patient survey showed that the practice scored in the middle range nationally for satisfaction with the practice.

Patients were positive about their experience of being patients at Quay House. They told us that they were treated with respect and that members of the staff team at the practice were warm, thoughtful and caring. A number of patients commented on their GP listening to them and involving them in decision making about their care and treatment. Some people remarked on the practice following up test results and hospital referrals efficiently.

Four patients commented on finding it difficult to get through on the telephone or to make an appointment while most said that they were able to do so easily or did not comment on this. In four of the comment cards, and in an email we received shortly after the inspection, patients reported that some reception staff were occasionally less polite and helpful than was normally the case. However many other patients made positive comments about the attitudes and manner of the whole staff team and told us they felt they received a considerate and personalised service.

Areas for improvement

Action the service SHOULD take to improve

- Review the dispensing training and monitoring of staff employed to work at the branch surgery.

Drs Knight, Hargraves & Flores (also known as Quay House)

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) lead inspector. The team included a GP Specialist Advisor and a second CQC inspector.

Background to Drs Knight, Hargraves & Flores (also known as Quay House)

Quay House is situated in a residential area on the northern edge of Hereford city. It has around 6,000 patients. The practice is in a purpose built building which also contains a separately owned pharmacy. Hereford has a mainly white British population with strong agricultural roots and some light industry. There is a substantial Eastern European population which dates back to the 1940s and has grown in recent years. The practice has a higher proportion of female patients between 35 and 45 than the England average and a higher proportion of children and young people, particularly in the under 10 age group. The practice provides primary care services for local armed service families.

The practice has three partners with a fourth (currently salaried) GP who was about to join the partnership. The practice also has a second salaried GP whose contract is flexible. This is because they are involved in providing medical services in the voluntary sector. Three of the GPs are male and two are female. The practice has two practice nurses and two health care assistants. The clinical team are supported by a practice manager, deputy practice manager and a team of reception staff and medical secretaries. All of the practice team are part time. This provides some inbuilt flexibility for covering annual leave and sickness.

The practice has a branch surgery in the Herefordshire village of Credenhill which provides appointments for two hours every weekday. The branch surgery also provides a limited dispensing service due to the lack of a nearby pharmacy in its rural location.

The practice has a General Medical Services (GMS) contract with NHS England. The GMS contract is the contract between general practices and NHS England for delivering primary care services to local communities.

This was the first time the CQC had inspected the practice. Based on information we gathered as part of our intelligent monitoring systems we had no concerns about the practice. Data we reviewed showed that the practice was achieving results that were in line with the England or Clinical Commissioning Group average in most areas and higher in some.

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

Detailed findings

Why we carried out this inspection

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

This provider had not been inspected before and that was why we included them.

Please note that references to the Quality and Outcomes Framework data in this report relate to the most recent information available to CQC at the time of the inspection.

How we carried out this inspection

Before this inspection, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. These organisations included Herefordshire Clinical Commissioning Group (CCG), NHS England Local Area Team (LAC) and Herefordshire Healthwatch. We carried out an announced visit on 10 October 2014. Before the inspection we spoke with a member of the practice's Patient Participation Group (PPG). We also sent CQC comment cards to the practice. We received 50 completed cards which gave us information about those patients' views of the practice. We received two emails from patients after the inspection. During the inspection we spoke with a range of staff (GPs, nurses, practice managers and reception staff).

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

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

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

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

Good

Are services safe?

Our findings

Safe Track Record

The practice had a system in place for reporting, recording and monitoring significant events and the staff we met understood the importance of this. Information about all significant events and the analysis of these was available for all staff to access on the practice's computer system. The practice had a structured reporting form to record the details of individual events and all staff could fill in a form if they needed to report something.

Records about significant events and concerns raised with the practice showed that there had been a long term commitment to improving the service. Information about significant events since 2009/10 was stored on the practice's computer system where it was organised into folders for each year. The practice had maintained paper records of significant events since 2004.

Learning and improvement from safety incidents

National and local safety alerts arrived at the practice by email and were circulated to all the GPs and nurses. The practice manager also checked the information and provided copies for reception and other staff if they needed to know about them. Staff we spoke with confirmed that they knew where information was stored and that they were involved in discussions about safety related matters.

We saw evidence of significant event analyses (SEAs) and of meetings to discuss actions and decisions made to prevent adverse events happening again. We found that there was clear communication within the practice and a culture of openness and shared learning. An hour of each quarterly clinical training day was used to discuss any significant events since the last meeting. All staff at the practice took part in these discussions. Staff told us it was important for non-clinical staff, not just the GPs and nurses to discuss when things went wrong because the practice valued everyone's views and ideas. The Practice Manager confirmed that if there was an adverse event directly related to the care and treatment of a patient they would inform the patient of this.

The practice was able to describe changes they had made at the practice as a result of their SEA processes. These included changes to the appointment system, adjustments to the confidentiality policy and developments to some aspects of patients' records.

Reliable safety systems and processes including safeguarding

The practice carried out criminal records checks with the Disclosure and Barring Service (DBS) when clinical staff were employed to work at the practice. The practice had not routinely carried out DBS checks for non-clinical staff in the past. This was because these staff were rarely on their own with patients who may be vulnerable, even when they did chaperone duties. The Practice Manager said they recognised that it would be best practice to carry out DBS checks for staff who would be undertaking chaperone duties and would do this when they employed new staff in the future. They immediately updated their recruitment policy to reflect this.

The practice had a chaperoning policy and provided training for those non-clinical staff who were asked to fulfil this role when needed. However, staff told us that the nurses and health care assistants carried out most chaperone duties and that other staff only did this occasionally. Staff we spoke with confirmed they had been trained for this role and showed that they understood their responsibilities regarding this. Information about the availability of chaperones was displayed within the practice.

The practice had a lead GP for safeguarding and staff we spoke with knew who this was. Staff we spoke with had a good understanding of their roles and responsibilities regarding safeguarding including their duty to report abuse and neglect. Multi agency safeguarding hubs (MASH) provide structures for all agencies with safeguarding responsibilities to communicate and work together effectively. Staff knew how to report any new safeguarding concerns to MASH and other health professionals and knew the name of the safeguarding lead at the Clinical Commissioning Group (CCG).

There was a clear safeguarding policy which included information about identifying and reporting abuse and neglect. Information about important contact numbers for the multi-disciplinary child and vulnerable adult safeguarding teams was available for staff to refer to.

Good

Are services safe?

Details of the local MASH safeguarding policy and reporting form were not referred to in the safeguarding procedures. The Practice Manager said they would add an electronic link to this. The practice had clear systems which made sure that relevant staff were aware of any child known to be at risk or who was in the care of the local authority. The practice also used the computer system to highlight adults known to be vulnerable.

GPs, nurses and other staff had attended safeguarding training arranged through the local authority safeguarding team. We saw certificates confirming that the safeguarding lead had done level three safeguarding training as expected for that role.

Several staff told us about a possible safeguarding concern recognised by a member of staff. The member of staff had immediately raised their concern and the practice had taken appropriate steps to ensure the safety of a child. This was subsequently recorded by the practice as a significant event and they had carried out a significant event analysis which identified that the team had taken the correct action.

The practice held quarterly meetings to discuss child safeguarding cases with health visitors and communicated with them on a case by case basis at other times. They had concerns about their ability to communicate as effectively as they would like with health visitors and district nurses who were based at other locations in the city. They considered that liaison was more effective in the past when these colleagues were based within the practice and there was regular daily contact.

The practice had a whistleblowing policy which included information about the rights and responsibilities of staff and patients. The document included a link to the General Medical Council's (GMC) guidance about raising concerns about patient safety and the telephone number for 'Public Concern at Work' an organisation that provided advice and support to whistleblowers.

Medicines Management

We saw that the practice had a range of policies and procedures relevant to the safe management of medicines and prescribing practice. These included written protocols for topics such as repeat prescribing and storage and transport of vaccines. The practice had been working closely with a pharmacist from the CCG since 2004. They visited the practice one morning a week to monitor prescribing practice.

The prescribing arrangements at the practice gave patients a variety of options available for obtaining their repeat prescriptions. There was a process for prompting patients who needed to have their medicines reviewed by a GP and this was done at suitable intervals depending on the specific requirements relating to individual medicines. There was a separately owned pharmacy in the same building as the practice. This made it convenient for patients to collect medicines after an appointment. The pharmacy also provided a delivery service to practice patients living within a two mile radius.

The practice kept small amounts of a limited range of medicines such as antibiotics at its branch surgery. These were for dispensing to patients where there was a need for a medicine to be started quickly and patients were not able to go into Hereford to the nearest pharmacy. Staff described the processes they used to ensure medicines were dispensed correctly; these included systems for stock control and monitoring of expiry dates. Once dispensed, a GP checked the medicines before patients left the surgery with them. Reception staff who worked at the branch surgery had received in house training to dispense the medicines at the branch and were experienced and long standing members of the team. We identified that the most recent training one of these staff had done was three years previously and that there had been no formally recorded observation of their practice since. However, the practice manager confirmed that all dispensing was supervised by the GP on duty at the branch surgery. This included checking medicines before to the dispensing staff handed them over to patients. The practice contacted the Clinical Commissioning Group (CCG) and NHS England local area team following our inspection to discuss the training requirements for staff carrying out dispensing duties at the branch surgery. The practice provided a delivery service by taking patients' medicines to the branch surgery from the pharmacy next door to Quay House. There was a written policy describing the processes staff were expected to follow for this.

We discussed the storage and security arrangements for medicines at the branch surgery. Staff told us that medicines were stored in unlocked cupboards but that these were in a location where there was always a staff member present. The practice manager confirmed that the property had an intruder alarm, CCTV and a metal grill on

the door. Following our inspection the practice sent us written confirmation that they had reviewed the storage of medicines at the branch surgery and moved them to an area which would be kept locked.

When GPs visited patients at home they usually gave them a handwritten prescription and then updated the patient's computer records when they returned to the practice. The practice staff described a clear process for making sure changes to patients' medicines by other health professionals, for example the Out of Hours service or the hospital, were recorded in patients' records.

We looked at the arrangements for storing prescription pads and for monitoring when GPs took these from stock ready to use. We found that the storage of the pads was not secure and that there were no records to provide an audit trail of prescriptions used. The practice manager immediately moved the stock of pads to a secure location and said they would create a robust recording system for prescription pads in stock and used in line with NHS guidance. Three working days after the inspection the practice sent us evidence that they had done this.

There was an independent pharmacy in the same building as the practice. The practice worked closely with the pharmacy to facilitate obtaining medicines promptly in urgent situations, for example if they believed they would need a particular medicine with them when visiting someone at home.

We found that some GPs had small numbers of medicines in their individual consulting rooms where security and temperature control could not be guaranteed. As a result of our raising this during the inspection the practice decided to store all medicines in one room. They confirmed that they had done this within three working days of our inspection. They also confirmed that having reviewed security they had arranged to fit a different type of lock on the door of that room.

The nurses were responsible for ordering vaccine stocks. This was done electronically and when stock arrived the delivery notes were scanned into the computer system to provide a stock record and an audit trail of batch numbers and expiry dates. These records were monitored by the Practice Manager and were available for the nurses and healthcare assistants to refer to. We saw evidence that staff monitored and recorded the temperatures of the fridges where vaccines and other temperature sensitive medicines were stored.

Cleanliness & Infection Control

Some patients who filled in comment cards specifically commented on the high standard of hygiene and cleanliness at the practice. The practice was visibly clean and tidy when we inspected. General cleaning of the premises was done by an external contractor who arranged monthly checks by one of their supervisors. The practice liaised with them over cleaning schedules and we saw examples of completed ones for September 2014. Clinical equipment was cleaned by the nurses and health care assistants and they had cleaning schedules in each room.

Cleaning equipment and products were kept secure. Specific equipment and products were available to deal with any bodily fluids that might need to be cleaned. We were shown examples of specific cleaning instructions for items of medical equipment. These included details of the responsible person, the process to be followed and when items should be cleaned. We saw that there was a good supply of personal protective equipment, such as disposable gloves and aprons, for staff to use.

The practice had a written infection prevention and control (IPC) policy and produced an annual IPC statement setting out the practice's IPC arrangements over the previous year. This covered topics such as staff training, hygiene monitoring and hand washing audits. The Clinical Commissioning Group (CCG) lead nurse for infection prevention and control (IPC) had carried out an IPC audit at the practice in 2012. The practice score for this audit was 88%. They made some recommendations for action and the practice provided us with information about the action they had taken.

The practice had an up to date legionella risk assessment which had established that the building had low levels of risk in relation to the legionella bacteria.

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

There was a 'needle stick' injury procedure so staff had information about the action to take if they accidentally

injured themselves with a needle or other sharp medical device. Staff at the practice were all offered Hepatitis B vaccinations to protect them against the risk of contracting this virus.

Equipment

In our discussions with staff we established that the practice had the equipment they needed for the care and treatment they provided. We saw evidence that equipment was maintained and re-calibrated as required. Portable electrical equipment was tested and there was a fire safety folder containing evidence of routine tests and checks including fire alarm tests and fire drills. However, we noted that there was no alarm system in the disabled toilet for a patient to summon help if they needed to. The staff had means by which they could call for help in an emergency including panic alarms and an alert system on the computers.

Staffing & Recruitment

The practice had a low turnover of staff and no new staff had been employed for 18 months. Other staff had been employed for at least six years and several for more than 10 years. The practice had a written recruitment procedure but this did not cover all the checks that could help the practice make sure any new staff they recruit in future were suitable. For example, the practice application form did not include information about the Rehabilitation of Offenders Act or ask applicants to declare if they had a criminal conviction. Immediately after our inspection the practice manager sent us evidence to show they had reviewed and updated their procedures and paperwork regarding this.

The overall staffing levels and skill mix at the practice ensured that sufficient staff were available to maintain a safe level of service to patients. The GPs told us that because they were all part time they were able to provide additional cover for each other without working excessive hours. Staff told us that when a member of staff had needed time off, other staff had covered their hours so that the person could take extended leave rather than having to hand in their notice.

Staff we spoke with, and information we were shown, confirmed that the GPs provided additional cover for each other when any of them were unexpectedly unavailable at short notice. If they were unable to cover sessions themselves they used locums. They did not use an agency for this because they preferred to use local GPs who they knew well and had worked at the practice before. The practice manager told us that when GPs or other staff worked a long day they had an hour and a half lunch break and none of the staff were routinely rostered for more than two evenings a week.

The clinical team provided a broad mix of specialist areas of knowledge and skills. The specialisms of the clinical team included dermatology, musculoskeletal medicine, children's health, women's health and minor surgery.

There were two part time practice nurses and two health care assistants at Quay House. The nurses' specialisms included child health, diabetes, family planning, coronary heart disease, travel health, sexual health, cervical cytology, asthma and COPD. The health care assistant was trained to take blood, give certain injections and carry out various health checks including blood pressure monitoring.

Monitoring Safety & Responding to Risk

The practice had robust arrangements for identifying those patients who may be at risk. There were practice registers in place for people in high risk groups such as those with long term conditions, mental health needs, dementia or learning disabilities. The practice included patients in those groups in their 'preventing unplanned admissions' patient register to help them identify those patients most at risk of their health deteriorating. The practice computer system was set up to alert GPs and nurses to patients in these groups and to adults and children who may be at risk due to abuse or neglect.

The practice premises were well maintained and the practice manager confirmed that they had the autonomy to arrange repairs and maintenance with the practice's handyman or, when necessary, with identified tradesmen

Arrangements to deal with emergencies and major incidents

All staff at the practice had completed Cardiopulmonary Resuscitation (CPR) training and the Practice Manager had a system for monitoring when refresher training was due. The clinicians' CPR training was up to date and a training day for other staff had been booked in January 2015. Each consulting room had a panic alarm staff could access in an emergency. The practice computer system included an instant messaging alert system. Staff explained that they

Good

Are services safe?

could use this in the event of a medical emergency in the building to send a message to GPs and nurses asking for urgent assistance. Staff had need to use this on one occasion and told us it had worked well.

The practice had oxygen, a defibrillator and emergency medicines available for use in a medical emergency at the practice. We saw evidence that staff checked these regularly to make sure they were available and ready for use when needed.

We saw evidence of fire safety checks and tests including fire alarms and drills. Staff we asked confirmed that they had taken part in fire safety training and drills.

Staff told us that in the event of a major incident resulting in the practice not being able to open, practices within Hereford city provided 'buddy' cover for each other. We saw that the practice had a comprehensive business continuity plan which staff were aware of and understood. This included contact information for the NHS England Local Area Team. The practice kept a copy of the business continuity plan off site so they could be sure they had access to it in an emergency. Each member of staff had the telephone numbers for everyone else at the practice. The practice also had a comprehensive pandemic 'flu plan.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Our discussions with the GPs and nurses showed that that they were aware of and worked to guidelines from local commissioners and the National Institute for Heath and Care Excellence (NICE) about best practice in care and treatment. The practice had a system to ensure these were circulated to all the GPs and nurses. The practice manager also checked the information and provided copies for reception and other staff if they needed to know about them. Data available to us showed that the practice had high achievement levels or the Quality and Outcomes Framework (QOF). QOF is a scheme which rewards practices for providing quality care and helps to fund further improvements.

GPs showed us examples of significant event analyses (SEAs) which showed that they had been rigorous in pursuing their concerns about patients' health. This had resulted in patients being referred to specialists promptly so they received the appropriate care and treatment as soon as possible.

Management, monitoring and improving outcomes for people

Members of the team described a proactive approach to making sure that people with long term conditions were reviewed regularly. The practice held clinics for people with long term health conditions such as diabetes, asthma and chronic obstructive pulmonary disease. People whose health prevented them from being able to attend the surgery were visited by a practice nurse at home so that they were not disadvantaged by this.

Whilst new patients were not routinely offered health checks the nurses stressed that this was monitored on an individual basis. For patients with long term conditions they made sure essential information was available and made contact with the patient about their care needs. For example, one nurse described how they had made sure a new patient's notes were obtained promptly. They had then worked with the patient to produce a management plan to follow in the event of their long term condition becoming worse.

We found evidence of the team listening to information from patients about their health; for example, a nurse described seeing a patient who raised a concern about their health while having a 'flu vaccine. The nurse had followed this up with the patient's GP so that this could be looked into further.

The practice worked hard to make sure that all their patients who were known to have mental health problems received an annual check of their physical health. The GPs described how they worked with some patients, particularly those reluctant to receive care to encourage them to look after their physical health. For example, one GP spoke about giving patients, "more leeway" if they were late or did not arrive for an appointment. One of the staff team was delegated the task of identifying and contacting patients who were due for various health checks. They explained that for patients with mental health needs this was a task that needed particular sensitivity. It was clear that the member of staff was aware of patients' individual needs and worked closely with the GPs and other professionals to encourage patients to come for their appointments.

The practice held a physiotherapy clinic two days a week with an additional day once a month. This provided patients with ease of access to physiotherapy treatment.

The practice had a system in place for completing clinical audit cycles, a process by which practices can demonstrate ongoing quality improvement and effective care. Examples of completed clinical audits included one about the use of a particular medicine carried out in July 2014. This included details of action taken by GPs to identify affected patients, review their medicines and arrange scans. The audit paper also contained an ongoing plan for monitoring the outcomes of this for the affected patients and evidence that the GPs had sought further guidance about this from a Consultant in Geriatric Medicine. We saw another clinical audit the practice had carried out in relation to cervical screening. This had been linked to monitoring the performance of one of the nurses to establish their competence to provide in house cervical screening training.

Effective staffing

The GPs and nurses at the practice had a wide range of knowledge and skills. The clinicians' knowledge and skill was updated with ongoing accredited training and in-house training. The practice manager liaised with the

Good

Are services effective?

(for example, treatment is effective)

GPs and nurses to assure themselves that they were able to meet their professional requirements for registration and revalidation. Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council. The GPs each had a half day to prepare for their annual appraisal and a half day for the actual appraisal. Two of the GPs at the practice had completed their revalidation in August and October 2014 respectively.

The practice had a 'buddy' system for new staff. For example, new reception staff had a 'buddy' for at least their first eight weeks at the practice. The practice manager told us this was flexible and if a new member of staff needed support for a longer period this would be provided.

Staff received ongoing training at the practice. Some of this took place during the practice's quarterly half day training afternoons. However, if something arose in between those days, training was arranged as necessary. For example, the practice manager had arranged individual training with all the reception staff about how to book appointments for patients with the local GP extended hours 'hub', a recent initiative in Herefordshire. The practice had had a training afternoon the day before our inspection. The topics covered in this included suicide awareness training provided by a mental health specialist and fire safety awareness training. Six reception staff had achieved NVQ Level 2 in customer service and the practice manager explained that two others were about to begin an extended NVQ 2 course.

The practice manager and their deputy told us that the partners gave them flexibility and autonomy for arranging training and additional staff cover for this when necessary.

The practice manager told us that the practice aimed to act quickly before concerns about staff performance developed into a problem. The practice investigated any issues with the benefit of specialist employment advice to make sure that correct processes were followed.

Staff could ask for discussions at any time and did not have to wait for scheduled supervision or appraisal. There was a specific structure so that all staff had supervision and annual appraisal with the most appropriate member of the team. This had been in place for a number of years.

Working with colleagues and other services

The practice told us they worked in partnership with other services such as Macmillan nurses, district nurses and the local hospice. They recognised the importance and value of this, particularly for patients with long term conditions or needing end of life or palliative care. The practice took part in monthly palliative care meetings with other health professionals to discuss patients receiving palliative care. Between these meetings the GPs maintained communication about patients' care and treatment either by telephone or face to face discussions.

The practice had a duty GP every day. One of their responsibilities was to check any correspondence and test results for colleagues not at work that day and, where matters were urgent, to begin any follow up action that might be needed.

The GPs told us that they missed having district nurses and health visitors based at the practice where they could have daily contact. They explained that because these were based in the community in other parts of the city, communication and liaison was often difficult to organise.

Hereford has a military base and the practice provided primary care to service families and to pregnant service women. The practice liaised with the Army welfare team about the care of these service staff and families.

The practice provided a number of clinics run by professionals employed by other NHS organisations such as the local NHS community and mental health trusts. These provided people with access to specialist mental health and dementia services, physiotherapy, and ante natal and post natal care.

Hereford County Hospital operates a 'virtual ward' scheme to help reduce hospital admissions and re-admissions. The practice was allocated 19 'beds' under this scheme which enabled them to support their patients at home and meant that patients were able to return home sooner after being in hospital.

In addition to the learning and development they did within the practice the GPs also participated in a monthly 'Journal Club' with other practices in the city to encourage and develop more opportunities for support and shared learning.

Information Sharing

There was a system in place for making sure test results and other important communications about patients were

Good

Are services effective?

(for example, treatment is effective)

dealt with. The practice used a digital dictation system to compose referral letters. The system enabled the GPs to indicate the urgency to be given to each letter so that the medical secretaries typed and sent these in order of priority.

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

The practice recognised the importance of confidentiality and of complying with data protection legislation. Staff were required to sign to confirm they had read and understood the confidentiality and data protection policies. The practice had a poster for patients to tell them about their rights regarding how their information was managed. The practice had a formal written code of practice regarding confidentiality and this included numerous links to national guidance about confidentiality and the types of situations where GPs may need to share information about patients.

Consent to care and treatment

In situations where people lack capacity to make some decisions through illness or disability health and care providers must work within the Code of Practice for the Mental Capacity Act 2005 (MCA) to ensure that decisions about care and treatment are made in people's best interests.

Not all clinical staff had received training about the Mental Capacity Act 2005. However, staff we spoke with were aware of their responsibilities in respect of consent and described the ways in which they would check whether people had capacity to make decisions. A GP described a situation where they had needed to work with staff from two other agencies to assure themselves that a decision was being made in the best interests of the patient concerned. Another GP described a different situation where they had liaised closely with mental health professionals to help ensure a patient's rights were protected. The practice had a detailed consent policy which described their approach to consent. This contained a link to the General Medical Council's comprehensive guidance for GPs about consent.

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

Health Promotion & Prevention

The practice had an informative website and a wide range of information about various health and care topics in the waiting room and reception where patients could see them. The GPs and Nurses also printed information for patients direct from the NHS computer system. This helped to ensure patients always received the most up to date information which could be printed in languages other than English if needed.

The practice had a rolling programme of patients between 40 and 74 years of age to invite them for NHS health screening checks and provided a cervical screening programme. Shingles vaccinations were available for people aged 70 or 79. Clinics for childhood immunisations were held and six week checks were carried out for babies. The practice explained that a proportion of the children registered with the practice had not received childhood immunisations because of the religious beliefs of their families.

GPs told us that they worked hard to be proactive in identifying women who needed to have cervical screening tests done. If necessary they arranged to speak with patients, for example to explore reasons why they were reluctant to book an appointment for this. The practice nurse arranged two diabetes clinics each month and had their own re-call system for this with dedicated time and support from reception staff.

The deputy practice manager was responsible for arranging 'flu vaccination clinics and for contacting patients in risk groups who needed to receive the 'flu vaccine. They advertised these from September each year, reminded all of the GPs to check when patients were at the practice for other reasons, and made telephone calls to people not already booked in. They were also responsible for calling patients for other health checks and making sure GPs were proactive in monitoring patient's health. This included annual health checks for people with learning disabilities, mental health needs and those receiving palliative care.

Good

Are services effective?

(for example, treatment is effective)

This was a significant part of their role at the practice and they showed commitment to doing this thoroughly. This work was reflected in the practice achieving100% in their Quality and Outcome Standards Framework (QOF).

The practice was also able to refer patients to a local council's 'Healthy Lifestyle Trainer Service' and 'Lifestyle Improvements for Today' (LIFT) services. These provided diet and exercise guidance and support for patients who needed to develop a healthier lifestyle.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We gathered the views of patients from the practice by looking at the 50 Care Quality Commission (CQC) comment cards that patients had filled in and spoke with a member of the patient participation group (PPG). These gave us a positive view of the care and treatment patients felt they received. Information we had from the NHS England GP Patient Survey showed that the practice was in the mid-range for patient satisfaction in a range of areas and above the national average in most.

Patients were positive about their experience of being patients at Quay House. They told us that they were treated with respect and that members of the staff team at the practice were warm, thoughtful and caring. A number of people commented on their GP listening to them and involving them in decision making about their care. Some patients remarked on the practice always following up test results and hospital referrals efficiently.

Four patients commented on finding it difficult to get through on the telephone or to make an appointment while most said that they were able to do so easily or did not comment on this. In four of the comment cards, and in an email we received shortly after the inspection, patients reported that on occasions some reception staff were less polite and helpful than was normally the case. However many other patients made positive comments about the attitudes and manner of the whole staff team and told us they felt they received a considerate and personalised service.

Staff confirmed that whilst it was not always possible, they did their best to accommodate requests from patients to be seen by either a male or female GP.

During the inspection the practice had a busy 'flu vaccine clinic and we saw the nurses collecting people for their appointments. Although it was busy we saw that staff were calm, friendly and considerate towards people. For example a nurse was mindful of the distance a patient had to walk to the consulting room and stayed close by to make sure they were alright.

Care planning and involvement in decisions about care and treatment

In many of the comment cards patients said that their GP took time to listen to them and treated them as individuals. People felt they were given clear information and were involved in decisions about their care. Some patients indicated that they or a family member had long term health conditions and that they were seen regularly. Two people specifically mentioned receiving a good service in emergency situations.

Information leaflets were available in reception and the GPs and nurses printed up to date information from NHS sources to give to patients at their appointments.

Patient/carer support to cope emotionally with care and treatment

The information contained in the comment cards showed that patients felt supported by the practice including when being given concerning news about their health. Some patients gave us examples of being well supported during illness and in bereavement.

When patients died the practice contacted families to check their well-being and offered the opportunity to speak with a member of the team. Information was provided about organisations specialising in providing bereavement support. The practice told us they sent sympathy cards to the family when a patient died.

Staff told us that they had a carers' lead as recommended by Herefordshire Carer Support (HCS), an organisation that provides support and guidance to carers in Herefordshire. This was one of the reception staff.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

All of the consulting rooms were on the ground floor and there was level access for patients coming into the building. The car park provided disabled parking spaces near to the entrance.

The practice had a register of people with mental health support and care needs. Each person on the register was invited for an annual review of their overall health. Contact to arrange this was done sensitively by the Deputy Practice Manager who assessed whether they should contact the person direct or through their family or mental health support worker or nurse. Staff described good working relationships with the local NHS mental health trust. A mental health worker was at the practice one day a week to support the team to identify patients' needs and to provide patients with counselling, support and information. Staff at the practice had all attended suicide awareness training. A GP described how this had provided them with a positive opportunity to reflect on their work with people with mental health needs.

The team were alert to the complex needs of people who were living with dementia and had a dementia register. The practice worked in partnership with the local NHS mental health trust which provided local GP practices with a designated dementia worker. This person worked at the practice one day every month and the practice worked with them regarding referrals for patients and their care and treatment.

The practice provided general practice cover to older people living in a care home near Hereford, most of whom were living with dementia. This reflected an arrangement between the CCG and GP practices in Hereford city to provide a more responsive service to older people living in care homes in the city. The practice told us they would continue to provide care for Quay House patients who moved into other care homes if they did not wish to change to a different GP practice.

The acting manager at the care home told us that the arrangement worked well and that the practice were working with them to have up to date personal care plans in place for each person living at the home. They told us that a GP would always visit on the same day that they made a request and that they felt that GPs were nice to work with. They told us that whilst not all patients with long term conditions had had routine health checks, the practice had been supportive regarding the care of a person with diabetes.

The practice provided primary medical care to armed service families on a nearby military base. This included antenatal care for pregnant service women.

Tackling inequity and promoting equality

Staff told us that the practice would be supportive to homeless people who came to the practice to be seen but were not aware of seeing any homeless people in recent times. Similarly the practice was not currently providing medical care to any traveller families.

The practice used a telephone interpreting service for any patients who were unable to converse in English. The staff told us that this was most frequently used by Eastern European families attending the baby clinics. They also used it periodically for a small number of Chinese speaking patients at the practice. We noted that information leaflets in the practice were only available in English. However, GPs also had the facility to print up to date NHS patient information leaflets during consultations with patients and it was possible to select other languages for this.

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

The practice team showed an awareness of the specific beliefs held by some patients in relation to their health care.

Access to the service

Quay House has a branch surgery in the village of Credenhill on the northern outskirts of Hereford. Patients registered with Quay House may choose to book appointments at either surgery.

The information from CQC comment cards indicated that the service was generally accessible. Most patients who commented on the subject said they were able to get an appointment on the same day they phoned if this was needed. Three patients commented that they had found it difficult to get an appointment at times but a fourth commented that this had improved. Other people either did not comment on this or said it was easy to get through on the telephone.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice provided routine appointments for patients up to five weeks ahead. They also had 'two day wait' appointments and same day appointments for people with a more urgent need. Appointments were also set aside for patients to book online. We were shown that four appointments were reserved for emergency appointments at the end of each day but that if more people than this needed to be seen they would be. Patients were also able to ask for a telephone consultations to speak with a GP without always needing to have an appointment at the practice. The practice leaflet asked patients to book additional time with their GP if needed and on the day of our inspection we learned that a patient with complex health needs had done this. Each GP had 'catch up' times scheduled during their day to help them absorb additional time spent with patients and enable them to deal with work such as dictating referral letters.

The practice provided routine bookable appointments on two weekday evenings up to 7pm. The days of the week for the evening appointments rotated so that people had a choice. They also provided appointments on one Saturday morning, a month, between 9.30 - 11.30am. Patients were able to book these appointments in advance by telephone, or on-line. Patients who wanted appointments outside those times were told about a local extended hours initiative by a federation of local GPs. This provided appointments between 6.30pm and 8pm on weekdays and between 8am and 8pm at weekends. Receptionists at all GP practices locally had access to the appointment booking system and could book appointments direct for patients.

The practice provided information about out of hours arrangements on their website and in a leaflet available in the practice. The telephone system automatically transferred patients to the NHS 111 service from 6pm to 8am.

Listening and learning from concerns & complaints

The practice had a system for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England.

GPs told us that they aimed to respond to all complaints within 48 hours. We saw that the practice had written promptly to people who had complained. The responses we saw showed an open approach and provided people with appropriate information including apologies where this was judged necessary. We saw evidence to show that the practice discussed complaints and used these to help them improve the service.

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

All of the team we met at Quay House showed that they wanted to provide patients with a safe and caring service and spoke about their patients in a respectful and caring way. The practice website contained information about the practice's patient charter and philosophy as well as the responsibilities of patients. This information reflected the practice's desire to provide high standards of health care to patients.

Whilst no changes were imminent, the practice was aware of the need to think of the future development of the practice including the challenges of recruiting key staff in the future.

Governance Arrangements

The GP partners all had lead roles and specific areas of interest and expertise. During the inspection we found that all members of the team understood their roles and responsibilities. There was an atmosphere of teamwork, support and open communication. The practice held quarterly education afternoons for shared training and learning. These were also used to discuss complaints and any significant event analysis (SEAs) that had been done. Additional discussions were arranged in between these meetings if necessary. Staff confirmed that they had daily discussions about all aspects of the running of the practice and, where appropriate, the care and treatment of patients.

The practice used information from a range of sources including their Quality and Outcomes Framework (QOF) results and the Clinical Commissioning Group to help them assess and monitor their performance. We saw examples of completed clinical audit cycles demonstrating that the practice reviewed and evaluated the care and treatment patients received.

Leadership, openness and transparency

The practice had a longstanding team of partners who had worked together over a number of years to provide stable leadership. They were supported by a practice manager and deputy practice manager who had also been in post a long time. Staff told us they felt listened to and said the partners supported them well. Staff particularly appreciated the fact that the partners were mindful of their family lives; for example they were flexible about staff negotiating their hours to allow them to attend events such as school sports days. We found that there had been very little staff turnover and staff enjoyed working at the practice.

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

The practice established a patient participation group (PPG) in 2011. This was run as a 'virtual' group with communication mainly by email. Information about the PPG and how to get involved was included on the practice website. Membership was open to anyone with an active email address. The practice had not found that patients had wanted to extend the PPG to include meetings but intended to seek their views about this.

The practice's telephone access survey in 2013 found that 74% of the patients who responded rated access by telephone as 'easy' or 'fairly easy' and 15% rated this as 'very easy'. The practice told us that following this survey they had improved the telephone system by having a separate line for outgoing calls.

Management lead through learning & improvement

We saw evidence that the practice valued the importance of quality, improvement and learning. There was a well-established staff development programme for all staff within the practice, whatever their role.

The whole practice team had a half day once each quarter for 'protected learning'. This was used for training and to give staff the opportunity to learn in a team environment. Cover for the practice was provided by another practice during this time. The partners believed that working part time allowed them more space for reflection and learning.

The results of significant event analyses and clinical audit cycles were used to monitor performance and contribute to staff learning. For example, a clinical audit had been carried out in relation to cervical screening. This had been linked to monitoring the performance of one of the nurses to establish their competence to provide in house cervical screening training.