Hendford Lodge Medical Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

Hendford Lodge Medical Centre was inspected on Tuesday 11 November 2014. This was a comprehensive inspection.

Hendford Lodge Medical Centre provides primary medical services to people living in the town of Yeovil, Somerset. The practice provides services to a mixed population group and is situated near the town centre.

Hendford Lodge Medical Centre also has a branch in Abbey Manor, Yeovil. The two practices were run by the same management group and owned by the same company Diamond Health Care.

At the time of our inspection there were 11,639 patients registered at Hendford Lodge with a team of 10 GPs, two trainee GPs, a practice manager, seven nurses, six health care assistants and approximately 24 administrative staff. GP partners held managerial and financial responsibility for running the business.

Patients who use the practice have access to community staff including district nurses, community psychiatric nurses, health visitors, physiotherapists, mental health staff, counsellors, chiropodist and midwives. The practice also runs specialist orthopaedic services and a leg ulcer service.

We rated this practice as good.

Our key findings were as follows:

Patient feedback about care and treatment was positive. The practice had a patient centred culture. Practice staff were well trained and experienced. Staff provided compassionate care to their patients. External stakeholders were positive about the practice.

Hendford Lodge Medical Centre was well organised, clean and tidy. The practice had well maintained facilities and was well equipped to treat patients. There were effective infection control procedures in place. Patients experienced relatively easy access to appointments at the practice. Patients had a named GP which improved their continuity of care.

The practice had a clear leadership structure in place and was well led. Systems were in place to monitor quality of care and to identify risk and manage emergencies.

Summary of findings

Patients' needs were assessed and care planned and delivered in line with current legislation. This includes assessment of the patient's capacity to make informed choices about their care and treatment, and the promotion of good health.

Recruitment, pre-employment checks, induction and appraisal processes were robust. Staff had received appropriate training for their roles and additional training needs had been identified and planned.

Information about the practice provided evidence that the practice performed comparatively with other practices within the clinical commissioning group (CCG) area.

Patients told us that they felt safe with the practice staff and confident in clinical decisions made. There were safeguarding procedures in place. Significant events, complaints and incidents were investigated. Improvements made following these events had been discussed and communicated with staff.

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. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. National Institute for Health and Care Excellence (NICE) guidance was referenced and used routinely. People's needs were assessed and care was planned and delivered in line with current legislation. This included assessment of capacity and the promotion of good health. Staff had received training appropriate to their roles and further training needs had been identified and planned. The practice had carried out staff appraisals and personal development plans for staff. Multidisciplinary working was evidenced.

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 said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice reviewed 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 were identified. Patients reported good access to the practice and a named GP and continuity of care, with urgent appointments available the same day. The practice had modern facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and other stakeholders.

Summary of findings

Are services well-led?

Good

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

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older people. For example, the practice had achieved a target below 2% of avoiding unplanned admissions to hospital (AUA) for patients in this population group. There was proactive care management for patients aged over 75.

The practice provided a complex care service to two local nursing homes. Four of the practice staff were dementia friends or carers champions maintaining close links with the homes and supporting patients in this group.

Specialists with expertise in caring for this population group had been invited to the practice to deliver presentations. A care talk had taken place in January 2014. Flu clinics for over 75 year olds (and other patients) were held all day on Saturdays at this time of year.

GPs and nurses made home visits for patients with specific medical needs in this population group in order to carry out a range of care and treatment options including blood tests, blood pressure and diabetic checks. Concerns about any of these patients, such as a cold house, feeling unwell or unsafe were fed back to other health and social care services.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. When needed longer appointments and home visits were available. For those patients with the most complex needs the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

The practice manager showed us evidence that chronic disease management and emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health.

GPs at the practice had undertaken a clinical executive team thematic review programme to support patients in this population group. This included having a named GP and structured annual reviews to check their health and medication needs were being met.

Expert speakers with specialisations affecting this population group had visited the practice to deliver training. This included a pain clinic talk in April 2014 and diabetes training evenings through the year.

Summary of findings

The practice maintained close links with health groups relevant to this population group including Support Federation Health Forums, e.g. asthma, cancer and men's health.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Systems were in place for identifying and following-up children living in disadvantaged circumstances and who were at risk.

Immunisation rates were relatively high for all standard childhood immunisations. Patients told us and we saw evidence that children and young people were treated in an age appropriate way and recognised as individuals.

Specialists in family planning had been invited to give presentations at the practice. This included pregnancy crisis talks in November 2014.

For example, the practice had endeavoured to make services relevant to this population group at times and on days convenient to patients. This included cytology appointments being held on Saturdays.

The practice had responded to patients in this population group's feedback by the expansion of Well Woman's Clinics.

We were provided with good examples of joint working with midwives, health visitors and school nurses. For example midwifery appointments and childhood immunisation clinics were held at appropriate and often flexible times.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the working-age people (including those recently retired and students).

The practice was proactive in offering online services as well as a full range of health promotion and screening which reflects the needs for this age group. The practice website contained comprehensive information and was regularly updated. Services relevant to this population group included cytology appointments and all day flu vaccination clinics on Saturdays at this time of year.

The needs of the working age population, those recently retired and students, had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offer continuity of care. For example, the practice had worked with their

Summary of findings

Patient Participation Group (PPG) to review the availability of appointments in order to become more responsive to the needs of this population group. As a result more early morning and evening sessions had been put in place.

The practice was working with its PPG to improve self-care for minor illnesses which was relevant to patients in this population group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with learning disabilities. The practice was working closely with two local care homes to ensure effective prescribing was in place.

The practice had shared service provision and regularly worked with multi-disciplinary teams in the case management of vulnerable people. The practice had sign-posted vulnerable patients to various support groups and third sector organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours.

The practice had a system which ensured patients were contacted after discharge from hospital or following A&E attendance. This was followed up and GPs alerted to any concerns.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). The practice regularly worked with local multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice had in place advance care planning for patients with dementia.

Several staff at the practice were dementia friends and carers champions to support this population group.

The practice had sign-posted patients experiencing poor mental health to various support groups and third sector organisations and charities. The practice had a system in place to follow up on patients who had attended accident and emergency where there may have been mental health needs. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

The practice supported patients in this population group through offering a dedicated dementia service. This included offering proactive consultation invitations to at risk patients.	

Summary of findings

What people who use the service say

We spoke with ten patients during our inspection. The practice had provided patients with information about the Care Quality Commission (CQC) prior to the inspection. A CQC comment box was displayed and comment cards had been made available for patients to share their experience with us. We collected one comment card. This contained positive comments.

Written feedback at the practice recorded that patients thought that staff at the practice provided a good service. Patients reported that the practice was tidy and well organised. Patients expressed confidence in all of the staff at the practice. The vast majority of patients were satisfied with the care and treatment they received and with the cleanliness of the practice.

This evidence was supported by our conversations with ten patients. The feedback from patients was positive. Patients told us about their experiences of care and praised the level of care and support they consistently received at the practice. Patients said they were satisfied and said they received good treatment. Patients told us that the GPs were professional, polite and kind.

Hendford Lodge Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The team also included a GP specialist advisor, a practice manager specialist advisor and an expert by experience. An expert by experience is someone with experience of using health and care services.

Background to Hendford Lodge Medical Centre

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The practice had opted out of providing out of hours care to its own patients. This service was provided by a dedicated out of hours provider.

The practice has a primary medical services contract with the NHS.

The practice is open Monday to Friday from 8.30 am to 6.30 pm. The practice offers late opening until 7.30 pm on Mondays and Thursdays. In addition the practice offers bookable Saturday morning opening 8.30 am to 11.30 am.

Why we carried out this inspection

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

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

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

Detailed findings

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

How we carried out this inspection

Before conducting our announced inspection of this practice, we reviewed a range of information we held about the service and asked other organisations to share what they knew about the service. Organisations included the local Healthwatch, NHS England, the local clinical commissioning group and local voluntary organisations.

We requested information and documentation from the provider which was made available to us either before, during or within 48 hours after the inspection.

We carried out our announced visit on Tuesday 11 November 2014. We spoke with ten patients at the practice during our inspection and collected patient responses from our comments box which had been displayed in the waiting room.

We obtained information from and spoke with seven staff at the practice including the practice manager, doctors, clerical staff, nurses and health care assistants. We observed how the practice was run and looked at the facilities and the information available to patients.

We looked at documentation that related to the management of the practice and anonymised patient records in order to see the processes followed by the staff.

We observed staff interactions with other staff and with patients and made observations throughout the internal and external areas of the building.

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

- 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
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Good

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, minutes from team meetings showed that approximately 30 minutes at each monthly meeting was used to discuss significant events, reported incidents, national patient safety alerts as well as comments and complaints received from patients.

We reviewed safety records and incident reports and minutes of meetings where these were discussed for the last two years. This showed the practice had managed these consistently over time and so could evidence a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events that had occurred and these were made available to us. A slot for significant events was on the practice meeting agenda and a dedicated meeting occurred monthly to review actions from past significant events and complaints. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. Staff including receptionists, administrators and nursing staff were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so.

Incident forms were available on the practice intranet. These were sent to the practice manager who showed us the system used to oversee these were managed and monitored. We tracked three incidents and saw records were completed in a comprehensive and timely manner. Evidence of action taken as a result was shown to us that learning took place. For example, when police had attended the practice with a prisoner in custody who needed medical treatment, some staff had been unclear about which areas of the practice the prisoner could access with their police escort. This had been followed up with a learning session at the team meeting.

National patient safety alerts were disseminated by the practice manager to practice staff. Staff we spoke with were able to give examples of recent alerts relevant to the care for which they were responsible.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records made available to us showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Contact details were easily accessible.

The practice had appointed GPs to act as leads in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak to in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended appointments. For example, patients on the domestic violence at risk register.

A chaperone policy was in place and visible on the waiting room noticeboard and in consulting rooms. Chaperone training had been undertaken by all nursing staff, including health care assistants. If nursing staff were not available to act as a chaperone, receptionists had also undertaken training and understood their responsibilities when acting as chaperones including where to stand to be able to observe the examination.

Patients' individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system which collated all communications about the patient including scanned copies of communications from hospitals. We saw evidence audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Medicines Management

Medicines stored in the treatment rooms and medicine refrigerators were stored securely and were only accessible

to authorised staff. There was a clear policy for ensuring medicines were kept at the required temperatures. This was being followed by the practice staff, and the action to take in the event of a potential failure was described.

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

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

We saw up to date copies of both sets of directions and evidence that nurses and the health care assistant had received appropriate training to administer vaccines. A member of the nursing staff was qualified as an independent prescriber and received regular supervision and support for the role as well as updating in the specific clinical areas of expertise for which they prescribed.

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

We checked the repeat prescriptions held at reception ready for patients' collection. We found that three of these were more than three months old. When we brought this to the attention of the practice manager they told us the system was under review and drew it to the attention of the partner GPs for immediate rectification.

Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Cleanliness & Infection Control

We observed the premises were clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead nurse for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and there after annual updates. We saw evidence the infection control lead had carried out audits for each of the last three years and that any improvements identified for action were completed on time. Practice meeting minutes showed the findings of the audits were discussed.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these in order to comply with the practice's infection control policy. There was also a policy for needle stick injury.

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

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

Equipment

Staff told us they had the equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place.

Staffing & Recruitment

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

Good

Are services safe?

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure there were enough staff on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave.

Staff told us there were usually enough staff to maintain the running of the practice and there were always enough staff on duty to ensure patients were kept safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring Safety & Responding to Risk

The practice had systems in place to manage risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, fire safety, medicines management, staffing, dealing with emergencies. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (AED) which is used to attempt to restart a person's heart in an emergency. All staff asked knew the location of this equipment and records we saw confirmed these were checked regularly. In the notes of the practice's significant event meetings, we saw that a medical emergency concerning a patient had been discussed and appropriate learning taken place.

Emergency medicines were stored securely and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia.

A business continuity plan was in place which covered a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff reference. For example, contact details of a maintenance contractor to contact in the event of failure of the electrical system.

A fire risk assessment had been undertaken that included actions required to maintain fire safety. We saw records that showed staff were up to date with fire training and that regular fire drills were undertaken.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinical staff were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and evidence we reviewed confirmed these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate.

GPs told us they had agreed lead roles in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work which allowed the practice to focus on specific conditions. Clinical staff told us the GPs supported all staff to continually review and discuss new best practice guidelines for the management of long term conditions. The review of the clinical meeting minutes confirmed this happened.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital which required patients to be reviewed within two weeks by their GP according to need.

National data showed the practice was in line with referral rates to secondary and other community care services for all conditions. We saw minutes from meetings where regular review of elective and urgent referrals were made, and that improvements to practise were shared with all clinical staff.

There was no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, gender and race were not taken into account in this decision-making. The GPs at the practice included both males and females.

Management, monitoring and improving outcomes for people

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. These roles included data input, clinical review scheduling, child protection alerts management and medicines management.

The practice showed us five health and safety audits that had been undertaken in the last 12 months. These included risk assessments of the position of the resuscitation trolley, lone working, slippery floor signage, manual handling and working at reception. The findings of these audits had led to safety improvements. For example, yellow warning signs were now in place to warn patients and staff about the slippery floor at the entrance when it was raining.

The practice gathered data on the services they provided and the outcomes and collated it into an audit tool known as the Somerset Practice Quality Scheme (SPQS). This was a nationally agreed replacement for the Quality Outcomes Framework (QOF) in Somerset for one year. The practice manager told us its purpose is to innovate new ways of integrated working with other providers to reduce the bureaucracy and target-chasing associated with QOF.

The practice used SPQS to focus on two work streams: integration and sustainability. The practice used the information they collected for the SPQS and their performance against national screening programmes to monitor outcomes for patients.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how as a group they reflected upon the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all clinical staff should undertake at least one audit per year.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual fire training, basic life support and safeguarding training.

GPs were up to date with their yearly continuing professional development requirements and all had either

Good

Are services effective?

(for example, treatment is effective)

been revalidated or had a date for 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.

All staff undertook annual appraisals which identified learning needs from which action plans were documented. Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses. As the practice was a training practice, doctors who were in training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. Feedback from those trainees we spoke with was positive.

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, the practice had a lead nurse for infection control who had received appropriate training and updates to carry out this important role.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage complex cases. Blood results, X-ray results, letters from the local hospital including discharge summaries, out of hours providers and the out of hours service were received both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and actioning any issues arising from communications with other care providers on the day they were received. The GP seeing these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

The practice was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital. Enhanced services are services which require an enhanced level of service provision above what is normally required under the core GP contract. Patients at this practice benefitted from access to enhanced services such as orthopaedic services and a leg ulcer specialist clinic.

The practice held multidisciplinary monthly team meetings to discuss the needs of complex patents e.g. those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information Sharing

The practice used several electronic systems to communicate with other providers. For emergency patients, there was a practice policy of providing a printed copy of a summary record for the patient to take with them to A&E.

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

Staff were aware of the Mental Capacity Act 2005 and the Children's and Families Act 2014 and their duties in fulfilling it. Clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity. All clinical staff demonstrated a clear understanding of Gillick competencies. These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment.

There was a practice policy for documenting consent for specific interventions. For example, for minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

Health Promotion & Prevention

The practice invited all new patients registering with the practice to have a health check with a practice nurse. The patient's named GP was informed of all health concerns detected and these were followed-up in a timely manner.

Good

Are services effective?

(for example, treatment is effective)

The GPs used their contact time with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering smoking cessation clinic support to patients who had a smoking habit.

The practice had numerous ways of identifying patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept a register of all patients with learning disabilities and these patients were offered an annual physical health check .

Mechanisms of identifying at risk groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The 2013 performance for all immunisations was above average for the CCG, and again there was a clear policy for following up non-attenders by the named practice nurse.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

The practice had carried out a patient survey in September – October 2014 and received 597 responses. These showed that patients believed the practice and its staff to be very caring. 92.3% of respondents had said they were extremely likely to recommend the practice to others. Patients had made positive comments about the care they received and how helpful staff were in delivering good quality care and how pleasant staff were. 2% of respondents had passed negative comments. These included a difficulty in communication with the practice and having to see a nurse practitioner rather than a GP on one occasion.

Patients completed CQC comment cards to provide us with feedback on the practice. We received one completed card which was positive about the service experienced. They said staff treated them with dignity and respect. There were no negative comments. We also spoke with 10 patients on the day of our inspection. They all told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

All consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

Staff followed the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. The practice switchboard was located away from the reception desk and was shielded by glass partitions which helped keep patient information private. In response to patient and staff suggestions, a system had been introduced to allow only one patient at a time to approach the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

Staff told us if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff.

Care planning and involvement in decisions about care and treatment

The practice patient representative group had carried out a survey over the last 12 months which included questions on this area. There had been 154 respondents to the survey. Analysis of the results showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, 95% of patients stated they were listened to and involved in decisions about their care.

Patients we spoke to on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive.

The population the practice supported included Polish and Romanian ethnic groups. Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available.

Patient/carer support to cope emotionally with care and treatment

96% of respondents to the patient representative group survey said that they were treated with compassion by GPs and staff at the practice. Comments included the fact that they had been informed how to access support services to help them manage their treatment and issues affecting them. The patients we spoke to on the day of our inspection were also consistent with this survey information.

Notices in the patient waiting room, on the visual display unit in the waiting room and patient website also signposted people to a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was responsive to patients' needs and had systems in place to maintain the level of service provided. For example, respondents to the patient representative group survey had requested information on out of hour's services. This was now shown on the visual display unit and on signage visible at the entrance when the practice was closed.

Other indications of the practice responding positively to feedback included that patients had said they would like to see an improvement in the "meet and greet" experience at reception. As a result the new role of Reception Manager had been created and a new member of staff had commenced in this role in September 2014 with a specific remit to improve this.

Patients reported that they had previously been unaware of the practice website. Information about the website, how to access it and where to find it was now on display on the visual display unit in the waiting room. The website itself contained useful information about the practice.

Staff retention at the practice was high which enabled good continuity of care and accessibility to appointments with a GP of choice. Longer appointments were available for patients who needed them and those with long term conditions. This also included appointments with a named GP or nurse. Home visits were made to two local care homes on a specific day each week, by a named GP and to those patients who needed a home visit.

Tackle inequity and promote equality

The practice had recognised the needs of different groups in the planning of its services. For example, the practice had taken account of different ethnic groups in its local population and offered a free telephone based interpreter service. In addition, some of the staff at the practice could communicate with patients in languages other than English.

The practice provided equality and diversity training via e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last twelve months and that equality and diversity was regularly discussed at staff appraisals and team events.

The premises and services had been adapted to meet the needs of people with disabilities. The patient facing areas were based entirely on the ground floor. Corridors and doorways were wide enough for wheelchair users to access the practice. There was a patient toilet with an alarm cord and sufficient space to turn a wheelchair.

Access to the service

Hendford Lodge Practice is open Monday to Friday from 8.30 am to 6.30 pm. The practice offers late opening until 7.30 pm on Mondays and Thursdays. In addition the practice offers bookable Saturday morning opening appointments 8.30 am to 11.30 am.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Patients were satisfied with the appointments system. They confirmed that they could see a GP on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of their choice.

Patients told us the practice's extended opening hours on Monday 6.30pm to 7.30pm was particularly useful to patients with work commitments.

The practice was situated on the ground floor and had automated doors at the entrance to allow easy access. There was a risk assessment for disability access which was annually reviewed. Wider doors had been put in place for wheelchair users. There was space in the waiting room for wheelchairs and pushchairs. A patient toilet had an alarm cord to summon assistance if required.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. The complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice. This was the practice manager.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had ever needed to make a complaint about the practice. There was written information about how to make a complaint on leaflets, posters and on the visual display unit in the waiting room at the practice.

We looked at six complaints received in the last twelve months and found these had been satisfactorily handled within a reasonable timescale.

Are services well-led?

Good

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

Our findings

Vision and Strategy

The practice had a clear vision to deliver high quality care to patients. We found details of the vision and practice values were part of the practice's business plan. These values were displayed in staff and patient areas. The business plan included the creation of a secure outbuilding for patient medical records storage, moving the records to this new location, obtaining another GP and the future expansion of the practice due to the incoming housing development in the area.

We spoke with eight members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. We looked at minutes of the practice away day held in July 2014 and saw that staff had discussed and agreed that the vision and values were still current.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. We looked at twelve of these policies and procedures and saw staff had completed a cover sheet to confirm they had read the policy and when. All policies and procedures we looked at had been reviewed annually and were up to date.

Staff were sent required reading material by the practice manager to ensure they were kept up to date. This online system would send the practice manager an email alert if staff had not completed this required reading.

The practice held weekly governance meetings. We looked at minutes from the last three meetings and found that finance, staffing and safeguarding referrals had been discussed.

The practice had completed a number of clinical audits. For example in the last twelve months GPs had completed clinical audits on minor operations and medicines. From these audits, GPs at the practice had produced a protocol on disease modifying anti rheumatic medicines which the local CCG had judged to be outstanding and had shared it with other practices as best practice.

Other audits included prescription audits, medicine audits, diabetic medicines and spleen antibiotic audits. The spleen audit evidence showed that there was a need to review a number of patients to check whether they had received immunisations for conditions such as pneumonia. A further audit was planned to ensure this had taken place and whether any further actions were required.

Leadership, openness and transparency

Staff told us the practice had a clear leadership structure which had named members of staff in lead roles. For example there was a lead nurse for infection control and a senior partner was the lead for safeguarding. We spoke with eight members of staff and they were all clear about their own roles and responsibilities. They all told us that felt valued, well supported and knew who to go to in the practice with any concerns.

We saw from minutes that team meetings of all staff were held on a bi-monthly basis. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. We also noted that team away days were held annually.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies including the induction policy which was in place to support staff. We were shown the electronic staff handbook that was available to all staff. This included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

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

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

The practice had gathered feedback from patients through an annual survey and from comment cards. We looked at the results of the most recent October 2013 annual patient survey and 84% of all patient ratings stated that the practice was good, very good or excellent. There had been 197 respondents. The practice manager showed us improvements which had been made in response to survey feedback. This included the creation of more space in the waiting area, the installation of glass walls to separate the reception desk from the waiting room, a visual display unit to replace the numerous paper posters and comfortable chairs in the waiting area.

The practice had an active patient participation group (PPG). The PPG contained representatives from various

Are services well-led?

Good

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

population groups including patients who were working or recently retired, families, people with long term conditions and older people. The PPG had carried out an annual survey and met every quarter. The practice manager showed us the analysis of the last patient survey which was considered in conjunction with the PPG. The results and actions agreed from these surveys are available on the practice website.

Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. All of the staff we spoke with told us they always had an opportunity to speak up at team meetings and in more informal settings at the practice. Team building events were held twice a year including a summer party and a Christmas party for all staff. Staff told us morale was high at the practice.

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. One member of staff told us they had requested training on chronic kidney disease. As a result the practice manager had arranged for a guest speaker on this subject to deliver a presentation at the practice. We looked at four staff files and saw that regular appraisals took place which included a personal development plan.

The practice was a GP training practice. Two of the GPs were qualified trainers. There were three trainee GPs currently receiving training at the practice. We spoke with one of these trainees and they told us they felt fully supported by the practice GPs in their development.

The practice had completed reviews of significant events and other incidents and shared with staff via meetings and away days to ensure the practice improved outcomes for patients. For example, an incident had occurred in the waiting room whereby a patient needed immediate medical attention. Learning points from the incident had been shared with the team. These included the need to evacuate the waiting room safely if required and the need to record the checking of expiry dates on all medicines. Records showed these learning points had been acted upon.