

Hastings House

Quality Report

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Date of inspection visit: 14 April 2015
Date of publication: 29/10/2015

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

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of Hastings House Medical Centre on 14 April 2015. Overall the practice is rated as Good. Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well-led services. It was also good for providing services for the 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, and people experiencing poor mental health (including people with dementia).

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.
- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.

- The practice was proactive in helping people 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 arrangements for reducing the risks from healthcare associated infections.
- The practice had a well-established and well trained team who had expertise and experience in a wide range of health conditions.
- 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 was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand.

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?

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. There were enough staff to keep people safe.

Good



Are services effective?

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 guidelines issued by the National Institute for Care and Health Excellence (NICE). Patients' needs were assessed and care was planned and delivered in line with current legislation. The practice was proactive in the care and treatment provided for patients with long term conditions 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.

Good



Are services caring?

The practice is rated as good for providing caring services. Patients told us they were treated with compassion, dignity and respect and they were involved in their care and treatment decisions. Accessible 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 long term conditions and to families following bereavement.

Good



Are services responsive to people's needs?

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 England Area Team (NHSE) and South Warwickshire Clinical Commissioning Group (CCG) to secure service improvements where these were 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 patients and meet their needs. There was a

Good



Summary of findings

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?

The practice is rated as good for being well-led. The practice had a clear vision with quality and safety as a high priority. High standards were promoted and owned by all practice staff and teams worked together across all roles. Governance and performance management arrangements had been introduced and dates set for them to be reviewed. They took account of current models of best practice. Staff had received inductions, regular performance reviews and attended staff meetings and events. The practice proactively sought feedback from patients and had an active patient participation group (PPG).

Good



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

This practice is rated as good for the care of older patients. Patients over the age of 75 had a named GP and were included on the practice's avoiding unplanned admissions list to alert the team to patients who may be more vulnerable. Care plans were also in place for the most vulnerable patients, including those within the local care homes served by the practice. GPs also carried out regular 'rounds' and medicines reviews within each nursing home. GPs and practice nurses carried out visits to patients' homes if they were unable to travel to the practice for appointments and one of the practice nurses specialised in home visits for older patients. Some of these visits were carried out jointly with the district nursing team when appropriate. For patients who lived over one mile away from the practice, the dispensary was able to deliver medicines to their home. The practice was involved with an over 75's project in conjunction with Age UK, for the practice or organisation (depending on the patient need) to visit the homes of the most vulnerable elderly people in order to provide additional support where possible.

Good



People with long term conditions

This practice is rated as good for the care of patients with long term conditions, for example asthma, arthritis and diabetes. The practice had effective arrangements for making sure that patients with long term conditions were invited to the practice for annual reviews of their health. Care plans were in place for the most vulnerable patients. Clinics were held for a range of long term conditions, including diabetes, arthritis and chronic obstructive pulmonary disease (COPD) which is a lung disease. Members of the GP and prescribing practice nurses (who could issue prescriptions) ran these clinics. Patients whose health prevented them from being able to attend the surgery received the same service from one of the practice nurses as home visits were arranged. Patients told us they were seen regularly to help them manage their health. When patients with long-term conditions required routine medical appointments, the practice tried to allocate appointments to a regular GP on each occasion.

Good



Families, children and young people

This practice is rated as good for the care of families, children and young people. The practice held weekly childhood vaccination clinics and its rates of immunisation for children was above average for the South Warwickshire Clinical Commissioning Group (CCG).

Good



Summary of findings

Weekly antenatal and baby and children's clinics were held and the practice demonstrated it had a close working relationship with the local midwives and health visitor teams. In addition, a GP gave regular post-natal talks at a local children's centre. The practice provided cervical screening and a family planning service.

Working age people (including those recently retired and students)

This practice is rated as good for the care of working age patients, recently retired people and students. The practice provided extended opening hours until 9pm on Mondays and telephone consultations for patients unable to visit the practice during the day. NHS health checks were carried out for patients aged 40-75. The practice provided patients who smoked with smoking cessation support.

Good



People whose circumstances may make them vulnerable

This practice is rated as good for the care of patients living in vulnerable circumstances. Patients had a named GP and regular reviews were carried out in conjunction with community nurses and matrons. One of the GPs was the lead for learning disability (LD) care at the practice and the practice had an LD register. All patients with learning disabilities were invited to attend for an annual health check. Staff were aware of safeguarding procedures and GPs told us how alerts were placed on the records of potentially vulnerable patients. The practice had a close working relationship with social services. When patients living in vulnerable circumstances required routine medical appointments, the practice tried to allocate appointments to a regular GP on each occasion. The practice allowed travellers to register as patients, however at the time of our inspection there were none on the patient list.

Good



People experiencing poor mental health (including people with dementia)

This practice is rated as good for the care of patients experiencing poor mental health (including people with dementia). The practice had a register of patients at the practice with mental health support and care needs and invited them for annual health checks. Care plans were in place for these patients. Staff described close working relationships with the community mental health team, community psychiatric nurse and social services staff. These teams worked with the practice to identify patients' needs and to provide patients with counselling, support and information. The practice carried out dementia screening.

Good



Summary of findings

What people who use the service say

We gathered the views of patients from Hastings House Medical Centre by speaking in person with 11 patients, three of whom were involved with the Patient Participation Group (PPG). The PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. No patients had filled in CQC comment cards, although they had been made available by the practice before our inspection and were clearly displayed in the waiting room.

Patients we spoke with were happy with the practice. They said they could obtain appointments when needed, could get through to the practice on the telephone and received a friendly and professional service from GPs and practice staff. Some patients told us the practice had previously had problems with appointment availability but this had now improved, although it could take longer to get an appointment if you wanted to see a GP of your choice.

We spoke to management staff at three of the six care homes the practice had patients in. Managers were highly complimentary about the service they received from Hastings House Medical Centre. We were told they

provided a high level of continuing care with a prompt, efficient and caring service. Some patients we spoke with had been patients at the practice for many years and their comments reflected this long term experience.

Data available from practice patient survey showed that the practice scored at or slightly above average within the South Warwickshire Clinical Commissioning Group (CCG) for satisfaction with the practice. However, data from the 2014 GP national patient survey had some areas below average for the CCG. For example, 47% of respondents found it easy to get through to this surgery by phone (the CCG average was 76%) and 59% of respondents described their experience of making an appointment as good (against a CCG average of 77%). Other areas within the survey were average or slightly above average for the CCG. For example, 92% of respondents said the last GP they saw or spoke to was good at listening to them (the CCG average was 92%) and 77% of respondents were satisfied with the surgery's opening hours (against a CCG average of 75%).

As part of the NHS Friends and Family test, 92.1% of patients surveyed in March 2015 (35 out of 38 who responded), said they would be extremely likely or likely to recommend the practice to friends and family.

Hastings House

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector. The inspection team also included a GP specialist advisor and a practice manager specialist advisor.

Background to Hastings House

Hastings House Medical Centre is one of 36 member GP practices of South Warwickshire Clinical Commissioning Group. It provides primary medical care service to approximately 10,500 patients in a mainly rural area. The service is provided at Hastings House in Wellesbourne and at the Little Thatch branch surgery in Kineton. Patients may be seen at either location. The practice has a General Medical Services (GMS) contract with NHS England. Hastings House Medical Centre is a dispensing practice and patients that live more than a mile from a pharmacy may have prescriptions dispensed from the practice dispensary. There is also a dispensary at the branch surgery.

Since our previous inspection on 15 May 2014, the practice had formed plans to move to a new purpose built facility within the local area in 2016. We were shown that land had been acquired for the new practice, plans approved and we were shown building work was due to start in June 2015.

The practice offers a range of NHS services including an antenatal clinic run by a community midwife, post-natal appointments, smoking cessation and minor surgery. The practice also cares for patients within six local care homes, this includes patients with dementia and learning disabilities.

The practice has eight GP partners (a mix of male and female), two salaried GPs, two trainee GPs and six practice nurses (three are nurse prescribers, so are able to issue prescriptions). The clinical team are supported by a practice manager, an assistant practice manager, the dispensary manager and team, along with administrative and reception staff. The practice also regularly hosts medical students from the University of Warwick.

Data we reviewed showed that the practice was achieving results that were average or in some areas slightly below average with the South Warwickshire Clinical Commissioning Group in most areas.

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

The Care Quality Commission had previously inspected the practice on 15 May 2014. The practice was required to take action in a number of areas. There were concerns the practice was not discussing and learning from complaints; not monitoring checks on emergency medicines; did not carry out full checks when recruiting staff; not always completing full clinical audit cycles and not promoting on-line appointment booking.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. This provider had been inspected before under our new comprehensive inspection programme on 15 May 2014, but had not been rated. We inspected again to ensure the improvements required had been carried out and to the rate the practice as part of our new comprehensive inspection programme.

Detailed findings

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

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

How we carried out this inspection

Before this inspection, we reviewed a range of information we held about Hastings House Medical Centre and asked other organisations to share what they knew. These organisations included South Warwickshire Clinical Commissioning Group (CCG), NHS England area team and Healthwatch. We carried out an announced inspection on 14 April 2015. During the inspection we spoke with a range

of staff (GPs, nurses, practice manager, reception and administrative staff). We spoke with 11 patients who used the service, three of whom were members of the Patient Participation Group (PPG).

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)

Are services safe?

Our findings

Safe track record

Hastings House Medical Centre used a range of information to identify risks and improve patient safety. This included reported incidents and national patient safety alerts as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns and discussed how to report incidents and near misses. Since our last inspection was carried out in May 2014, we saw the practice fully discussed such incidents, recorded actions that were needed and followed these up when required. The practice had also planned and implemented a process for completing clinical audit cycles to demonstrate improvements that had been carried out and learning needs that had been identified.

We reviewed safety records, incident reports and minutes of meetings where these had been discussed, for the last 12 months. Eight significant events had been recorded during this time. This showed the practice had managed these consistently over time. We were shown records that demonstrated information gained from clinical audits and health and safety audits was assessed with patient safety as top priority. For example, contraceptive implant audits were carried out in April 2013 and March 2014. A further audit was due to be carried again in 2015. This identified a patient who experienced health complications as a result of the procedure being carried out and corrective action was taken.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last three years and we were able to review these. Significant events were discussed at practice meetings and complaints were reviewed. There was evidence that the practice had learned from these and that the findings were shared with relevant staff.

We reviewed an incident where a patient with chest pains had not been given an ECG (an electrocardiogram test to record electrical activity of the heart to detect abnormal rhythms and the cause of chest pain). We saw how the practice discussed this at a staff meeting and reviewed its

procedure. It was agreed all patients with chest pain would be given an ECG which would be reviewed by a GP before the patient was allowed to leave the practice. This was later reviewed to ensure the change in procedure continued.

We were shown the system used to manage and monitor incidents. New procedures had been implemented since our last inspection was carried out. Staff, including receptionists, administrators and nursing staff knew how to report incidents and were involved in discussion and follow-up afterwards. We tracked three incidents and saw records were completed in a comprehensive and timely way. We saw evidence of action taken when a patient was given an incorrect medicine. The practice ensured there had been no detrimental effect on the patient's health. The matter was raised with staff concerned and we saw evidence that appropriate re-training had been given and the situation monitored afterwards. When patients had been affected by something that had gone wrong, they were given an apology and informed of the actions taken. This was in accordance with practice policy.

National patient safety alerts were discussed in staff meetings. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. For example, changes to the diagnosis of type 2 diabetes. Staff also told us alerts were discussed during meetings held for clinical staff to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

At the time of our inspection, the practice had started to analyse the result from a minor surgery audit that had been completed in March 2015, to ensure procedures were being carried out appropriately and safely with any risk to the patient minimised. The practice had already scheduled a date to repeat this audit in March 2016.

Reliable safety systems and processes including safeguarding

Hastings House Medical Centre had appropriate systems in place to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about the training they had received. Staff we spoke with knew how to recognise signs of abuse in older people, vulnerable adults and children. Staff were also aware of their responsibilities and knew how to share information, properly record

Are services safe?

documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details for relevant agencies were easily available to staff and staff told us the practice regularly reviewed these to ensure they were up to date. Safeguarding policies were based on those issued by the safeguarding team at Warwickshire County Council.

The practice had appointed a dedicated GP as lead in safeguarding vulnerable adults and children. They had received appropriate training. All staff we spoke with were aware who the lead was and who to speak to in the practice if they had a safeguarding concern. The lead safeguarding GP was aware of vulnerable children and adults who were registered at the practice and records demonstrated good liaison with partner agencies such as the local authority. We saw evidence that safeguarding concerns were discussed at the bi-monthly multi-disciplinary team meetings and GPs told us how and when safeguarding alerts were placed on the records of vulnerable patients.

There was a chaperone policy in place, which was visible on the waiting room noticeboard and in consulting rooms. We saw records that demonstrated nursing staff had been trained to be a chaperone and understood the requirements.

Systems were in place to identify potential areas of concern. For example, for clinical staff to identify children and young people with a high number of accident and emergency attendances and following up children who failed to attend appointments such as childhood immunisations.

Medicines management

During our inspection, we checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. We saw that practice staff followed this policy.

Processes were in place to check medicines were within their expiry date and suitable for use. As part of this process, stocks of medicines that were due to expire within

the next two months were highlighted and re-ordered. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

Dispensing staff at the practice were aware prescriptions should be signed before being dispensed. If prescriptions were not signed before they were dispensed, staff checked with a member of the clinical team, in line with their guidance. There was a system in place to assess the quality of the dispensing process. The practice had signed up to the Dispensing Services Quality Scheme, which rewarded practices for providing high quality services to their dispensary users.

The dispensary received patient orders for repeat prescriptions in person, on-line or by a dedicated telephone line. The service was used by 5,500 patients at both Hastings House Medical Centre or at Little Thatch, the branch surgery. This was 50% of the total patient list. The practice had established a service for patients to pick up their dispensed prescriptions at either the main or branch surgery. We saw that patients who collected medicines from these locations were given all the relevant information they required.

A delivery service was also available from both locations for patients to have medicines delivered if they were unable to collect them in person. The delivery service ran on a monthly basis and prescriptions for medicines for home delivery were issued with this mind, subject to prescribing guidelines. The practice had tried to increase the frequency of this delivery service, but found there was little additional demand for an enhanced service. They were satisfied the monthly deliveries worked well, but had decided to keep this under review and try to increase the service again if they detected there was an increased demand.

We looked at the training records of dispensary staff and saw all members of staff involved in the dispensary had received appropriate training and their competence was checked regularly. This was linked into the annual staff appraisal scheme.

We saw there were guidelines in place to support the nursing staff in the administration of vaccines. These had been signed by all staff who administered vaccines. There was also a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. No stocks of controlled drugs were held

Are services safe?

within the practice, only within the dispensary. These were stored, audited, issued and disposed of in line with current regulations. Since our last inspection in May 2014, the practice had introduced a new system of checks on emergency medicines. This was being carried out in accordance with the new procedure.

Prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. The practice had also signed up to the electronic prescription service.

Cleanliness and infection control

We noted the practice was visibly clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. The practice employed its own cleaner. Since our last inspection in May 2014, we observed cleaning equipment was neatly stored in one location within the practice. All patients we spoke with told us they always found the practice to be clean and had no concerns about cleanliness.

The practice had a lead 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 received regular updates. We saw evidence the infection control lead had carried out an infection control audit during July 2014 and approximately annually in previous years. This was due to be carried out again in July 2015 as part of the practices' programme of planned audits. During our inspection we saw that any improvements identified for action were completed on time unless they were impractical due to the move to the new purpose built facility next year. For example, the last infection control audit had identified that repairs were needed to some areas of flooring and some of the waiting room chairs. We saw this had been promptly actioned. We saw minutes of practice meetings that demonstrated the findings of these audits had been discussed with all staff and relevant actions had been carried out in a timely way.

There was an infection control policy with supporting procedures, such as the safe use and disposal of sharps; use of personal protective equipment (PPE); spills of blood and bodily fluid available for staff to refer to. This enabled

staff to plan and implement measures to control infection. We saw hand washing sinks had soap. Additionally, 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 carried out annual checks in line with this policy to reduce the risk of infection to staff and patients. The latest legionella risk assessment had been carried out in July 2014.

There were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades. We saw evidence that their disposal was arranged through a suitable company and the appropriate procedures were in place.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. We saw that equipment was tested and maintained regularly and we saw equipment maintenance logs to confirm this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. There was also a schedule of testing in place.

Staffing & Recruitment

We were told and shown how the practice ensured there were sufficient numbers of suitably qualified, skilled and experienced staff on duty each day. There was a staff rota which was regularly reviewed and updated as changes were needed. Some administrative staff were part time and able to work additional hours or different shifts to provide staff cover if a staff member was unexpectedly absent. We saw how the practice had monitored their staffing needs to ensure sufficient staff were available to meet the needs of the population they served. Management confirmed they had sufficient staff on duty throughout the week. We saw a selection of staffing policies and procedures in place, for example, staff sickness, and planned absences.

We were shown the business continuity plan which had been adopted by the practice which advised what to do should there be an shortage of GPs and practice staff due to sickness for example. This included arrangements for

Are services safe?

using locum GPs, for which service level agreements were in place. This would help to ensure sufficient availability of GPs to continue the primary care service provision to patients.

The practice had a comprehensive and up-to-date recruitment policy in place. This had been fully revised since our last inspection on 14 May 2014. It detailed all the pre-employment checks to be undertaken on a successful applicant before that person could start work in the service. This included identification, references and a criminal record check with the Disclosure and Barring Service (DBS). These were checks to identify whether a person had a criminal record or was on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. When DBS checks were not required, for example, for administrative staff who did not work alone with patients, a risk assessment had been carried out to confirm this. We looked at five recruitment files for GPs, administrative staff and nurses. They demonstrated that the new recruitment procedure had been followed and all included references, DBS checks or DBS risk assessments.

Monitoring safety and responding to risk

Hastings House Medical Centre had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the building, medicines management, staffing, dealing with emergencies and equipment. 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 who had received appropriate training for the role.

The practice had identified some areas of risk that were impractical to completely eliminate before the new practice building was opened. This included carpets in the consulting rooms. During our inspection, we saw that all such risks had been identified, assessed and were kept under constant review to minimise any risks to patients.

Identified risks were included on a risk log. Each risk was assessed and rated and actions recorded to reduce and manage the risk. We saw that any risks were discussed during staff meetings.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. GPs explained how patients with long term medical conditions were monitored and appropriate alerts were placed on patients' medical records.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including oxygen and an automated external defibrillator (AED), used to attempt to restart a person's heart in an emergency. When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest and anaphylaxis (an allergic reaction). Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. These were revised following our last inspection on 14 May 2014 and now included regular checks on oxygen and oxygen masks, all of which were in date and suitable for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Management staff confirmed copies of this were kept at the homes of GPs and practice management. Risks identified included power failure, adverse weather including flooding and access to the building. The practice had carried out an annual fire risk assessment and all staff received regular fire safety training.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care & treatment in line with standards

Hastings House Medical Centre assessed the needs of its patients and delivered their care and treatment in line with their individual needs and preferences. All patients we spoke with were happy with the care they received and any follow-up needed once they obtained an appointment and said GPs and practice staff provided professional and considerate care.

The practice nursing team, in conjunction with GPs managed the care and treatment of patients with long term conditions, such as diabetes, asthma and chronic obstructive pulmonary disease (COPD) (a lung disease). We found there were appropriate systems in place to ensure patients with long term conditions were seen on a regular basis. Within the last 12 months, 88% of all patients with dementia had been reviewed and all patients with suspected cancer (331 were identified) had been referred for secondary healthcare within the two week national target.

We saw an example of how the practice learnt from incidents and was able to identify and take appropriate action on areas of concern. For example, when patients complained of chest pain, they were given an ECG (an electrocardiogram test to record electrical activity of the heart to detect abnormal rhythms and the cause of chest pain) and monitored.

Patients who required palliative care (palliative care is a holistic approach to care for patients with incurable illnesses and their families) were regularly reviewed. Their details were passed to the out of hours practice each weekend to ensure care would continue when the practice was closed.

Staff showed us how they used the National Institute for Health and Care Excellence (NICE) templates for processes involving diagnosis and treatments of illnesses. NICE guidance supported the surgery to ensure the care they provided was based on latest evidence and of the best possible quality. Patients received up to date tests and treatments for their disorders. We saw records of meetings that demonstrated revised guidelines were identified (for example with the treatment of diabetes) and staff were trained appropriately.

Regular staff meetings were held and improving patient outcomes was a regular agenda item. For example, we saw evidence the weekly meeting of GP partners included discussion on the performance of the practice.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles, including minor surgery. They were used to ensure the practice was providing care and treatment in line with current medical standards and improving the outcome for patients. For example, an improving dementia audit which was repeated in December 2014 examined the records of all 139 patients on the dementia register. One additional patient was discovered to have been missed off the register and six additional patients were identified as needing a dementia assessment. All had been contacted by the practice.

Some of this monitoring was carried out as part of the Quality and Outcomes Framework (QOF). QOF is a national performance measurement tool. The results are published annually. Data for the 2013-2014 financial year, the last available, showed the practice had a QOF performance of 94.4%, average for the South Warwickshire Clinical Commissioning Group (CCG).

We also saw evidence that the practice attended training events hosted by other local practices to identify and discuss best practice. This included CPR training and safeguarding children.

Effective staffing

Staff employed by the practice included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending courses such as annual basic life support and safeguarding. Both of these had been updated within the last 12 months. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

We saw that all staff had annual appraisals that identified learning needs from which action plans were documented.

Are services effective?

(for example, treatment is effective)

Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. Medical students based at the practice had access to a senior GP for support when needed.

Practice nurses had clearly defined duties which were outlined in their job description and were able to demonstrate that they were trained to fulfil these duties. For example, in the administration of vaccines. We were shown certificates to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage complex cases. It received blood test results, x-ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles.

The practice held weekly GP partners and clinical staff meetings to discuss concerns. There was also a multi-disciplinary team meeting held every four to six weeks. Subjects discussed included the needs of complex patients, those with end of life care needs or children who are at risk of harm. These meetings were attended by district nurses, social workers, palliative care nurses as appropriate and decisions about care planning were documented. Each of the GP partners were also allocated a care home where they provided care for residents. This helped to ensure patients received good continuity of care.

Clinical staff and the GP partners met regularly outside practice opening times. We saw evidence that clinical updates, difficult cases, significant events and emergency admissions to hospital were discussed and actions identified.

We saw records that confirmed the practice worked closely with the community midwife service, health visitors, the community mental health team and community drug teams. Clinics were held for blood testing, hypertension (high blood pressure), diabetes and minor surgery amongst others, to which patients were referred when appropriate.

There was a large range of information leaflets about local services in the waiting room. Relevant information was also displayed on a screen within the patient waiting room. This information was only available in English as the majority of patients spoke English as their first language, but staff told us information in other languages could be provided on request.

Information sharing

The practice used electronic systems to communicate with other providers, for example when making patient referrals. The practice made most of its referrals through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). There was also a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely way. The practice received details of all patients who attended the out-of-hours service by 8am on the following working day. The practice manager advised us that the GPs would inform the out-of-hours service if patients were likely to need care when the surgery was closed.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patient care. All staff were fully trained on the system.

Consent to care and treatment

Hastings House Medical Centre had appropriate processes in place to obtain, record and review consent decisions. We saw there were consent forms for patients to sign agreeing to minor surgery procedures. We saw that the need for the surgery and the risks involved had been clearly explained to patients. We also saw evidence that audits of consent for minor surgery were carried out.

There was a process to obtain signed consent forms for children who received immunisations. The practice nurse was aware of the need for parental consent and what action to follow if a parent was unavailable. There was information available for parents informing them of potential side effects of the immunisations. The GPs and nurses that we spoke with demonstrated a clear understanding of the importance of determining if a child was Gillick competent especially when providing contraceptive advice and treatment. A Gillick competent

Are services effective?

(for example, treatment is effective)

child is a child under 16 who has the legal capacity to consent to care and treatment. They are capable of understanding the implications of the proposed treatment, including the risks and alternative options.

Staff we spoke with understood the key requirements of the Mental Capacity Act 2005 and knew when to make best interest decisions for patients who lacked capacity. Mental capacity is the ability to make an informed decision based on understanding a given situation, the options available and the consequences of the decision. People may lose the capacity to make some decisions through illness or disability.

If a patient did not have English as a first language and could not understand procedures, the practice had access to an interpretation service.

Health Promotion & Prevention

We saw all new patients were offered a consultation with the practice nurse when they first registered with the practice. If any medical concerns were found, the patient was referred to the GP or another healthcare professional if more appropriate. The practice also offered NHS health checks to all its patients aged 40-75. Since the beginning of January, 667 checks had been carried out. The practice's performance for cervical screening uptake was average compared to others in the South Warwickshire Clinical Commissioning Group (CCG) area. During the last 12 months, 2431 patients out of 6859 who were eligible had been screened.

We were shown work the practice had carried out to identify and promote particular health needs within the area. For example, smoking cessation support and well woman clinics. Health promotion events were also carried out at Kineton High School.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

The patients we spoke with were positive about the care given by Hastings House Medical Centre and any follow-up needed once patients had obtained an appointment. Patients we spoke with said they were always treated respectfully and with dignity by all members of staff. Patients told us how friendly, helpful and professional GPs and staff were.

During our inspection we saw that staff were helpful, polite and understanding towards patients, in person and over the telephone. Staff we spoke with told us they put patient needs first and we saw this was the case throughout our time at the practice.

The GP national patient survey results for 2014 showed that 92% of respondents said the last GP they saw or spoke with was good at explaining tests and treatments, slightly above the Clinical Commissioning Group (CCG) average of 90%. Additionally, 92% of patients who responded said the last GP they saw or spoke with was good at listening. This was in line with the CCG average.

We saw curtains could be drawn around treatment couches in consultation rooms. This would ensure patients' privacy and dignity in the event of anyone else entering the room during treatment. The curtains had been replaced since our last inspection was carried out on 14 May 2015. It was noted during the last inspection that the curtain in one consulting room did not go all the way round the examination couch to ensure the patient's privacy and dignity was maintained. This had now been actioned.

Care planning and involvement in decisions about care and treatment

During our inspection we looked at patient choice and involvement. GPs explained how patients were informed about procedures and any available options before their treatment started and how they determined what support was required for patients' individual needs. Clinical staff also told us how they discussed any proposed changes to a patients' treatment or medication with them. Some patients we spoke with confirmed this. GPs said they treated patients with consideration and respect and said they kept patients fully informed during their consultations and subsequent investigations. Patients we spoke with confirmed this and told us decisions were clearly explained and options discussed when available. Patients had the information and support available to them to enable them to make an informed decision about their care and treatment needs. Some patients we spoke with had long term conditions and they told us they were seen regularly.

The GP national patient survey results for 2014 showed that 72% of respondents felt the last practice nurse they saw was good at involving them about their care, against an average for the Clinical Commissioning Group of 85%. Following this, the practice had reviewed its appointment system and made additional practice nurse appointments available, including until 9pm on Mondays

Patient/carer support to cope emotionally with care and treatment

GPs and staff described the support they provided for carers and links to refer patients to appropriate organisations, including a counselling service for professional support. Information about this was displayed in the waiting room. This included support after a time of bereavement.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Hastings House Medical Centre responded to the needs of its patients and had appropriate systems in place to maintain the level of service required. The needs of the practice population were understood, particularly within the context of the local area and systems were in place to address identified needs in the way services were delivered. The practice also planned its services carefully to meet the demand of the local population.

We saw minutes of meetings that demonstrated regular meetings were held to discuss capacity and demand. As a result of the 2014 GP national patient survey results, changes were made to staffing and clinic times when required. The survey revealed that 47% of patients who responded found it easy to get through on the phone, against an average of 76% for the Clinical Commissioning Group (CCG). Also, 59% of patients who responded described their experience of making an appointment as good, against an average for the CCG of 77%. Following these patient concerns about appointment availability, two new GPs had been employed during the last 12 months and a third new GP was due to start at the practice in April 2015, shortly after this inspection. The practice also introduced more practice nurse appointments including during extended hours, opening on Monday evenings, introduced telephone triage and appointments, heavily promoted its on-line booking facility and made improvements to the telephone system. The practice manager told us a vastly improved telephone system would be incorporated into the new practice building. Patients we spoke with on the day of our inspection said they could now get an appointment easily and could get through to the practice on the telephone. Several patients mentioned that the changes made by the practice had improved the situation.

As part of this improvement process, the practice took advice from another practice and also carried out a series of patient appointment audits to access capacity and demand. These will continue to be carried out on a regular basis.

There was an established Patient Participation Group (PPG) in place at the practice. This was a 'virtual' group and information was circulated on-line, not in physical meetings. This ensured that patients' views were included

in the design and delivery of the service, but might exclude those with no computer access or knowledge. Staff told us they planned to re-examine this after the practice moved to its new building. We saw how the PPG played an active role and was a key part of the organisation, including decisions about the changes made to the patient appointment system and with promoting on-line appointment booking.

Tackling inequity and promoting equality

Almost all patients who used Hastings House Medical Centre spoke English as their first language. The practice had access to an interpretation service if this was needed. The practice had an induction loop to assist people who used hearing aids and staff could also take patients into a quieter private room to aid the discussion if required.

Most areas of the practice were fully wheelchair accessible, however it was noted during our last inspection on 14 May 2014 that the reception desk was too high for patients who use a wheelchair to access easily. We were told by the practice manager that this would be taken into account during the building of the new practice and reception staff would speak to wheelchair users in the reception area or a private room if needed.

Access to the service

Patient appointments were available from 8.30am to 10.30am and from 2pm to 6pm, although the practice building remained open between the morning and afternoon surgery times. Extended hours appointments were also available until 9pm on Mondays. Telephone consultations were also available. In addition, a telephone triage system was operated for patients who could not be immediately offered same day appointments. When the GP called the patient back, if they decided the patient needed to be seen the same day they would be called into the practice. Outside of these times and during the weekend, an out of hours service was provided by another organisation and patients were advised to call the NHS 111 service. This ensured patients had access to medical advice outside the practice's opening hours.

Appointments could be booked for the same day, or up to six weeks ahead. Patients could make appointments and order repeat prescriptions through an on-line service. Home visits were available for patients who were unable to go to the practice. In the 2014 national GP patient survey, 77% of patients who replied said they were satisfied with the practice's opening times. This was slightly above the CCG average of 75%.

Are services responsive to people's needs?

(for example, to feedback?)

Patients we spoke with said the service was easily accessible and felt the practice had listened to concerns that had previously been raised about difficulties that had occurred with appointment availability.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. The complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. During our last inspection on 14 May 2014, we found the complaints system was not brought to the attention of patients who used the practice and the complaints process did not include current information to support patients in making a complaint. During this inspection, we found there was clear information displayed in the waiting room about how to make a complaint. This was also detailed in the patient leaflet for the practice. There was an explanation of what patients should expect if they made a complaint and this included the timescales for a response.

Staff told us how patients' concerns were listened to and acted upon. All of the patients we spoke with said they had never had to raise a formal complaint. The practice had a complaints summary which summarised the complaints for each year, which we examined. The practice used this to identify any trends.

We looked to see whether the practice adhered to its complaints policy. Over the last 12 months 22 complaints had been received, this included complaints discussed verbally. It was clear that verbal complaints were dealt with in the same way as written complaints. We found that the complaints had been dealt with appropriately and within the timescales set out in the practice's complaints policy. Patients were given an explanation and when appropriate, an apology. Between January and July 2014, patients had made five complaints about difficulty making appointments and getting through on the telephone. This comprised a total of 30% of the complaints received by the practice during this period of time. Since July 2014 which coincided with changes made by the practice, no such complaints had been received.

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 aimed to provide an excellent standard of services to its patients, keep patients informed and involved in their care and make sure care was personalised. This was stated on the practice website and in literature produced by the practice. GPs and staff we spoke with understood the vision and values and knew what their responsibilities were in relation to these.

When we spoke with staff, it was clear the team at the practice shared a desire to provide patients with a safe and caring service where people were treated with dignity and respect. This was confirmed by patients we spoke with. Staff told us the working environment was good and they were well supported by management and GPs.

The GP partners held regular partners' meetings outside of surgery opening times, to discuss important issues such as forward planning, succession planning, practice objectives and future direction and vision. We saw how previously there had been discussions about enlarging the GP team to provide more patient appointments and how this had led to the appointment of two new salaried GPs with a third due to join the practice shortly after our inspection. The practice regularly reviewed its objectives at staff meetings.

The practice had developed a five year plan. This included the planning and opening of a new purpose built practice in 2016 and provision to expand the services provided by the practice as the patient list grew to include more patients.

Governance Arrangements

The GP partners at Hastings House Medical Centre had lead roles and specific areas of interest and expertise. This included governance with clearly defined lead management roles and responsibilities. During the inspection we found that all members of the team we spoke with understood these roles and responsibilities.

Throughout the practice there was an attitude of teamwork, support and open communication. The practice held a regular meeting of clinical staff which included discussions about any significant event analyses (SEAs) that had been done. All of the clinical staff attended these meetings and where relevant, other staff also took part in

the discussions about SEAs. This helped to make sure that learning was shared with appropriate members of the team. GPs also met regularly to discuss clinical and governance issues.

GPs explained how the practice kept up to date with clinical leadership and governance recommendations and communicated these to staff accordingly. We also saw how the GP partners led the investigation and review of significant events, initiated and reviewed clinical audits.

The practice used information from a range of sources including their Quality and Outcomes Framework (QOF) results and the Clinical Commissioning Group (CCG) to help them assess and monitor their performance. QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions e.g. diabetes and implementing preventative measures. The results are published annually. The practice's performance was average or above average in some areas for the South Warwickshire Clinical Commissioning Group (CCG) for QOF. We saw examples of completed clinical audit cycles, such as minor operations. This demonstrated the practice reviewed and evaluated the care and treatment patients received.

Leadership, openness and transparency

The practice had a team of partners to provide a consistent leadership. They were supported by salaried GPs and a practice manager who was described by clinical and other staff as being very open and approachable. Staff we spoke with told us they were well supported by GPs and the practice manager and they were always open and approachable.

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

The practice had an established Patient Participation Group (PPG) in place. This was a group of patients registered with the practice who work with the practice to improve services and the quality of care.

This ensured patient views were included in the design and delivery of the service. We saw minutes of previous PPG meetings and saw how the PPG has been fully involved in initiatives such as promoting on line patient services and increasing patient appointments. The PPG was a 'virtual'

Are services well-led?

Good 

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

group, so all activity was carried out on-line. This might preclude patients with no on-line access or skills, however the practice manager told us this would be re-examined after the new practice building was opened.

All staff were fully involved in the running of the practice. We saw there were documented regular staff meetings. This included meetings for clinical staff and meetings that included all staff. This ensured staff were given opportunities to discuss practice issues with each other. Staff suggestions were welcomed and we saw how a new system for labelling patient samples brought into the practice by patients was made following a staff suggestion. This made the handling of specimens easier and more efficient for staff.

The practice asked patients who used the service for their views on their care and treatment and they were acted on. This included the use of surveys to gather views of patients who used the service. We saw that there were systems in place for the practice to analyse the results of the survey so that any issues identified were addressed and discussed with all staff members.

We saw records of discussions within the minutes of staff meetings. All the patients we spoke with on the day of our inspection told us they received a high quality service from the practice. It was clear patients experienced the quality of service that met their needs.

Management lead through learning & improvement

We saw evidence that the practice was focussed on quality, improvement and learning. There was a staff development programme for all staff within the practice, whatever their role. The whole practice team had sessions each year for 'protected learning'. This was used for training and to give staff the opportunity to spend time together. Topics had included thyroid disease and medicines management.

The results of significant event analyses and clinical audit cycles were used to monitor performance and contribute to staff learning.