Hastings House

Quality Report

Kineton Road
Wellesbourne
Warwickshire
CV35 9NF
Tel: 01789 840245
Website: www.hastingshouse.org.uk

Date of inspection visit: 15 May 2014
Date of publication: 24/09/2014

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.

Summary of findings

Contents

Summary of findings

Overall summary

Hastings House Medical Centre provides primary medical services for a local population of approximately 10,500 patients in the local area. A branch surgery is also provided at Little Thatch in Kineton. As part of our inspection we visited Hastings House. We spoke with seventeen patients including two members of the virtual patient group, clinical and administrative staff. This included four GPs and both the business and practice managers.

All the patients that we spoke with during our inspection were very complimentary about the service they received. The service performed well against quality outcomes relating to patient care. Patients described a caring service in which they were treated with dignity and respect, they felt listened to and received a good continuation of care from practice.

The practice was responsive to the needs of patients. Patients with urgent needs were able to access the surgery when they needed to and arrangements were in place to ensure those with chronic or complex health needs were prioritised. Referrals to other health care providers had been made in a timely way.

We found an open and supportive culture at the practice. Staff had opportunities for personal development and felt able to raise issues or concerns with senior staff. Patients felt listened to and comments raised were acted upon. The practice had identified risks and developed a business plan to address an expected increase in demand for the service due to to a new housing development in the locality.

We were concerned about the lack of robust governance arrangements at the practice to ensure information and learning from incidents and complaints was disseminated among all staff as appropriate and in a consistent way. Formal opportunities for staff to discuss issues relating to their role were not clearly defined. Some of the policies and procedures required review so they reflected current practice and local arrangements for staff to follow. We found recruitment processes were not robust and monitoring arrangements were not always effective in identifying issues relating to safe care. We have therefore identified this as an area for improvement.

Services were available to all population groups with the main strength being the consistency of care provided to patients from the same GP.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

There were some aspects of the way in which the provider managed the service that did not support a safe service. Although there were systems in place to ensure patients received a safe service these were not always robust. We were concerned about the adequacy of checks on emergency medication and equipment and systems around the recruitment of new staff. The practice had systems for investigating incidents that occurred but were unable to show how the learning from these incidents was shared with all staff to reduce the risk of reoccurrence. Guidance on local reporting arrangements for safeguarding children from harm was available but was not evident for safeguarding vulnerable adults meaning that there was a risk concerns may not be appropriately investigated and addressed.

Are services effective?

While the practice did provide an effective service we found there were some areas for improvement. Patients were satisfied with the service they received and the practice performed well against quality standards. Staffing was used flexibly to meet changing demands for the service and the practice worked with other providers to support good continuation of patient care. However, it was not always evident that best practice guidance, auditing and monitoring of service provision was effectively used to inform service improvement.

Are services caring?

A caring service was provided at the practice. Patients were very complimentary about the service they received and enjoyed the consistency of seeing their preferred GP who knew them. Patients who used the service were treated with dignity and respect.

Are services responsive to people's needs?

The service was responsive to patients' needs. The practice was accessible to patients and had systems in place that ensured patients with urgent needs were seen with minimal delay. Complaints received had been investigated but patients were not made aware of the processes in place for making complaints which could result in some patient concerns going unheard.

Are services well-led?

The practice was supportive of staff development and patients' views. The practice received high levels of patient satisfaction. Staff were aware of key risks to the organisation and had undertaken

Summary of findings

planning in order to address these risks. However, governance arrangements at the practice were not always clear and it was not always evident how information and learning was shared among staff to help improve the service.

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
The practice offered services to patients of all age groups with long term conditions including older people.

Patients were encouraged to see their own GP who became familiar with their individual health needs. If patients were unable to attend the practice because they were housebound they would be seen at home. This helped ensure patients received the care and treatment they needed.

People with long-term conditions
The practice offered services to patients of all age groups with long term conditions.

Patients were encouraged to see their own GP who became familiar with their individual health needs. Patients with long term conditions were kept under review. This meant any changes in their condition could be addressed at the earliest opportunity.

Mothers, babies, children and young people
The practice offered child vaccination and family planning services and was able to signpost patients to specific services which met the needs of mothers, babies and young people.

The working-age population and those recently retired
The practice provided a service that supported patients who worked or had other commitments to access the surgery. This was provided through an evening open until 8.30pm once per week and alternative surgeries on a Saturday. Health promotion and prevention clinics were available to support patients to live healthier lives and identify illnesses at early onset.

People in vulnerable circumstances who may have poor access to primary care
Although there were no specific services for vulnerable groups of patients such as homeless, travellers or people with learning disabilities the practice advised us they were receptive to all patients to access health care with them.

Summary of findings

People experiencing poor mental health

There were no specific services for patients with poor mental health at the practice however patients were encouraged to see their own GP who got to know their individual health needs. GPs were aware of referral processes for people to access specialist mental health care if they needed it.

Summary of findings

What people who use the service say

We spoke with seventeen patients who used the service either in person or by telephone; this included two members of the practice's virtual patient group. The virtual patient group is a way in which patients and GP practices can work together to improve the quality of the service. The practice makes contact with this group via email. Many of patients we spoke with had been with the practice for a long time and spoke highly of the service they received. Patients described the practice as caring and told us that they would recommend it to others. The main concern that some patients raised with us related to increasing difficulty in making an appointment with their usual GP as service demand increased.

We also looked at results from a recent GP Patient Survey and feedback from patients about the practice on the NHS choices website. Feedback was very positive about the practice and staff.

Areas for improvement

Action the service MUST take to improve

- Systems in place for assessing and monitoring the quality of service provision were not sufficiently robust to identify and manage risks to the safety of service users. There was a lack of arrangements for discussing and learning from complaints, incidents and audits to support service improvement.
- Monitoring checks of emergency medicines and equipment were not sufficiently robust to ensure equipment was available and in good working order when needed.
- Recruitment processes were not sufficiently robust to help safeguard patients from unsuitable staff.

Action the service COULD take to improve

- Consulting rooms seen were carpeted and had chairs which were not impermeable making them difficult to clean.
- Cleaning equipment for the different areas of the practice where not present in the cleaning cupboard.
- Audits undertaken had not always completed their full cycle in order to demonstrate improvements or learning. Forums for shared learning to take place were not evident.
- The curtain around in one consulting room did not go all the way round the examination couch to ensure the patients privacy and dignity was maintained.
- The process to book online appointments was not promoted by the practice so that patients would know how to access the surgery this way.
- The reception desk was too high for patients who use a wheelchair to access easily.
- The complaints system was not brought to the attention of patient's who use the practice. The complaints process did not include current information to support patients in making a complaint.
- Current methods of patient participation could exclude patients who are not able to access computers easily.

Good practice

- Our inspection team highlighted the following areas of good practice:
- In most cases patients received a good continuation of care from experienced GPs that knew them. Patients were encouraged by the practice to see the same GP.
- Commuter clinics were available until 8.30pm one day each week and alternative Saturdays during the evening and at weekends for patients who were unable to attend appointments during the week.

Hastings House

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a GP. The team also included a second CQC inspector and an expert by experience (a person who has experience of using this particular type of service, or caring for somebody who has).

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.

There are currently seven GP partners at the practice. 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.

Hastings House Medical Centre is registered to provide the regulated activities of diagnostic and screening procedures, family planning, maternity and midwifery services, surgical procedures and treatment of disease, disorder or injury.

Hastings House Medical Centre is a dispensing practice and patients that live more than a mile from a chemist may have prescriptions dispensed from the practice dispensary. Minor surgical procedures are also carried out at the practice.

Why we carried out this inspection

We inspected this out-of-hours service as part of our new inspection programme to test our approach going forward. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

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?

The inspection team always looks at the following six population areas at each inspection:

- Vulnerable older people (over 75s)
- People with long term conditions
- Mothers, children and young people
- Working age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problem.

Before visiting, we reviewed a range of information we hold about the service and asked other organisations to share what they knew about the service. We carried out an announced visit on 15 May 2014 to the main practice site at Hastings House in Wellesbourne. During our visit we spoke

Detailed findings

with a range of staff including general practitioners, the business and practice manager, nurses and other clinical and administrative staff. We spoke with patients who used the service. We also looked at a range of documents that were made available to us relating to the service.

We sent CQC comment cards to the practice in advance of our inspection to obtain views from patients about the service. The practice manager advised us that only the box for collecting the cards had arrived, this was displayed but no comments were received.

Are services safe?

Summary of findings

Although there were systems in place to ensure patients received a safe service these were not always robust. We were concerned about the adequacy of checks on emergency medication and equipment and systems around the recruitment of new staff. The practice had systems for investigating incidents that occurred but were unable to show how the learning from these incidents was shared with all staff to reduce the risk of reoccurrence. Guidance on local reporting arrangements for safeguarding children from harm was available but not for safeguarding vulnerable adults meaning that there was a risk concerns may not be appropriately investigated and addressed.

Our findings

Safe patient care

There were systems in place for delivering safe care. Responsibilities for specific areas such as management of incidents, health and safety, significant events, infection control and safeguarding were shared between staff. We saw that safety issues were reported and staff described an open culture within the organisation with which to raise concerns. However, safety issues tended to be addressed in isolation and the practice was not always able to demonstrate robust arrangements for discussing and implementing action needed.

Learning from incidents

We saw evidence that significant events were reported and investigated. The general practitioners (GPs) we spoke with were able to talk about incidents that had occurred and gave examples of how they had used the learning from them and try to improve the service patients received. Such incidents included concerns about patients discharged from a local hospital on specific medication. This had led to extra vigilance of these patients by clinicians to manage their condition and medication. We were advised that sharing the learning from incidents took place at weekly meetings and at annual meetings however the practice was unable to formally demonstrate this and some staff we spoke with were not aware of any such meetings. Sharing learning from incidents is important as it helps to ensure any action required to minimise the risk of reoccurrence is implemented.

Safeguarding

Records showed that staff at the practice had recently received training in safeguarding children. The practice had a named lead GP for safeguarding who staff could go to if they had any concerns. They also had access to safeguarding children policies and procedures on their computers. This provided support for staff in recognising what abuse might look like and what to do if they suspected abuse might be occurring. Some of the staff we spoke with confirmed they had been trained in safeguarding children but not safeguarding vulnerable adults. There were no practice specific policies and procedures for safeguarding vulnerable adults to ensure

staff would know what to do if they had any concerns. Clear guidance helps to ensure staff members have the information needed in order to protect patients that may be at risk of harm.

During our inspection we were alerted to an incident in which there were concerns about the propriety of a member of staff. While the issue was investigated and dealt with by the practice, which led to the member of staff resigning, action taken did not fully consider the implications of future employment and potential risks to people. Staff advised us that the incident was very recent and they were still considering the issues that had been raised by it.

Medicines management

Hastings House is a dispensing practice, this is an additional service in which GP practices can dispense medicines. Patients who live more than one mile from a pharmacy were able to use this service. The practice had a named lead GP accountable for the quality of the dispensary service and a dispensary manager who managed the day to day operation of the practice dispensary. We spoke with the dispensary manager who told us that they were a qualified pharmacy technician and that most of the reception staff were dispensary trained. We saw that staff competencies for dispensing medication were checked as part of the staff appraisal process using the dispensing doctors association competencies checklist. A range of standard operating procedures were in place for the management of medicines at the practice. These are a set of specific procedures for staff to follow. Records showed that standard operating procedures been shared with staff although most staff had not signed to say that they had read them.

There were systems in place for rotating stock and reordering medicines when stock was low. This helped to minimise the risk of patients receiving out of date medicines. We looked at a sample of medicines held in the dispensary and fridge vaccines and found these were all within their expiry dates.

We looked at how controlled drugs were managed. Controlled drugs are medicines that require extra checks and special storage arrangements because of their potential for misuse. Records showed that controlled drugs were appropriately stored, recorded and checked.

Medicines were also held in the practice by each doctor for home visiting. We were told that The doctors' bags were checked monthly to ensure medicines were in date. However, we were unable to verify this as the member of staff responsible was not available during our inspection . We were advised that anaphylaxis kits (treatment for severe allergic reactions) were available in the nurses and minor operations room and were checked monthly. We looked at the anaphylaxis kit in the minor operations room and saw that the medicines contained within it did not match what was recorded on the lid. Evidence of checks had been recorded but these had not been effective in identifying this issue. Checks had been recorded on post it notes with no space for recording any concerns. Lack of robust checks could result in medicines not being readily available when needed in an emergency.

Vaccines were appropriately stored in medicines fridges where daily temperatures were recorded. Information was displayed which informed staff what they should do if there were any problems with the fridge temperatures which could affect the quality and effectiveness of the vaccines. Staff advised us that they had in the past had to dispose of vaccines due to problems with the fridge and replace the medicines fridges. This provided assurance that staff would take appropriate action if there were concerns about vaccines in stock.

Cleanliness and infection control

We found the practice clean and tidy. In the clinical rooms we inspected we saw that staff had access to hand washing facilities and guidance. Personal protective equipment such as gloves and aprons were also readily available for staff to use. There were clear distinctions between clinical and non-clinical waste including any sharp instruments such as needles to ensure safe disposal. However, we did notice that some of the consulting rooms had carpets and some of the chairs were not resistant to fluids. This made them difficult to clean because contaminated liquids and fluids could be absorbed into the materials making them a risk for cross contamination. We spoke with the infection control lead who explained that they had had to dispose of a chair when it had become soiled to protect patients from cross infection.

Effective cleaning schedules were in place and cleaning equipment was colour coded which helps to prevent cleaning equipment being used across both clinical and non-clinical areas. The business manager showed us where

cleaning equipment was kept. We saw that there were no designated cloths available in the colour used for some of the non-clinical areas which could result in cross contamination if such equipment is used across practice areas. We were later told that these had been found in another cupboard.

Staffing and recruitment

We looked at the recruitment records for the two recently recruited members of staff. We were concerned that the recruitment checks for new staff were not robust and identified some gaps in the process for checking the suitability of staff employed. For example we found staff references were not always available and a poor reference had not been followed up. There was no evidence of a criminal record check for either member of staff. The business manager advised us that criminal records checks would only be obtained for clinical and cleaning positions. However we did not see any evidence of risk assessments having been made against the roles and responsibilities of the positions to indicate whether a criminal check might be needed. We also looked at the recruitment file for one member of staff in which there had recently been concerns relating to their conduct, although this person was no longer in post we found that there had been no criminal checks undertaken when they were recruited. The practice recruitment policy made no reference to criminal checks and the vetting and barring guidance available contained out of date information. Robust recruitment processes help to ensure staff members have the necessary qualifications, skills and experience for the role they are employed and that they are of good character.

Dealing with Emergencies

Staff received training in basic life support so that they would know what to do in an emergency and those spoken with knew where to find the emergency equipment if needed. There was a defibrillator and oxygen available for use in an emergency. We saw that checks were carried out on most days to ensure the defibrillator was in working order. However, we found no evidence that the oxygen was checked regularly to ensure it was in date and in working order. We spoke with the member of staff responsible for checking emergency medicines and equipment and they advised us that they did not include the oxygen as part of their checks. We found three oxygen masks that had passed their expiry date. Routine checks on emergency equipment helps ensure that the equipment is available and in good working order when needed.

Reception staff had been given training and guidance to enable them to identify symptoms of critical illness. This helps to ensure patients in urgent need are appropriately attended to with minimal delay.

Are services effective?

(for example, treatment is effective)

Summary of findings

Overall the practice provided an effective service although there were some areas for improvement. Patients were satisfied with the service they received and the practice performed well against quality standards. Staffing was used effectively to meet changing demands for the service and the practice worked with other providers to support good continuation of patient care. However, it was not always evident that best practice guidance, auditing and monitoring of service provision was effectively used to inform service improvement.

Our findings

Promoting best practice

We spoke with the GPs about how they implemented best practice. We were shown print outs of examples of best practice guidance and told that it was discussed at quarterly clinical meetings. However, the practice was unable to demonstrate how it was taken forward in the practice or implemented. Systems for discussing and sharing best practice help ensure that all members of staff are made aware and able to act on it.

Management, monitoring and improving outcomes for people

During the inspection we spoke with seventeen patients all of whom were very complimentary about the service they received at the practice. Patients described the service they received as “excellent” and “very good” and were happy to recommend the practice to others.

We looked at some of the performance information available about the practice. This included the Quality and Outcomes Framework (QOF) and General Practice Outcomes Standards (GPOS). QOF is a voluntary incentive scheme for GP practices which rewards them for how well they care for patients. GPOS are a set of standards developed by clinicians to improve quality. Results for this practice indicated that performance was in line with expected standards.

During the inspection we were shown some of the audits that had been carried out over the last year. Audits are a way in which the practice can identify how it is performing and identify areas for improvement.

From the evidence provided it was not clear how audits were used by the practice to deliver service improvement. Staff at the practice were not consistently aware as to what audits had been carried out and what action had been taken in response to them. The practice was unable to demonstrate how audit findings were discussed with staff so that any actions identified could be implemented. We were shown a dispensary audit of uncollected medication and an infection control audit both were carried out during the last year but we were unable to determine whether any action had been taken as result of these audits.

Staffing

The practice had a stable and experienced workforce. Many of the staff had worked at the practice for a number of

Are services effective?

(for example, treatment is effective)

years. The workforce included seven GP partners, three nurse prescribers and a practice nurse. The nurse prescribers were able to see and treat a number of specified conditions which helped to manage some of the patient demand for the GPs and enabled the patients to be seen more quickly. Conditions which could be treated by the nurse prescribers were promoted in the practice leaflet so that patients would know when they could use this service.

The practice had identified an increasing demand for the service over recent years. To help manage the increased demand a triage system had been introduced. This enabled patients who were unable to get an appointment to speak with a doctor on the telephone and if needed an appointment was made.

The business manager advised us that the GPs were flexible in their working and would plan annual leave ahead to help ensure there was sufficient GP cover to see patients.

Staff told us that they did not receive formal supervision sessions but had received annual appraisals to discuss their performance and any learning needs. Regular supervision sessions provide an opportunity for staff to discuss their performance, any learning needs and other issues relating to their work so that any issues can be managed as appropriate for the benefit of patients.

Working with other services

The practice held multi-disciplinary meetings every six weeks in which the GP partners met with hospice and district nurses to discuss patients with complex and palliative care needs. Each of the GP partners were also allocated a care home where they provided care for residents. This helped to ensure patients received a good continuation of care.

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. Sharing information with the out-of-hours GP services is important as it helps to ensure patients receive a good continuation of care.

Health, promotion and prevention

We saw from the practice leaflet that nursing staff provided various health promotion and prevention services. These included health checks, dietary advice, smoking cessation and immunisation clinics. Health promotion is important because it supports patients to take responsibility for their own health and can help prevent illness in the future.

GPs also undertook medicine reviews. Patients were reminded when they reached their last prescription that they needed to be reviewed and further prescriptions were authorised by the GPs. Medicine reviews help to ensure that medication taken by patients is working as intended.

Are services caring?

Summary of findings

A caring service was provided at the practice. Patients were very complimentary about the service they received and enjoyed the consistency of seeing their preferred GP who knew them. Patients who used the service were treated with dignity and respect.

Our findings

Respect, dignity, compassion and empathy

Results for the practice from the national GP patient survey carried out in 2013 were mostly within the expected range with no areas of concern identified. In particular the practice scored well in areas such as patients being able to see their preferred GP and having confidence and trust in their GP. Approximately 130 patients responded to the survey. We received similar comments from patients during our inspection. All the patients we spoke with described the practice as caring and told us that staff treated them with dignity and respect. Interactions observed between patients and staff during our inspection were respectful.

We looked at the patient survey carried out by the practice for 2013/14. The survey was completed by 290 of the 10,500 patients and focused on services provided at the practice and issues to help inform plans for a new surgery. Whilst there was no overall score of satisfaction comments received were mainly positive. Patients were mainly concerned with the increasing demand for the service brought about by a new housing development nearby.

The practice had a patient dignity policy. We spoke with clinical staff that were familiar with the steps they needed to take to protect patients' dignity when undergoing physical examinations. The practice also had a chaperone policy. A chaperone can help to provide some protection to patients and clinicians during sensitive examinations.

Reception desks were separate from the main waiting area which helped to reduce the potential for personal information being overheard. We saw that doors and blinds in the consulting rooms were kept closed so that patients were able to hold private consultations. Curtains surrounded patient examination couches to protect patient privacy and dignity. However, we did see in one consulting room the curtain did not go all the way around the couch which could compromise a person's privacy and dignity if used. We spoke with one clinician who advised us that they did not use this room for examinations because of this.

We discussed with staff how they supported patients near the end of life and their carers. Staff told us that they held a register for patients at the end of life and would meet every six weeks with hospice managers, district nurses and health visitors to discuss individual care for these patients. The

Are services caring?

minutes from these multi-disciplinary meetings were not formally documented however we were advised that any actions would be recorded on the patient's notes. Staff told us that they did not keep a register of patients with caring responsibilities because of difficulties keeping this up to date but would document this on the patient record. Where possible the practice tried to ensure consistency of GPs who got to know their patients and their individual needs. This was promoted in the practice leaflet.

The practice was very much seen as part of the local community. We saw and spoke with staff about an incident in which the practice was unable to get immediate specialist support needed for a patient in a mental health crisis. Support was provided by a local church until specialist support could be provided the next day. Concerns about the delay in specialist treatment were fed back as appropriate.

Involvement in decisions and consent

Patients we spoke with told us that they felt listened to and that they were involved in discussions about their care and treatment. One patient described how the doctor printed out information about their condition which they could read at their leisure. Patients enjoyed the fact that they were usually able to see their own GP who knew their needs and helped ensure consistency of care.

One GP at the practice carried out minor surgical procedures. The GP explained that they met with the patient and obtained formal consent before the patient underwent the surgical procedure. This helped to ensure patients had an opportunity to discuss the procedure and that they agreed to it.

Information about the practice and how to access the service was available in the patient leaflet and website. Information about opening times, prescriptions and who to contact for medical advice when the practice was closed was also displayed at the entrance to the practice. This helped to ensure patients had access to information so that they could receive the health care they needed.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

Overall the service was responsive to patient's needs. The practice was accessible to patients and had systems in place that ensured patients with urgent needs were seen with minimal delay. Complaints received had been investigated but patients were not made aware of the processes in place for making complaints which could result in some patient concerns going unheard.

Our findings

Responding to and meeting people's needs

The practice had arrangements for managing patients with chronic conditions such as asthma, diabetes and heart disease. Patients were invited for regular reviews of their condition which were carried out by the GPs and trained nurses. Some of the patients we spoke with told us that they had chronic health conditions and that they felt supported and well looked after by the practice. Regular reviews of patients' health conditions helps to ensure any changes in their condition can be identified and managed promptly.

Patients received timely referrals to hospital and other services. We looked at six routine referrals that had been made within the last week. Five out of the six had been processed within one working day of the decision to refer being made and all within five working days. This helped to ensure patients that needed specialist care or treatment received it with minimal delay.

Patients who had undergone medical tests told us that they had no problems obtaining their test results and that staff were good at explaining what they meant. Patients usually contacted the surgery to obtain their results but if they were of particular concern the patient would be contacted directly. One patient confirmed that they had at they had received feedback from test results very quickly when the GP had been concerned. This enabled any urgent care or treatment needed to be commenced as soon as possible.

Access to the service

Patients that we spoke with during our inspection gave mixed reviews about the appointment system and the ability to make an appointment but all felt that if their need was urgent the practice would see them quickly. Patients were usually able to see their choice of GP which helped with the continuity of care. Some patients were also given what the practice called 'gold patient status' which meant that if they needed an appointment due to complex health conditions they would be seen quickly. We spoke with one patient who told us that they were a gold patient and that the practice was always accommodating to them. Systems that were in place helped ensure priority was given to those who most needed it.

Are services responsive to people's needs?

(for example, to feedback?)

The practice had introduced systems to improve access to appointments and the service. Staff told us that there had recently been issues with the telephone system and that this was currently being addressed. We were advised patients could book appointments on-line via the practice website. However, this was not well promoted and when we looked on the website we did not see any information available advising patients how to do this. The practice had also introduced a triage system which enabled patients to speak to a GP if they could not get an appointment as quickly as they would like. We also found that a commuter clinic was available on Monday evenings until 8.30pm and on alternate Saturday mornings. This helped to improve access for patients who were unable to attend appointments during week days.

The surgery was accessible to patients who may have mobility difficulties. The practice had allocated parking spaces for patients with a disability. The entrance to the practice was via a ramp and automatic doors. Most consulting rooms were on the ground floor. We observed patients with walking aids accessing the surgery and staff assisting patients with mobility difficulties to the consulting rooms. We did however notice that the reception desks were too high for a wheelchair user making it difficult for patients in a wheelchair to speak with reception staff. The business manager advised us that they were aware but were waiting for a decision regarding the new build surgery.

We saw a recent example where translators had been used to support people access the service who did not speak English. This meant patients were able to communicate their health needs and access health care services at the practice.

Concerns and complaints

The provider had arrangements in place for the management of complaints received about the service. We saw from complaints received in 2014 that these related mainly to telephone access and about patients not being able to make an appointment with their usual GP. Patients had been used to and therefore had expectations of seeing their usual GP; however increasing demand on the service was making this more difficult. We saw that complaints had been responded to in line with the practice's complaints procedure.

Although patients were invited to make comments and suggestions about the practice we did not see any information displayed in the practice advising patients on how to make a formal complaint. We asked one receptionist what they would do if someone wanted to make a complaint, they advised us that they would notify the practice manager and after a short while were able to provide us with the complaints procedure. However information provided in the complaints procedure was out of date. The alternative address provided for complaints was for an organisation that was no longer in existence. This could result in some patients not getting their concerns heard or addressed. We were advised that discussions and learning from complaints took place at practice meetings however the practice was unable to demonstrate this.

Are services well-led?

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

Summary of findings

Governance arrangements at the practice were not always clear and it was not always evident how information and learning was shared among staff to help improve the service. However, the practice was supportive of staff development and patients' views. The practice received high levels of patient satisfaction. Staff were aware of key risks to the organisation and had undertaken planning in order to address these risks.

Our findings

Leadership and culture

The practice consisted of seven GP partners including a senior partner. Leadership roles for the day to day running of the practice were shared between the partners and other staff. There were named leads for areas such as safeguarding, dispensing and complaints. This ensured staff were clear of their responsibilities and who they should go to for support.

Staff described an open and supportive culture and we saw evidence where staff felt able to raise concerns so that they could be addressed. The practice had recently employed a business manager to help develop and support the practice through change. The business manager had undertaken a constructive review of the service which the partners had been receptive to.

Governance arrangements

Governance arrangements at the practice were not always clear. We were advised that issues such as complaints, incidents and significant events were discussed at staff meetings. Although we saw evidence of staff meetings they contained little detail as to what was discussed and who had attended. Not all members of staff we spoke with were aware of the meetings and so were unable to formally raise issues or concerns they had. This meant the practice could not be assured that key messages were disseminated among staff and issues raised addressed. Governance arrangements have an important function in helping to maintain the quality and safety of the service provided.

Staff had access to a range of policies and procedures to support them in their role. We found that some of the policies and procedures did not adequately support staff. For example the practice provided guidance regarding the vetting and barring scheme (March 2014) however we found information contained within it was out of date and had not been reflected in the practice's recruitment policy. We also asked one receptionist what they did if someone visiting the practice could not speak English but they were unable to find any guidance to arrange for a translator. Clear and up to date policies and procedures help to ensure staff are clear about their role and provide a consistent service.

Are services well-led?

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

We spoke with nursing staff who told us that they met with one of the GP partners each week. The meetings were not formally documented but were used to discuss any concerns about patients. These arrangements helped to ensure patients received the care they needed.

Patient experience and involvement

A comments and suggestion box was available at the practice and patients were invited to share their views. The practice also had a virtual patient group which started in 2011. The virtual patient group is a way in which patients and GP practices can work together to improve the quality of the service. The practice made contact with this group via email. We spoke with two members of this group. They told us how their comments had been sought for the patient survey and how they were consulted about changes to the practice telephone system. One of the patient group felt the practice was good at listening to them. The other member found the group less helpful and told us that they were not that computer literate. As the virtual patient group operates mainly via email this could potentially exclude some patients from fully participating in the group and having the opportunity to feedback their views.

We saw that that an action plan had been produced as a result of the patient survey and evidence of action taken in response to issues that had been raised.

Learning and improvement

Staff we spoke with told us that they received protected learning time to help them keep their skills up to date and that sometimes the practice had external speakers come into the practice. One member of staff told us how they had been supported by the practice to undertake a course specific to their area of work. Staff also told us about the provider's mandatory training they had received in areas such as basic life support and safeguarding. This provided assurance that patients were cared for by staff who received appropriate training to enable them to do their job. However, staff training records had not been kept up to date so that any staff that were not up to date with their training could not easily be identified.

Identification and management of risk

The practice had identified that the main risks it faced was the increase in the number of consultations over recent years and the limitations of the premises to expand services any further. A new housing development of over 400 new homes in the local area had been identified as further increasing demand for the service. A business plan had been drawn up by the practice to build a new primary care facility to meet the expected growth in the local population. The business plan was submitted to NHS England in March 2014 and at the time of our inspection was awaiting a response.

There were plans in place to deal with emergencies that might affect the smooth running of the service. The business continuity plan identified the practice branch surgery nearby for use if the main surgery became unavailable to see patients. There was also an informal agreement with another local surgery to provide support. Staff spoke about discussions held with this practice to prepare for emergencies. For example we were told about meetings to prepare for outbreaks of swine flu that had occurred when the risk was identified. On this occasion plans did not need to be used, but it meant that the practice had prepared to respond to the risk in the eventuality of an outbreak of swine flu.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Summary of findings

The practice offered services to patients of all age groups with long term conditions including older people. Patients were encouraged to see their own GP who got to know their individual health needs. If patients were unable to attend the practice because they were housebound they would be seen at home.

Our findings

The practice held multi-disciplinary meetings with hospice and district nurses to discuss patients with complex and palliative care needs for patients of all ages. This helped ensure patients received co-ordinated care which met their individual needs.

GPs undertook home visits to elderly patients that were housebound. This helped to ensure patients received the care and treatment they needed.

The practice was aware that there were a higher proportion of older patients that used the service compared to the national average. The practice offered a range of clinics to all age ranges including older people over 75 years such as health checks, and reviews of long term conditions and medication. These helped to closely manage the patient's condition.

The practice was accessible to patients who may have mobility difficulties with disabled car parking facilities and ramp access to the practice.

Where possible GPs encouraged all patients to see their usual GP including those aged 75 years and over. The GPs also took responsibility for different care homes so that they got to know the residents. This meant the GP was familiar with patients' health concerns and helped patients to receive consistency of care.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Summary of findings

The practice offered services to patients of all age groups with long term conditions. Patients were encouraged to see their own GP who got to know their individual health needs. Patients with long term conditions were kept under review. This meant any changes in their condition could be addressed at the earliest opportunity.

Our findings

The practice held multi-disciplinary meetings with hospice and district nurses to discuss patients with complex and palliative care needs. This helped ensure patients received co-ordinated care which met their individual needs.

The practice offered health checks to it's patients. Patients also received reviews of their long term conditions and medication. These helped to closely manage the patients' condition. Nurses who undertook the reviews received appropriate support and training.

The practice was accessible to patients who may have mobility difficulties with disabled car parking facilities and ramp access to the practice.

Patients with complex health care needs were given 'gold' status which meant they would be seen promptly to minimise the risk of their condition exacerbating.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Summary of findings

The practice offered child vaccination and family planning services and was able to signpost patients to specific services which met the needs of mothers, babies and young people.

Our findings

Information was available in the practice leaflet about local services for mothers, babies and children. These included antenatal clinics which operated from Hastings House once a week which were run by the midwife and the Well Baby and child health clinics run by health visitors in the village.

Child immunisations were offered at the practice by appointments. Parents received automatic reminders to make these appointments. The practice also offered family planning services.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Summary of findings

The practice provided a service that supported patients who worked or had other commitments to access the surgery. This was provided through late night and weekend surgeries. Health promotion and prevention clinics were available to support patients to live healthier lives and identify illnesses at early onset.

Our findings

The practice offered commuter clinics on Monday evenings until 8.30pm and on alternate Saturday mornings which enabled patients to make appointment who were unable to attend during the week through work and other commitments.

Nurses were trained in family planning for advice and contraceptive devices. They also ran health screening and promotion clinics such as blood pressure checks and cervical smear tests so that any early signs of disease could be picked up quickly.

People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Summary of findings

Although there were no specific services for vulnerable groups of patients such as homeless, travellers or people with learning disabilities the practice advised us they were receptive to all patients to access health care with them.

Our findings

We did not see any specific services for patients in vulnerable circumstances. Staff advised us that there was an open door policy and patients who were in vulnerable circumstances such as homeless people would not be turned away. However we were not told of any recent examples of this.

Translation services were used for patients who could not speak English so that they could access the service.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Summary of findings

There were no specific services for patients with poor mental health at the practice however patients were encouraged to see their own GP who got to know their individual health needs. GPs were aware of referral processes for people to access specialist mental health care if they needed it.

Our findings

The GPs were aware of referral routes to mental health services for patients at crisis point. In one reported incident at the practice the mental health team were unable to provide immediate support. This was raised as an incident and fed back to commissioners. Alternative support was provided to keep the patient safe until the specialist care they needed was available.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision. Systems in place for assessing and monitoring the quality of service provision were not sufficiently robust to identify and manage risks to the safety of service users. Checks of emergency medicines and equipment were ineffective. The practice was unable to show how audits undertaken had been acted upon or learning from incidents shared to minimise future risks considered. Regulation 10 (1) (a)(b)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision. Systems in place for assessing and monitoring the quality of service provision were not sufficiently robust to identify and manage risks to the safety of service users. Checks of emergency medicines and equipment were ineffective. The practice was unable to show how audits undertaken had been acted upon or learning from incidents shared to minimise future risks considered. Regulation 10 (1) (a)(b)

Regulated activity	Regulation
Family planning services	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision.

This section is primarily information for the provider

Compliance actions

Systems in place for assessing and monitoring the quality of service provision were not sufficiently robust to identify and manage risks to the safety of service users.

Checks of emergency medicines and equipment were ineffective. The practice was unable to show how audits undertaken had been acted upon or learning from incidents shared to minimise future risks considered.

Regulation 10 (1) (a)(b)

Regulated activity	Regulation
Maternity and midwifery services	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision. Systems in place for assessing and monitoring the quality of service provision were not sufficiently robust to identify and manage risks to the safety of service users. Checks of emergency medicines and equipment were ineffective. The practice was unable to show how audits undertaken had been acted upon or learning from incidents shared to minimise future risks considered. Regulation 10 (1) (a)(b)

Regulated activity	Regulation
Surgical procedures	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision. Systems in place for assessing and monitoring the quality of service provision were not sufficiently robust to identify and manage risks to the safety of service users. Checks of emergency medicines and equipment were ineffective. The practice was unable to show how audits undertaken had been acted upon or learning from incidents shared to minimise future risks considered. Regulation 10 (1) (a)(b)

This section is primarily information for the provider

Compliance actions

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 21 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, requirements relating to workers. Recruitment processes did not provide adequate safeguards to protect patients from being cared for or supported by unsuitable staff. The provider did not undertake adequate checks to ensure staff were of good character. Disclosure and Barring Service checks were not always obtained or roles risk assessed in the absence of such checks. Regulation 21. (a)(i) (b)

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 21 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, requirements relating to workers. Recruitment processes did not provide adequate safeguards to protect patients from being cared for or supported by unsuitable staff. The provider did not undertake adequate checks to ensure staff were of good character. Disclosure and Barring Service checks were not always obtained or roles risk assessed in the absence of such checks. Regulation 21. (a)(i) (b)

Regulated activity	Regulation
Family planning services	Regulation 21 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, requirements relating to workers. Recruitment processes did not provide adequate safeguards to protect patients from being cared for or supported by unsuitable staff. The provider did not undertake adequate checks to ensure staff were of good character.

This section is primarily information for the provider

Compliance actions

Disclosure and Barring Service checks were not always obtained or roles risk assessed in the absence of such checks.

Regulation 21. (a)(i) (b)

Regulated activity	Regulation
Maternity and midwifery services	Regulation 21 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, requirements relating to workers. Recruitment processes did not provide adequate safeguards to protect patients from being cared for or supported by unsuitable staff. The provider did not undertake adequate checks to ensure staff were of good character. Disclosure and Barring Service checks were not always obtained or roles risk assessed in the absence of such checks. Regulation 21. (a)(i) (b)

Regulated activity	Regulation
Surgical procedures	Regulation 21 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, requirements relating to workers. Recruitment processes did not provide adequate safeguards to protect patients from being cared for or supported by unsuitable staff. The provider did not undertake adequate checks to ensure staff were of good character. Disclosure and Barring Service checks were not always obtained or roles risk assessed in the absence of such checks. Regulation 21. (a)(i) (b)