Heene Road Surgery

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an unannounced comprehensive inspection of Heene Road Surgery on 15 September 2015. Overall the practice is rated as requires improvement.

Specifically, we found the practice to require improvement in being well-led and for providing safe, responsive and effective services. It was good for providing a caring service.

The Heene Road Surgery provides primary medical services to people living in Worthing. At the time of our inspection there were approximately 5839 patients registered at the practice. The partnership consists of three registered GPs. However only one GP was working at the practice at the time of our inspection and we were informed that two of the partners have recently left the practice. The practice was using locum GPs to cover the shortfall and was also being supported by another practice in the area. The practice was also supported by a team of nurses, healthcare assistants, reception and administrative staff.

The inspection team spoke with staff and patients and reviewed policies and procedures. The practice understood the needs of the local population and engaged effectively with other services. There was a culture of openness and transparency within the practice however staff told us they did not always feel supported. The practice was committed to providing high quality patient care and patients told us they felt the practice was caring.

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Infection control audits and cleaning schedules were in place and the practice was seen to be clean and tidy.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.

Summary of findings

- Staff had received training appropriate to their roles. However the systems for monitoring training were inconsistent in their implementation and lacked detail.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- The practice had good facilities and was equipped to treat patients and meet their needs.
- Whilst there was a leadership structure this was depleted by recent changes of staff and staff had not always felt supported by the practice management.
- The practice had the appropriate equipment, medicines and procedures to manage foreseeable patient emergencies.
- Patients were generally unsatisfied with the appointments system. They confirmed that they found it difficult to see a doctor on the same day if they needed to. The feedback we received on the day of our inspection and the national data we reviewed showed that the practice was struggling to meet patient appointment needs. The system that was in place failed to address the practice and patient needs.
- The practice, with assistance from another local primary care provider was in the process of responding to concerns from patients about not being able to get appointments at a time that suited them.
- The practice had systems to keep patients safe including safeguarding procedures and means of sharing information in relation to patients who were vulnerable. However staff were not always clear on who the safeguarding lead was in the practice due to changes in staffing.
- The practice had not proactively sought feedback from staff and patients, to improve the service.
- Whilst significant events and complaints were discussed at practice management meetings there was no evidence that the practice had learned from these incidents as there were no follow up reviews undertaken.
- The practice was significantly behind in meeting the total number of annual health checks for patients with a learning disability and the nurse we spoke with estimated they had over 50% still to complete.

However there were areas of practice where the provider needs to make improvements.

The areas where the provider must make improvements are;

- Ensure systems are put in place to demonstrate that the practice learns from and disseminate information related to risk, complaints and incidents.
- Ensure the proposed improvements to patient access to appointments is implemented and maintained.
- Ensure that plans are developed for a Patient Participation Group and that other ways are developed of gathering feedback from patients including hard to reach patients and groups.
- Ensure progress against plans to improve the quality and safety of services are monitored, and take appropriate action without delay where progress is not achieved as expected.
- Develop plans to implement and record regular multidisciplinary meetings, practice and clinical meetings.
- Improve the recording and management of staff training records.

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?

Requires improvement

The practice is rated as requires improvement for providing safe services as there are areas where it should make improvements. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed. Outcomes from reviews of incidents and complaints were not communicated widely to support improvement.

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services, as there are areas where improvements should be made. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included promoting good health. There was evidence of appraisals and personal development plans for staff. Multidisciplinary working was in place although was generally informal as multidisciplinary meetings were not regularly recorded. Data showed patient outcomes were at or below average in some areas and above average in others for the locality. Staff had received training appropriate to their roles however these were poorly documented and this made it difficult to assess and ensure staff training needs had been met.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice similar to or higher than others in some aspects of care including having confidence and trust in the last nurse they saw or spoke to. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Requires improvement

The practice is rated as requires improvement for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and clinical commissioning group (CCG) to secure improvements to services where these were identified. Urgent appointments were available the same day. The practice had good facilities and was equipped to treat patients and meet their needs. Information about how to

Summary of findings

complain was available and easy to understand and evidence showed that the practice responded quickly to complaints. Learning from complaints was not always shared with staff and other stakeholders. Patients said they found it difficult to make an appointment with a named GP and that there was not always continuity of care.

Are services well-led?

Requires improvement

The practice was rated as requires improvement for being well-led. While staff were clear about their responsibilities in relation to their role there had been issues with creating a stable team within the practice. The leadership structure was defined but at present due to changes it was not always clear to the staff team. There was an open culture and staff knew and understood the lines of responsibility and accountability to report incidents or concerns. There were some systems in place to monitor and improve quality and identify risk, however the practice lack an embedded quality assurance system. For example, the practice had not consistently carried out an annual practice audit or sought feedback from staff and patients. The practice did not carry out a patient survey and we did not see evidence of action to improve patient satisfaction in relation to the national GP patient survey where the practice performed below the local and national average. Staff we spoke with generally felt valued and were supported through appraisals. However regular meetings with managers and team meetings had not taken place in some time. Staff felt generally supported by the principle partner; however the staff told us that the practice managers were not always available.

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

Requires improvement

The practice is rated as requires improvement for the care of older people. The practice was rated as requires improvement for providing safe, effective, responsive and well-led services. The concerns which led to these ratings apply to everyone using the practice, including this population group. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered continuity of care with a named GP. Elderly patients with complex care needs and those at risk of hospital admission all had personalised care plans that were shared with local organisations to facilitate the continuity of care. The practice was responsive to the needs of older people, and offered home visits. The practice supported residents within local residential and nursing homes.

People with long term conditions

Requires improvement

The practice was rated as requires improvement for providing safe, effective, responsive and well-led services. The concerns which led to these ratings apply to everyone using the practice, including this population group. The practice nurse had a lead role and was trained in chronic disease management, including asthma and COPD. We viewed plans for additional training for clinical staff in diabetes management. Patients at risk of hospital admission were identified as a priority and longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Requires improvement

The practice was rated as requires improvement for providing safe, effective, responsive and well-led services.The concerns which led to these ratings apply to everyone using the practice, including this population group.

There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances would be flagged on the electronic system. Immunisation rates were relatively high (90%) for all standard childhood immunisations. Appointments were available outside of

Summary of findings

school hours and the premises were suitable for children and babies. Safeguarding policies and procedures were readily available for staff and the appropriate processes to follow were clearly visible on notice boards in staff areas.

Working age people (including those recently retired and students)

Requires improvement

The practice was rated as requires improvement for providing safe, effective, responsive and well-led services.The concerns which led to these ratings apply to everyone using the practice, including this population group.

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. The practice opened longer on Monday evenings to allow for evening appointments.

People whose circumstances may make them vulnerable

Requires improvement

The practice was rated as requires improvement for providing safe, effective, responsive and well-led services.The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice held a register of patients living in vulnerable circumstances including patients with a learning disability. The practice offered longer appointments for people with a learning disability. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and Out of H ours.

People experiencing poor mental health (including people with dementia)

Requires improvement

The practice was rated as requires improvement for providing safe, effective, responsive and well-led services.The concerns which led to these ratings apply to everyone using the practice, including this population group.

Patients at risk of dementia and those with dementia were flagged on the practice computer system and had an annual review. We saw

Summary of findings

that 81% of dementia reviews had been carried out. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. The practice had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

Patients mostly told us they were satisfied overall with the practice in the delivery of care and treatment however they found the appointment system frustrating and this did not meet their needs. We spoke with five patients on the day of the inspection. As this inspection was unannounced we did not use comment cards as part of the process.

We reviewed the results of the national patient survey which contained the views of 108 patients registered with the practice. The national patient survey showed patients were generally pleased with the care and treatment they received from the GPs and nurses at the practice. The survey indicated that 79% of respondents said the last GP they saw or spoke to was good at explaining tests and treatments and 96% had confidence and trust in the last nurse they saw or spoke to.

However, the practice performed below the CCG and national average across a number of points of the GP patient survey for example 88% of patients had confidence and trust in the last GP they saw or spoke to compared to the CCG and national average of 95.3%.

78% of respondents said they were able to get an appointment to see or speak to someone the last time they tried compared with 87.3% across the CCG and 85.4% nationally.

85.8% of respondents said the last appointment they got was convenient compared with 92.4% of patients across the CCG and 91.8% nationally.

58.2% of patients describe their experience of making an appointment as good compared to 73.3% of patients across the CCG and 73.2% nationally.

This was reflected in comments made by patients with regard to the lack of appointments, the difficulty they had in making follow up appointments when they had been asked to by their GP or nurse.

The patients we spoke with were positive about all aspects of their care with the exception of appointments and continuity of care due to GP changes. This was broadly in line with the national surveys and other forums.

Areas for improvement

Action the service MUST take to improve

- Ensure systems are put in place to demonstrate that the practice learns from and disseminate information related to risk, complaints and incidents.
- Ensure the proposed improvements to patient access to appointments is implemented and maintained.
- Ensure that plans are developed for a Patient Participation Group and that other ways are developed of gathering feedback from patients including hard to reach patients and groups.
- Ensure progress against plans to improve the quality and safety of services are monitored, and take appropriate action without delay where progress is not achieved as expected.
- Develop plans to implement and record regular multidisciplinary meetings, practice and clinical meetings.
- Improve the recording and management of staff training records.

Heene Road Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector and included a GP specialist advisor, a second CQC Inspector and a practice manager specialist advisor.

Background to Heene Road Surgery

Heene Road Surgery offers general medical services to people living in Worthing. There are approximately 5839 registered patients.

The practice is registered as a partnership with three GP partners. Currently only one of these partners now works at the practice supported by locum GPs, two nurses, a healthcare assistant, a phlebotomist and a team of receptionists and administration staff. Operational management was provided by two practice managers.

The practice runs a number of services for its patients including asthma clinics, child immunisation clinics, diabetes clinics, new patient checks, and weight management support.

The practice has opted out of providing Out of Hours services to their patients. There are arrangements for patients to access care from an Out of Hours provider.

Why we carried out this inspection

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 was 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

How we carried out this inspection

Before visiting the practice we reviewed a range of information we hold. We also received information from local organisations such as NHS England, Health watch and the NHS Coastal West Sussex Commissioning Group (CCG). We carried out an unannounced visit on 15 September 2015 due to concerns raised about the practice. During our visit we spoke with a range of staff, including GPs, practice nurses, and administration staff.

We observed staff and patients interaction and talked with five patients. We reviewed policies, procedures and operational records such as risk assessments and audits.

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?

Detailed findings

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)

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

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. We saw that incidents were reported on the online system via the practice intranet and all staff we spoke with had a good understanding of this process.

We reviewed safety records, incident reports and minutes of meetings where incidents were discussed for the last year.

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, incidents and accidents that had occurred during the last year and we were able to review these. Significant events were discussed at practice management meetings and we saw that this included a review of actions and learning outcomes from significant events and complaints. There was no evidence that the practice had learned from these incidents as there were no follow up reviews undertaken.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. They showed us the system used to manage and monitor incidents. We tracked incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result of the incidents.

National patient safety alerts were disseminated by the practice manager via email to practice staff. These were also received directly by the GPs. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at practice meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems 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 their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible and flow charts of action to be taken were visible in treatment areas. There was also information visible for patients in the waiting area relating to concerns about abuse and this included relevant contact numbers for people to report concerns.

The practice staff were unclear on who the lead in safeguarding vulnerable adults and children was. We were told that a new individual had taken the lead due to the reduced numbers of GPs in the practice. Staff we spoke with named different members of the team who had the lead as they had not been made aware of the changes. One nurse did know who the new named lead was as they had been party to the discussions about changes.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. A chaperone is a person who can offer support to a patient who may require an intimate examination. The practice policy set out the arrangements for those patients who wished to have a member of staff present during clinical examinations or treatment. We saw there were posters on display within the waiting room which displayed information for patients. All nursing staff had been trained to be a chaperone. Some receptionists had also undertaken chaperone duties and we were told they had received specific training in this. Staff we spoke with understood their responsibilities when acting as chaperones. Not all staff undertaking these duties had received a criminal records check through the Disclosure and Barring Service and a risk assessment had not been

undertaken in this area. One staff told us that they had been told they could not undertake this task until a DBS check had been completed and returned. They had undertaken the training to carry out the role.

Patients' individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system, which collated all communications about the patient including clinical summaries, scanned copies of letters and test results from hospitals.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely. There was a clear policy for ensuring that medicines were kept at the required temperatures and we viewed temperature logs that demonstrated regular checks were being carried out. Staff were able to tell us of an example of where there had been a problem with a medicine refrigerator. The action they had taken to ensure the safety of medicine storage included seeking advice from the manufacturer, discarding affected stock and using a temperature probe that would continuously monitor the fridge temperature at times when the practice was closed.

The practice had processes to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. There were no controlled drugs stored at the practice. Controlled drugs are medicines that require extra checks and special storage arrangements because of their potential for misuse.

GPs took ownership of their own patient repeat prescription requests and patient medicines reviews and we were told they were organised by individual GPs in line with the National Prescribing Centre guidance. GPs maintained records showing how they had evaluated the medicines and documented any changes. Where changes were identified the practice liaised with the patient to describe why the change was necessary and any impact this may have. All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Vaccines were administered by nurses using directives that had been produced in line with legal requirements and national guidance. We saw up to date copies of directives that had been signed by the lead GP. We saw evidence that nurses had received appropriate training to administer vaccines.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were treatment room and general cleaning schedules in place and cleaning records were kept. We saw that single use items such as nebuliser or oxygen masks were in use. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. The practice had a contract with an external cleaning provider which specified the cleaning requirements and frequencies. We observed that this was checked on a regular basis.

The practice had a lead for infection control. They had attended infection control training. Staff had received induction training about infection control specific to their role and received annual updates. We saw evidence the lead had carried out infection control audits. The results had been recorded and used to monitor any improvements identified and these were discussed at meetings. We viewed meeting minutes that included a discussion about checking on actions from a recent infection control audit within the practice.

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

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

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested

and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. We saw evidence of calibration of relevant equipment and pat testing that had last been completed in the past 12 months.

Records showed essential maintenance was carried out on the main systems of the practice. For example, fire safety equipment was serviced annually by an external contractor. Panic alarms were available via the computer system in all consulting and treatment rooms in case of emergency. All staff would respond if a call was raised.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. We found that the practice had not carried out a DBS check on all staff. They had not completed a risk assessment to support their decision not to carry out these checks on administration and reception staff.

Staff told us there were suitable numbers of nursing and administration staff on duty and that staff rotas were managed well. Staff we spoke with told us they were flexible in the way they worked to meet the needs of patients. Staff told us there was usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe. Due to changes in the partnership the practice was reliant on locum GP cover and we saw that appropriate checks were carried out and information available for locums to ensure they operated within practice guidelines.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice managers were the lead for health and safety and a health and safety policy was produced by head office and was available via the practice intranet. A local health and safety policy was also available.

We saw that any risks, significant events and complaints were discussed at practice meetings. For example, we saw information concerning medicine management, patient safety and staff injury discussed at meetings that took place in March, July and August 2015. However these meetings were held with only a few attendees and did not include key people within the practice.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (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, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit 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. Risks identified included power failure, staff shortage and access to the building.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence and from local commissioners. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The nurses working at the practice were trained in specific chronic disease management that included diabetes, heart disease and asthma. They also carried out patient health checks. They regularly assessed patients during appointments to help them manage their conditions and to offer advice and support. Patients with learning disabilities and with poor mental health received annual health checks. We were told the practice was significantly behind in meeting the total number of annual health checks and the nurse we spoke with estimated they had over 50% still to complete. Patients eligible for flu vaccinations were identified and encouraged to attend the practice to receive them. The practice monitored their performance in this area and had taken action to improve uptake for eligible patients.

There was a system in place for the effective management of patients requiring cervical smear tests. Patients were invited to book an appointment. The practice monitored performance in this area and had identified improvements to be made. A system was in place for dealing with abnormal results that included contacting the patient and arranging a follow-up appointment with a GP. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support.

The practice used computerised tools to identify patient groups who were on registers. For example, carers, patients with learning disabilities or patients with long term conditions. We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

The practice had a system for completing clinical audit cycles. Examples of clinical audit included an audit of prescribed dressings to ensure they were in line with CCG guidance. The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, The percentage of patients on the diabetes register, with a record of a foot examination and risk classification within the preceding 12 months was 89.34%compared to the national average of 88.35%. We also noted that 92.94% of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months compared to the national average of 86.04%.

The nursing team was making use of clinical audit tools meetings to assess the performance of clinical staff. The staff we spoke with discussed, how they reflected on the outcomes being achieved and areas where this could be improved. Staff recognised that there were limited systems in place to take a wider view of the practice.

There was a protocol for repeat prescribing which was in line with national guidance, and in line with national guidance, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We were told that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice had a palliative care register and regular multidisciplinary meetings to discuss the care and support needs of patients and their families.

Requires improvement

Are services effective?

(for example, treatment is effective)

Effective staffing

Practice staffing included GPs, nursing, managerial and administrative staff. The practice was run by a GP partnership however two of the three partners had recently left the practice and currently only one GP was left. The practice was using locum GPs to cover the reduction in permanent staff. In addition GPs from another practice in the local area was providing support and assistance to manage the practice and cover some of the patient appointments. Accessing appointments due to changes in the GP availability had been problematic for the surgery and we saw this reflected in some of the feedback we received from patients. All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practice and remain on the performers list with NHS England).

The nurses at the practice had the necessary skills, qualifications and experience to carry out their role. They were given time to undertake their continuous professional development to enable them to keep up to date with their skill levels. Nurses had received appropriate specialist training in delivering the services provided. These included managing patients with long term conditions such as asthma or diabetes, providing immunisations for children and adults, cervical smear testing and smoking cessation advice.

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. The records we saw confirmed that staff had undertaken training however we noted that the records were limited and not well managed. The lead nurse had implemented her own records to keep track of their nursing and healthcare team and these were detailed. The overall system for monitoring training and development was not as detailed and this made it difficult to review.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, travel health and cervical cytology. Those with extended roles, for example seeing patients with long-term conditions such as asthma and chronic obstructive pulmonary disease (COPD) were able 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 patient 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.

The practice held multidisciplinary meetings for patients with complex needs, particularly those with palliative care needs. Minutes of these meetings had not been maintained. However, staff acknowledged there needed to be a better system for recording joint working with other services.

Information sharing

The computerised patient record system was used to record all relevant details about patients on their records.

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP Out-of-Hours provider to enable patient data to be shared in a secure and timely manner. We found that information was being shared appropriately between other healthcare providers and the practice in relation to their patients. Electronic systems were also in place for making referrals

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

Consent to care and treatment

We found that staff had some awareness of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling them. All the clinical staff we spoke

Requires improvement

Are services effective?

(for example, treatment is effective)

to understood the key parts of the legislation and demonstrated a degree of understanding about how they would implement it in practice but this was not embedded in the practice.

Patients with a learning disability and those with dementia were recorded on a register and monitored regularly. We saw they were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it). When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

There was a practice policy for documenting consent for specific interventions. Staff we spoke with demonstrated an understanding of the need to seek consent prior to carrying out a procedure, ensuring that patient's had a good understanding of what they were consenting to.

Health promotion and prevention

It was practice policy to offer a health check with the practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. The practice also offered NHS Health Checks to all its patients aged 40-75. GPs we spoke with told us that regular health checks were offered to those patients with long term conditions and those experiencing mental health concerns. We also noted that medical reviews took place at appropriate timed intervals.

We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, the practice provided weight management advice, smoking cessation advice and could refer patients on for wellbeing support. There were services in place for patient's to be referred to smoking cessation clinics outside of the practice and we saw information about these on posters and leaflets in the waiting area.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with dementia and we saw that 82% of them had attended a dementia review appointment in the preceding 12 months similar to the national average of 83%. Patients with a long term condition were offered regular health checks and we saw that additional support services were available.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccines in line with current national guidance. There was a clear policy for following up non-attenders by the named practice nurse. The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and invited them to yearly annual reviews.

The practice offered a full range of immunisations for children, and flu vaccines in line with current national guidance. We reviewed our data and noted that 90.9% of children aged below 24 months had received their mumps, measles and rubella vaccination.

Health information was made available during consultation and GPs used materials available from online services to support the advice they gave patients. There was a variety of information available for health promotion and prevention in the waiting area and the practice website referenced websites for patients looking for further information about medical conditions

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We spoke with five patients during our inspection. Patients said they felt the practice offered a caring service and staff were kind and helpful. All of the patients told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Four of the five patients had concerns about appointment times and continuity of care. They were all aware of increased use of locum GPs and this meant they would see someone different each time.

We reviewed the most recent GP national survey data available for the practice on patient satisfaction. The evidence from the survey showed patients were generally satisfied with how they were treated and this was with compassion, dignity and respect. However, the practice generally performed below the CCG and national averages in terms of patient feedback. For example:

- 82% of patients rated their overall experience of the practice as good compared with CCG and national averages of 85%.
- 82.2% of practice respondents said the GP was good at listening to them compared with the local average of 89.2% and the national average of 88.6%.
- Patients who stated that the last nurse they saw or spoke to was good at listening to them was at 92.1% compared with the local and national average of 91%.
- 88.2% of patients had responded that they had confidence and trust in the last GP they saw or spoke to compared with the local and national average of 95.3%.
- 96.1% said the same about the last nurse they saw compared with the local average of 97.8%and national average of 97.2%.

The practice was working with another local primary care service provider to review and revise their systems for patient appointments and support.

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

We observed that staff were careful to follow the practice's confidentiality policy when discussing patient treatment in order that confidential information was kept private. The reception area and waiting room were separate which allowed for improved privacy for patients and we saw that patients were given the option of speaking with reception staff away from the main entrance to the surgery if they wished. We also noted that telephone calls were taken away from the reception desk so staff could not be overheard. Staff were able to give us practical ways in which they helped to ensure patient confidentiality.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded generally positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice reasonably well in these areas. For example, data from the national patient survey showed:

76.6% of practice respondents said the GP involved them in care decisions compared with 81.5% of patients across the CCG and nationally.

78.7% of patients felt the GP was good at explaining treatment and results compared with 86.2% across the CCG and 86.3% nationally.

The practice was working towards improving care planning for patients with long term conditions and mental health issues. For example, we saw on the day of our inspection that 92% of care plans and mental health reviews had been undertaken for patients on the register.

Patients we spoke to on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment

Good

Are services caring?

they received. Patients we spoke with also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive.

Staff told us that translation services were available for patients who did not have English as a first language.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. The results of the national GP survey showed that:

84.7% of patients said the last GP they saw or spoke to was good at treating them with care and concern compared with 86% across the CCG and 85.1% nationally.

94.2% of patients said the nurses were also good at treating them with care and concern compared with 91.2% across the CCG and 90.4% nationally. The feedback from patients we spoke with on the day of our inspection was also consistent with this survey information. For example, these highlighted that staff responded compassionately when patients needed help and provided support when required.

Notices in the patient waiting room and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We saw information was available for carers to ensure they understood the various avenues of support available to them. Staff told us they were made aware of patients or recently bereaved families so they could manage calls sensitively and refer to the GP if needed. We were informed that the GP would contact the family and when appropriate advice on how to access support services would be given.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Patients experiencing poor mental health were supported by the GPs and local mental health teams. A mental health lead clinician oversaw patients with a diagnosis of depression or severe mental health problems. Patients with likely dementia were offered an annual review at the practice or at home with discussion with carers following diagnosis. We saw that mental health was an area where the practice had been working to improve performance. Patients could be referred to counsellors as needed and staff were aware of the availability support from the community mental health team.

The practice had a register of patients who were house bound. The register ensured the practice was aware when these patients had medicine requests, required home flu jabs, annual reviews or care planning. The practice also supported patients who were resident in a local care home and we saw that the lead GP was involved in supporting best interest decisions for patients who did not have mental capacity.

The practice supported patients with either complex needs or who were at risk of hospital admission. The practice were involved with a local proactive care team project which included district nurses, community matron, physiotherapists, occupational therapists and pharmacists. Personalised care plans were produced and were used to support people to remain healthy and in their own homes. The practice had a palliative care register and had regular internal discussions to support patients and their families, although there had been limited success in scheduling multidisciplinary palliative care meetings. The practice was working with a neighbouring practice to arrange shared multidisciplinary meetings due to the small numbers of patients on each of their palliative care registers.

Patients with a long term condition had their health reviewed in one annual review. This provided a joined up service working with the patient as a whole rather than just their individual condition and worked with community matrons, district nurses and proactive care team to provide support. The practice provided care plans for asthma, chronic obstructive pulmonary disease (COPD), coronary heart disease, diabetes, dementia and severe mental health.

Childhood immunisation services were provided through dedicated clinics and administrative support to ensure effective follow up.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. Staff knew how to access language translation services if these were required.

The practice provided equality and diversity training through an on-line training programme. The practice had policies for equality and diversity and we saw that the service was planned to meet the needs of individuals.

The premises and services met the needs of people with disabilities. The patient areas within the practice were accessible and on the ground floor. Patients with restricted mobility could easily enter the practice and had level access to reception. The waiting area was accessible for wheelchairs and mobility scooters.

Access to the service

The practice was open between 8am and 7.30 pm on Mondays and 8am and 6.30 pm Tuesday to Friday. Patients were asked to call the surgery in the morning for appointments and home visits where possible. The system was based on a first come first served basis. From discussion with the staff and patients in the practice we found that there were very few appointments available to book ahead either on line or at the surgery. Patients expressed frustration at not been able to pre-book appointments for follow up GP consultations even when the GP had requested they do so. The records and feedback from staff showed that there were no advanced bookings available further than a week and when appointments were release they were quickly filled.

Patients were generally unsatisfied with the appointments system. They confirmed that they found it difficult to see a doctor on the same day if they needed to. Comments received from patients showed that patients in urgent need of treatment were able to make appointments on the same day of contacting the practice. We noted data from the national patient survey indicated that:

78% of respondents said they were able to get an appointment to see or speak to someone the last time they tried compared with 87.3% across the CCG and 85.4% nationally.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

85.8% of respondents said the last appointment they got was convenient compared with 92.4% of patients across the CCG and 91.8% nationally**.**

58.2% of patients describe their experience of making an appointment as good compared to 73.3% of patients across the CCG and 73.2% nationally.

The practice has, with the support of another primary care provider, put in place a new procedure to address the shortfall in patient appointments this was due to be implemented on 21 September 2015. The practice will make appointments available for four weeks with three clinicians available on a Monday and two at all other times. A new triage system is also being introduced to ensure patients who need to see a GP are seen on the day.

There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the Out-of-Hours service was provided to patients.

We were told that longer appointments were also available for people who needed them and those with long-term conditions. Home visits could be arranged and GPs visited a local care home.

The practice also signposts patients to a MIAMI clinic. Minor Injury Assessment & Minor Illnesses (MIAMI) is a new service launched by 19 local GP practices across Adur and Worthing. The practice has been using this service during times when appointments have been unavailable.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints. There were posters in the waiting room to describe the process should a patient wish to make a complaint or provide feedback, including through a comments/suggestion box. Information was also advertised on the practice website and there was a dedicated leaflet to explain the process and signpost patients to organisations who could support them with their complaint or concern.

We looked at three complaints received in the last 12 months and found these were all discussed, reviewed and learning points noted. We saw these were handled and dealt with in a timely way. Whilst lessons learnt from individual complaints had been noted at a senior practice staff meeting there was no information to demonstrate that these lessons had been shared across the practice team. Staff we spoke with knew how to support patients wishing to make a complaint and told us that learning from complaints was shared with the relevant team or member of staff involved in the complaint.

The culture of the practice was that of openness and transparency when dealing with complaints and the practice tried to encourage patients to share their opinions. The practice did not have a patient participation group (PPG) involved in the practice and had not undertaken a patient survey. The practice had not undertaken an audit or review of complaints to determine if there were and trends or reoccurrences.

Are services well-led?

Requires improvement

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

Our findings

Vision and strategy

From speaking with the partner GP and staff from the practice it was clear that they wanted to provide high standards of care, involve patients in decision making about their treatment and care, promote healthy lifestyles and ensure continuous improvement of healthcare services. However we found that this had not been translated into a documented vision and practice priorities.

We spoke with seven members of staff and the response was mixed on what the vision and values and were unclear on their responsibilities were in relation to these. Staff spoke positively about the practice and thought there was good team work with a good level of active support from senior clinical staff. Staff told us that the practice management team was not always available to them and at times communication was limited. They all described the culture of the practice as being positive and open to their suggestions and ideas but would like more structure to the practice.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at some of these policies and procedures and found these had been reviewed annually, were up to date and contained relevant information for staff to follow. This included recruitment, medicine management, whistleblowing, complaints, business continuity, chaperoning and infection control.

The changes that have recently taken place meant that the leadership structure was unclear with some roles being clearly defined and others not embedded. For example, there was a lead nurse for infection control however we were given three different names for the lead in safeguarding.

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, audits in the preceding 12 months included prescribed dressings use and the use of opioids.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us risk assessments, which addressed a wide range of potential issues, such as infection control, manual handling, fire, COSHH (control of substances hazardous to health), and violence and aggression.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards in some areas, for example asthma, atrial fibrillation, cancer, depression and chronic kidney disease.

The practice did not hold regular meetings to discuss performance, quality and risks. Clinical audits and significant events were discussed at management meetings. We did not see evidence that meetings were held which enabled staff to keep up to date with practice developments and facilitated communication between the GPs and the staff team. Staff told us that they wanted to have regular meetings but they were aware of the issues with GP availability. They all commented that the lead GP would make themselves available if they had any concerns.

Leadership, openness and transparency

We saw that team meetings had not been held in some time the last was held in April. The practice managers and the lead GP had a regular meeting to discuss complaints, incidents and risks however these meetings did not involve other key staff in the practice. The lead nurse told us that they meet with the nursing team on a regular basis however they do not minute these meetings. Members of the nursing team confirmed that meeting did take place.

We saw there were a number of human resource policies and procedures in place to support staff, including equality and diversity, complaints and whistleblowing. Staff were aware of the whistle blowing policy. They told us they knew it was their responsibility to report anything of concern and knew the management of the practice and their clinical colleagues would take their concerns seriously. Staff we spoke with knew where to find these policies on the electronic system if required.

Practice seeks and acts on feedback from its patients, the public and staff

The practice had gathered feedback through patient complaints and feedback but they did not routinely conduct their own patient survey and they did not have an active PPG in operation. Results from the GP patient survey

Are services well-led?

Requires improvement

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

showed that the practice had performed below both the local and national average in a number of areas. We did not see evidence that the practice had used this information to improve patient experience.

The practice had gathered feedback from staff through staff discussion, meetings and appraisals. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and supervision. We looked at staff files and saw that regular appraisals took place and included personal development plans

The practice had completed reviews of significant events and other incidents. However these were not shared generally with staff at meetings to ensure the practice improved outcomes for patients and staff. The lead nurse told us that were information had been shared with her this was cascaded to the nursing team. For example incidents involving medicines management were shared and discussed.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The provider had failed to ensure access to appointments for patients at appropriate times to meet their healthcare needs.** **This was a breach of regulation 9 (1) (a)(b)(c), 3(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider had failed to ensure that the risks to patients from staff undertaking tasks who did not hold a DBS were fully assessed.** **This was a breach of regulation 12 (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider had failed to seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services;** **The provider had not ensured all staff were aware of significant information to improve the quality of the service. Regular practice meetings were not held.**

This section is primarily information for the provider

Requirement notices

Systems to assess and learn for incidents and complaints were not in place.

The provider had failed to establish a system for involving the experiences of patients in the development of the services provided.

Records related to the training and development of staff were not accurately maintained.

This was a breach of regulation 17 (2) (e) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014