Broadway Surgery

Quality Report

Wellsbourne Health Centre
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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.

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Summary of findings

Overall summary

Broadway Surgery is situated within Wellsbourne Health Centre in the Whitehawk area of Brighton. The practice shares its modern, purpose built premises with a second doctors practice, a children's centre and dentist. There is also a pharmacy adjoining the centre.

Broadway Surgery provides primary medical services to approximately 2200 patients who reside in the local area. The practice is registered with the Care Quality Commission (CQC) to provide diagnostics and screening, family planning, maternity and midwifery services, surgical procedures and treatment of disease, disorder and injury. There was evidence of collaborative working between the practice and the local clinical commissioning group (CCG). Information from the CCG and Public Health England showed higher levels of deprivation and unemployment amongst patients registered at Broadway Surgery. This was in comparison to other primary medical services in Brighton and Hove and across England.

This was an announced inspection which focused on how systems and practice were: safe, caring, effective, responsive and well led. The practice understood the needs of the local population and provided caring, flexible and responsive services to meet patients' needs. Staff worked collaboratively with other professionals to minimise risk and safeguard vulnerable adults and children from abuse.

The practice is open from 9am to 1pm and 3pm to 6pm Monday to Friday with early closing on Thursdays at 1pm to enable staff training and meetings to take place. A telephone triage system is in operation at the practice. Patients may be invited to speak with a doctor by telephone if they feel they need urgent treatment.

We spoke with 12 patients on the day of inspection and received other information from Care Quality Commission (CQC) comment cards and results of the practice's patient satisfaction surveys undertaken in 2013. We found patients were complimentary about the quality of care and treatment provided by the practice. They told us that staff were caring, respectful and kind and always involved them fully in their treatment. They told us they were always treated with dignity and respect by staff.

Staff told us they felt valued in their work role and were well supported by management of the practice. They told us they had opportunities to have their say and be involved in how services were delivered to patients.

The service monitored its own performance against recognised national targets and standards. There were effective governance and risk management systems in place to ensure patient safety.

During our inspection we looked at how well services were provided for specific groups of people and what good care looked like for them. The population groups we reviewed were:

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

The practice was effective at meeting the needs of older patients. The practice had been purpose built to provide level access and accessible facilities to older patients. There was a wheelchair available for use by patients with mobility difficulties. The proportion of older patients registered with the practice was lower than other practices in the local area and in England. However, older patients spoken with on the day of our inspection confirmed they received a good quality service that was consistent, flexible and coordinated.

The practice was supportive to patients with long term conditions such as diabetes, asthma and heart disease. The nurse saw newly diagnosed diabetics to ensure they understood their condition. There was a coordinated approach to care with multi-disciplinary working.

The practice worked with other health and social care agencies to safeguard children from harm. Mothers, babies, children and young people were well supported by the practice. The practice had a particularly successful campaign that encouraged young adults to be aware of and to participate in screening for chlamydia.

Summary of findings

Working age patients were able to access services at the practice. Late afternoon appointment slots were prioritised for patients who worked during the day.

Patients who were in vulnerable circumstances were over-represented at the practice. There were high levels of deprivation and homelessness in the practice area. The practice worked in liaison with drug and alcohol services to provide targeted support to patients with specialist needs.

The practice worked collaboratively with other health and social care professionals to support patients with mental health needs. The practice was involved in multi-agency meetings when necessary in order to facilitate safe and consistent care.

Site visited for inspection:

Broadway Surgery

Wellsbourne Health Centre

179 Whitehawk Road

Brighton

East Sussex

BH2 5FL

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice was safe. The practice had a safeguarding policy and procedure in place and staff were knowledgeable about what constituted abuse and how to report it. The practice worked collaboratively with the local authority safeguarding team to protect vulnerable adults and children from harm. There were effective infection control measures in place and medicines were managed in line with best practice. The premises were modern, clean, well maintained and safe.

Are services effective?

The practice was effective. The practice was purpose built and was accessible to patients with mobility difficulties and patients who use wheelchairs. The practice was modern and well equipped and equipment was suitably serviced and maintained. The practice provided care and treatment that was in line with best practice. Staff were trained and knowledgeable and had opportunities to further develop their skills and practice. The practice audited its own records to ensure it was meeting its own aims and objectives.

Are services caring?

The practice was caring. Patients we spoke with told us they were treated with dignity, respect and courtesy by staff. Patient privacy and confidentiality were respected. Staff provided patients with appropriate choices and involved patients in their care. Patients told us they felt involved in their healthcare and were provided with sufficient information to make informed choices about their care and treatment.

Are services responsive to people's needs?

The practice was responsive. The practice understood the needs of the population it served. Patients told us they felt the practice met their care needs effectively. Services were planned in a way that promoted person-centred, individualised care and recognised each patient's unique circumstances and culture. The practice actively engaged with other health and social care professionals to benefit patients and provide continuity and joined-up care. The availability of appointments was monitored to ensure that patients could be seen when necessary. Patients were enabled to make complaints and raise concerns with the practice, Their feedback was listened to and valued.

Summary of findings

Are services well-led?

We found the practice was well-led. The practice operated an open and inclusive culture where staff and patient feedback was valued and acted upon. Informal staff meetings were held on a daily basis. It was clear that communication between staff was effective. There were management systems in place which identified and managed risks, enabled learning and improved overall performance.

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 was effective at meeting the needs of older patients. We found the practice was safe, effective, caring, responsive and well led for older patients. The proportion of older patients registered with the practice was lower than other practices in the local area and in England. However, we found older patients received a good quality service that was consistent, flexible and coordinated.

People with long-term conditions
Patients with long term conditions were well supported to manage their health, care and treatment. They were signposted to sources of support and information about their condition. The practice monitored the prevalence of long term conditions across the practice population and worked closely with the Clinical Commissioning Group (CCG) to improve services to patients.

Mothers, babies, children and young people
The practice was effective at meeting the needs of mothers, babies and younger patients. Broadway Surgery worked closely with other health care organisations to improve the health and wellbeing of their younger population. Vulnerable patients and those from disadvantaged backgrounds were provided with appropriate care, treatment and support.

The working-age population and those recently retired
We found the practice was safe, effective, caring, responsive and well led for working age patients. The practice acknowledged that access to appointments for working age patients was limited by the practice opening hours. However, the practice prioritised late afternoon/early evening appointments for working patients. Telephone triage was provided to patients who felt they needed to see a GP when no appointments were available. Patients who needed to be seen were invited to sit and wait at the end of surgery.

People in vulnerable circumstances who may have poor access to primary care
The practice was responsive to the needs of vulnerable patients. The practice effectively assessed and monitored the practice population needs, including patients in vulnerable circumstances. The practice was particularly responsive in providing care and treatment in patients' homes for those who found it difficult to attend the practice.

Summary of findings

People experiencing poor mental health

We found the practice was safe, effective, caring, responsive and well led for patients experiencing poor mental health. The practice worked collaboratively with local mental health organisations to provide support for patients with mental health conditions.

Summary of findings

What people who use the service say

We received verbal feedback from 12 patients who were visiting the practice at the time of our inspection. We also received two comments via a Care Quality Commission (CQC) questionnaire that had been left for patients to complete in reception. We found that patients generally made positive comments about the practice. They told us they felt involved in their health care and were provided with sufficient information to make informed choices about their treatment. They told us they were always treated with dignity and respect and felt listened to by both clinical and non-clinical staff at the practice.

Patients said the premises were always clean and well maintained. They said that staff always washed their hands between patients and wore appropriate personal protective equipment such as gloves, aprons and masks before providing treatment. They said staff were never too busy to explain things to them in terms they could understand. They said they were asked to provide their consent to treatment.

Patients said they were able to get an emergency appointment when they needed one, even if they had to sit and wait to be seen. Patients said they could normally see a GP of their choice and gender preference but that it might mean they had to wait a while longer. One patient told us they would like the practice to open before 9am in order for them to be seen before they went to work. Patients said that staff were good with children and explained treatments and care to them in terms they understood. Patients told us staff used diagrams and pictures to help younger patients understand their care and treatment.

Seven patients were not aware of what they should do if they had a complaint. Of those spoken with, only two patients said they would know how to raise concerns and the procedure they should follow. However, none of the patients spoken with said they had ever needed to complain to the practice.

Areas for improvement

Action the service COULD take to improve

- Staff records should include a system that allows easy retrieval of information. There should be a formal structure, checklist or index to identify content.
- Staff should be made fully aware of the whistleblowing policy.
- There should be regular team meetings and records should be kept of the content.
- Patients under 16 should be more effectively signposted to family planning/contraception advice.

Good practice

Our inspection team highlighted the following areas of good practice:

- The call back triage system for patients had been particularly successful and was well received by patients who felt they needed to see a GP urgently.

Broadway Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC Lead Inspector and a GP specialist advisor. The team included a second CQC inspector and an expert by experience. An expert by experience is someone who has experience of using services.

Background to Broadway Surgery

This was the first inspection of Broadway Surgery since it registered with the CQC in April 2013. Broadway Surgery is situated in the Whitehawk area of Brighton. It is situated within the Wellsbourne Health Centre where it shares purpose built premises with another GP surgery, a dentist's surgery and a child health centre. The premises are owned by Sussex Community NHS Trust. For patients convenience there is a pharmacy situated alongside the health centre.

The Whitehawk area of Brighton is an area of deprivation with low numbers of older people and high numbers of people aged between 18 and 45. There are large numbers of one parent families and unemployed people who live in social housing in the area. There are a high number of transient people who stay in the area for a short time before moving elsewhere. The practice provides services to approximately 2200 patients in the local area.

The practice had one experienced GP. A second GP partner had recently left the practice. Locums had been used to cover surgery sessions when the GP was off duty. A second GP was to be employed and become a partner in the practice in July 2014. There was a practice manager, a nurse, a healthcare assistant and a team of receptionists who worked part time. Other healthcare professionals, such as community nurses, health visitors and midwives provided sessions at the practice.

Broadway Surgery is open Monday to Friday 9.00am to 6.00pm. The practice closes for lunch each day between 1pm and 3pm. During this time patients can contact the GP by mobile phone. The practice provides an extended surgery on Wednesday evenings from 6.30pm to 7.30pm and is closed during the afternoon on Thursdays. Out of hours the surgery telephone diverts patients to the out of hours 111 service.

Why we carried out this inspection

We inspected this 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:

Detailed findings

- 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 the practice we reviewed a range of information we hold about the service. We met with the local clinical commissioning group, NHS England area team and Healthwatch. We attended a listening event with local patient representatives.

Prior to and following the inspection we spoke with the practice manager who provided us with detailed information about the operation of the practice. The information helped us to understand how the surgery met the needs of patients. We found the service worked collaboratively with other health and social care services to benefit patients. The practice had good links with the local clinical commissioning group (CCG).

We carried out an announced inspection on the 27 May 2014. As part of the inspection we looked at management and staff records. We saw policies and procedures and we observed staff talking and interacting with patients.

On the day of inspection we spoke with the GP, the practice nurse, the manager of Wellsbourne Health Centre and three reception staff.

We also spoke with 12 patients who used the service and observed how people were being cared for. We received feedback from two comment cards that had been left for us in a box in reception and viewed the patient satisfaction survey for 2013, carried out by the practice.

Are services safe?

Summary of findings

The practice was safe. The practice had a safeguarding policy and procedure in place and staff were knowledgeable about what constituted abuse and how to report it. The practice worked collaboratively with the local authority safeguarding team to protect vulnerable adults and children from harm. We found the practice had systems in place to record, investigate and learn from incidents. We found there were effective infection control measures in place at the practice and medicines were managed in line with best practice. The practice staff had been trained to deal with medical emergencies and the practice had drugs and equipment available for use in emergency.

Our findings

Safe patient care

Children and vulnerable adults were protected from the risk of abuse because the practice had taken reasonable steps to identify and prevent abuse from happening. There were effective arrangements in place for reporting safety incidents and allegations of abuse. The practice nurse we spoke with gave examples of how they contacted the local authority safeguarding team when concerns about abuse were observed or disclosed to them. We heard from staff that they were aware of how to recognise types of abuse and how to report their concerns. They told us how information was shared within the practice and how the safeguarding lead was alerted. Staff explained how patient records were updated to include concerns. Staff told us they always ensured locum GPs we're aware of the situation if abuse or exploitation were suspected. We were told by staff that alerts were placed on the patient's record to highlight any vulnerability.

The practice had clear incident reporting procedures in place. Nursing staff were able to describe the process and indicated there were clear lines of accountability for incident reporting. We were told when incidents occurred, staff recorded the incident appropriately in the incident record. If the incident involved a patient, details would be kept in the patient record to ensure all clinical staff were alerted to the matter. Non clinical staff told us they were informed of incidents concerning patients if they were likely to be affected. For example, if a patient's behaviour could be challenging or disruptive. We looked at the incident log for the practice and saw there had been three incidents in the past year. One of the incidents concerned finding a used hypodermic needle in the patient toilet. This had led to discussion about how to avoid a repeat of the incident and procedures to deal with potentially infected items. The second incident concerned the unplugging of a server cable by a visiting information technology technician. This left the clinicians temporarily without access to the patient records and the computer system. The third concerned a locked drawer that needed to be opened when the keys were mislaid. All of the incidents had been fully discussed in staff meetings and procedures had been put in place to reduce the likelihood of recurrence.

The practice manager explained how the practice followed standard protocols for health issues. For example,

Are services safe?

hypertension (raised blood pressure), asthma (asthma can cause coughing, wheezing, and breathlessness) and diabetes (a condition where the amount of glucose in the blood would remain too high without a particular diet and/or treatment). All clinicians followed these protocols which required regular checks, screening and medication review.

Staff in the adjoining family centre reported receiving referrals from the practice about children who had not attended for immunisation in line with recognised timescales and clinical guidance. We heard how care plans were jointly agreed between the practice and family centre, for children identified as having missed immunisation sessions. We heard that a monitoring system was put in place to ensure immunisations were provided at the required time.

The practice worked in partnership with other health and social care professionals to safeguard, treat and support patients in high risk groups. For example those patients who misused substances, drugs or alcohol. Patients who were at high risk of sexually transmitted disease were referred to appropriate treatment centres. The practice had a robust referral system in place to ensure patients received advice and treatment from a central service in Brighton.

Learning from incidents

The practice participated, actively learnt and acted on recommendations from relevant investigations, inquiries and safety alerts. The practice nurse told us how the practice received regular clinical updates from the Royal College of Nursing (RCN), British National Formulary (BNF), the National Institute for Health and Care Excellence (NICE) and other national organisations. They told us how information was shared and applied across the practice. Staff meetings were held when necessary to exchange information. Practice policies and procedures were reviewed to reflect essential recommendations. For example, antibiotic prescribing had reduced following recent guidance in relation to the effective use of antibiotics.

Safeguarding

The practice worked with partner agencies to ensure that vulnerable adults and children were identified and kept safe. Patient records were coded to identify children on the 'at risk register' and other high risk groups, so that early intervention could be carried out in timely way to safeguard patients from harm. The practice worked collaboratively with the local authority safeguarding team to protect vulnerable adults and children from harm.

All the staff we spoke with were able to describe the signs and symptoms of abuse. They were able to identify the things that were most important when protecting people from abuse and promoting patient safety. We saw that relevant safeguarding contact telephone numbers were available in reception. There was a vulnerable adults and child protection policy available to staff in the practice. The provider may like to note, in the staff files we looked at, not all the staff had undertaken formal safeguarding training.

Monitoring safety and responding to risk

The practice had a significant event/incident log which identified issues that could impact on the service being delivered. There was evidence of analysis and learning from the log. Incidents were discussed and shared with staff. Where necessary, processes and procedures were put in place to reduce the likelihood of recurrence.

Emergency equipment and drugs were available and could be used by the trained and competent staff (including locums) who worked in the practice. We saw the practice nurse routinely monitored the expiry dates and stocks of emergency drugs and equipment. There was an automated electronic defibrillator and oxygen available for use in emergency. The equipment was tested regularly to ensure it was functional.

Medicines management

There were clearly defined systems, processes and standard operating procedures that minimised potential for error and promoted safety of patients who used services. For example, repeat prescription requests were checked before being provided. The GP reviewed medication, where there were discrepancies between what was requested and what was recorded on the patient's record, before a prescription was issued. Routine monitoring of fridge temperatures, emergency medicines and medical equipment ensured patient safety.

Cleanliness and infection control

The practice was clean and well maintained. Staff had received training in infection control and regular checks and audits were carried out to ensure patients health and safety. Building maintenance was managed centrally by an NHS premises manager. They told us any faults or defects

Are services safe?

were routinely reported to them by the practice manager. Health and safety was managed in accordance with current guidelines by the practice manager, with all staff contributing to a safe environment. Personal protective equipment (PPE) such as gloves, aprons, couch covers and hand gels were available in the clinical areas and patients reported appropriate use of PPE during examination.

Staffing and recruitment

All of the patients we spoke with told us there were the right staffing levels and skill-mix at all hours the service was open, to support safe, effective and compassionate care.

On the day of our inspection there were four staff on duty; a locum GP; a practice nurse; a receptionist and an administrator. The practice manager was on holiday and the phlebotomist was not working that day. The practice staffing levels and skill mix were set to keep patients safe and meet their needs based on the size of the patient list of 2200 patients and the practice opening hours. During our inspection we saw that patients were generally seen at the time stated for their appointment. However, the provider may like to note that three patients told us they felt more appointment times would improve the service. Two staff we spoke with also felt additional appointment times would help improve patient access to the service. Staff told us about how they covered each other. For example in reception, during holiday periods or during sickness absence. This meant there was a small risk that if absence was for longer periods, some administrative work may be delayed.

We saw that all clinical staff had undertaken a criminal record check using the Disclosure and Barring Service (DBS) . Risk assessments were carried out on newly recruited reception and administrative staff to decide if there was a need to carry out a criminal record check. Results of the risk assessments were kept on file.

Dealing with Emergencies

The practice had a business continuity plan in place for events such as bad weather or loss of essential services such as gas, electricity, water, telephone or computer access. The continuity plan also covered emergency response to major incidents and response to chemical, biological, radiological and nuclear incidents. We were shown the plan by the premises manager of Wellsbourne Health Centre who was responsible for activating the plan in the event of an emergency.

Staff received training in life support and dealing with medical emergencies. There were emergency drugs and equipment in the practice ready for use and staff were aware of where these were stored. It was however, noted that the emergency equipment was not all kept in the same place which could impact on the time taken to provide essential support in an emergency situation.

Equipment

There was a proactive approach to anticipating potential safety risks, including disruption to facilities, or periodic incidents such as bad weather. The practice had contingency plans in place to deal with issues that could affect service delivery. The practice had considered premises issues such as breakdown in gas supply, electrics, telephone, IT and water. Maintenance of practice equipment was carried out routinely to lessen the risk of breakdown. The premises were modern and well equipped and were overseen by a shared premises manager. The premises manager told us how they could access support services or temporary supplies of basic services to enable the practice to continue to function.

The facilities and equipment in use at the practice were routinely maintained and checked. Many items were for single use only and were disposed of immediately, resulting in a positive impact on patient outcomes. Equipment was appropriately stored and was secure.

Are services effective?

(for example, treatment is effective)

Summary of findings

Overall the practice was effective. Care and treatment were provided in line with best practice guidance. The practice was purpose built and was accessible to patients with mobility difficulties and patients who use wheelchairs. The practice was modern and well equipped and equipment was suitably serviced and maintained. The practice provided care and treatment that was in line with best practice and which met current guidelines. Staff were trained and knowledgeable and had opportunities to further develop their skills and practice. The practice audited its own records to ensure it was meeting its own aims and objectives.

Our findings

Promoting best practice

The practice undertook a range of clinical audits. The audits were either part of a cycle of audits or were undertaken in response to national guidance such as that from the National Institute for Health and Care Excellence (NICE). The results of audits were shared with clinicians to help promote 'best practice'. We were told about the results of an audit carried out in April 2014 on patients who were prescribed a certain type of medication. A care plan was in place for each patient which gradually reduced the dose of the medication, if and when it was deemed clinically appropriate by the GP. The results of the audit and subsequent actions by the clinicians had reduced the prescribing of this type of medicine significantly at the practice. Similarly, a quarterly audit of inadequate cervical smear tests helped clinicians identify changes in policy and practice.

We were shown the consultation rooms and clinical areas. We saw how GPs and other clinical staff were able to perform appropriate patient examinations with consideration for the patient. The surgeries were of good size and had screens which could surround examination areas. Windows had blinds which enhanced privacy within the surgery.

The patients we spoke with told us they always felt their privacy and dignity was respected throughout examinations and felt their care was personalised and supported their recovery. Patients told us they were asked for their consent before an examination or a treatment commenced. Clinical staff told us they recorded the patients consent in their records. Where patients capacity to consent was unclear, clinical staff told us they assessed patients in line with the Mental Capacity Act 2005 and involved family members or carers in the process to ensure any decision was made in the patient's best interest.

Management, monitoring and improving outcomes for people

We saw from the Quality Outcomes Framework (QOF) that the practice completed accurate and timely performance information. We used this information to inform our inspection and saw that the information was readily available to staff, patients and the public. The QOF is a voluntary incentive scheme for GP practices in the UK, rewarding them for how well they care for patients and

Are services effective?

(for example, treatment is effective)

contains groups of indicators, against which practices score points according to their level of achievement. Overall the QOF reflected positive outcomes for patients and included positive comments from patients. Some areas of prescribing such as for hypnotic type medicines and non-steroidal anti-inflammatory drugs were indicated as being slightly above the national average. However, discussions with the GP indicated that there was good reason for this, due to the practice population.

Staffing

We looked at staff recruitment records during our inspection. We found permanent and temporary clinical staff were appropriately qualified and competent to carry out their roles safely and effectively. We saw evidence of appropriate checks being carried out when recruiting new staff, including locums. We saw that non-clinical members of staff had a risk assessment in place that identified if they needed a criminal records check by the Disclosure and Barring Service (DBS).

We saw evidence of staff induction programmes. However, these were not consistent and it was difficult to identify what training courses had been completed during an induction period, as staff files and information were poorly structured. Staff told us about online learning they undertook as well as other learning they were provided with. However, one member of staff told us they had not completed formal safeguarding vulnerable adults training. It was clear however, that their knowledge of the subject was good and they knew how to recognise safeguarding issues and how to report concerns. Supervision of non-clinical staff was carried out informally due to the small size of the practice and was largely unrecorded. However, non-clinical staff told us they felt well supported and were kept informed of key issues relating to the practice.

The learning needs of staff were identified during annual appraisals. Training was put in place which had a positive impact on patient outcomes, particularly in relation to emergency medical situations. There were opportunities for clinical staff to enhance their professional development beyond mandatory training through locally arranged training and shared learning events.

Working with other services

There was proactive engagement with other health and social care providers and other bodies to co-ordinate care and meet patient's needs. We heard about joint working arrangements with the adjacent family centre and maternity clinic, which enabled services to work together effectively. There were effective partnership arrangements with other services in the health centre including chiropody and dental services.

There was effective communication, information sharing and decision-making about a person's care across multiple services. The staff regularly attended multi-disciplinary meetings, particularly when a patient had complex health needs. We heard from staff about referrals being made to external consultants. This was confirmed by one of the patients we spoke with who told us about their need for a minor operation and how the GP had made a referral on their behalf. They told us the appointments went to plan and that following their operation they had appointments made with the practice nurse for aftercare treatment.

Health, promotion and prevention

The practice proactively identified patients, including carers who may need on-going support. Clinics were available to provide support for patients with diagnosed diabetes or to help prevent the onset of the condition. A similar service was available for patients with chest conditions such as asthma, chronic obstructive pulmonary disease (COPD) and emphysema. Information was available for patients on a range of health conditions and guidance was provided by clinical staff in relation to this. New patients were offered a consultation to find out details of their past medical and family histories. The consultation included finding out about social factors that may have impacted on treatment. Routinely, new patients were asked about their occupation, lifestyle and prescribed medications. Routine assessment of risk factors, for example smoking, alcohol intake, blood pressure and obesity were considered and recorded in patient's notes.

Are services caring?

Summary of findings

We found the practice was caring. Patients we spoke with told us they were treated with dignity, respect and courtesy by staff. Patient's privacy and confidentiality were respected. Staff provided patients with appropriate choices and involved patients in their care. Patients told us they felt involved in their healthcare and were provided with sufficient information to make informed choices about their care and treatment.

Our findings

Respect, dignity, compassion and empathy

Patients and those close to them were treated with respect. Staff in all roles were seen to treat patients with dignity and respect whether arriving at reception or being taken to their appointment. Patients who used the service told us they felt supported and well-cared for by all staff in the practice. We observed that staff demonstrated a kind and caring attitude and built positive relationships with patients using the service. Staff spent time talking to patients to help understand their needs, particularly for those where English was not their first language.

Confidentiality was respected at all times when care was provided in the consultation rooms. Doors were closed and window blinds were lowered. Consultation rooms were lockable. Areas were set aside so patients were able to talk in confidence with reception staff, the practice manager or clinical staff. The patients we spoke with told us their care was provided in a dignified way and took into account their physical support needs and their individual preferences.

Involvement in decisions and consent

The patients we spoke with told us staff involved them in decisions about their care. Patients told us they felt involved in planning their care, choosing and making decisions about their care and treatment and were supported to do so where necessary. They told us how they were supported to understand their diagnosis and given options for care and treatment and aftercare.

We heard how staff had effective communication skills and how they communicated with patients in a way they could understand. For example, when a patient requested medicines which they no longer took. We heard how the member of staff explained clearly the reasons why a new prescription could not be immediately provided. We also heard how the patient was asked if they had sufficient medicines left to cover the short wait until a GP could review their medication.

Patients and relatives were able to contact the service when needed and speak to someone about their care. We saw how staff in the practice understood issues relating to confidentiality which did not exclude carers from being given appropriate information. For example, we saw a

Are services caring?

family member attend the surgery on behalf of a relative. Before discussing the patient we saw the staff member contact the patient by telephone first to gain permission before sharing information.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The practice was responsive. The practice understood the needs of the population it served. Patients told us they felt the practice met their care needs effectively. Services were planned in a way that promoted person-centred, individualised care that recognised patient's unique circumstances and culture. The practice actively engaged with other health and social care professionals to benefit patients and provide continuity and joined-up care. The availability of appointments was monitored to ensure that patients could be seen when necessary. Patients were enabled to make complaints and raise concerns with the practice. Their feedback was listened to and valued.

Our findings

Responding to and meeting people's needs

Services were planned in a way that promoted patient-centred and coordinated care, including for patients with complex or multiple needs. Patients told us about referrals to consultants and access to services in local hospitals and clinics. The practice nurse told us how the practice promoted good health and wellbeing by holding specific clinics for long term illnesses such as diabetes and asthma. They told us they worked with patients to encourage compliance with treatment.

We heard from staff and patients how the practice encouraged personal continuity of care by doctors and other team members. For example, patients could request appointments with their preferred doctor or with a male or female doctor where possible. We were told these preferences were recorded on patient's notes to ensure preferred options were made available to them whenever possible.

The practice took steps to remove barriers that some patients may face in accessing or using the service. This included making reasonable adjustments for patients with a disability, a learning disability or autism or patients with English as a second language. Language interpreters were available through an NHS contract and were available at short notice. Staff were aware of patients who had a learning disability or autism and made longer appointments or appointments at quieter times of the day to avoid distressing patients.

Where the practice may not be able to meet the needs of the different types of patients it served, it worked with other local practices, services or commissioners to ensure their needs were met. This meant that in regard to drugs, alcohol and substance misuse the practice had arrangements with centrally funded support services in Brighton. Patients could be referred to these services immediately to receive specialist support. There were similar locally based referral arrangements in place for family planning and chiropody services.

The environment and facilities within the health centre were appropriate. Equipment was available promptly for patients. For example, there was adequate seating in the waiting room with sufficient space for wheelchair users. A lift was available to the upper floor surgeries and offices

Are services responsive to people's needs?

(for example, to feedback?)

and access into the centre was accessible to patients of all abilities. Toilet facilities appeared clean and had facilities for disabled patients. The practice manager maintained an office procedure manual. It supported the daily running of the practice, to which team members contributed and had access.

Access to the service

The practice had a standard telephone appointments system. Patients reported that it was easy to use, supported choice of appointments and generally enabled patients to access the right care at the right time. However two patients we spoke with told us they sometimes found it difficult to get through to the service at busy times, such as first thing in the day. They told us that when they finally got through by telephone appointments were not always available that morning.

The practice opening hours covered Monday to Friday and were generally between 9:00am and 13:00pm and 15:00pm to 18:00pm. On a Thursday the practice only offered morning appointments and on Wednesday they offered extended hours between 18:30pm and 19:30pm. These hours helped meet the needs of the practice population and were clearly stated on the NHS choices website and in the surgery leaflet. The provider may like to note that the hours displayed outside the surgery did not show all the available opening hours.

Patients were able to be assessed by a GP in a timely way which met their needs. This included access to urgent appointments, telephone call back consultations, or home visits for patients who would benefit from them. We saw evidence of telephone call backs, which the GP used to triage patients. Following triage, the patient could be asked to visit the surgery, collect a prescription, or a home visit could be arranged by the GP. We saw telephone calls to the surgery were dealt with promptly and patients did not wait long to be seen by the doctor.

The practice had a surgery leaflet containing information about services provided. There was also information about the practice on the NHS choices website. Information was in the main accurate, however information about the GPs needed updating.

Concerns and complaints

Information about how to make a complaint about the service was available in the waiting area of the practice, as well as in the practice leaflet and on their NHS choices website. A suggestion box was also available in the waiting area. However, a number of the patients we spoke with were unclear about how to raise concerns or make a complaint.

We looked at the record of complaints at the practice. The majority of complaints had been acknowledged, investigated and a written outcome had been provided to the complainant. However, two complaints had been escalated and the outcomes were yet to be decided.

We were told by the GP and practice manager that complaints were discussed with staff in an open and transparent way during frequent informal meetings. Feedback from patients was viewed positively and complaints were used as a learning tool to develop new ways of working.

Are services well-led?

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

Summary of findings

The practice was well-led. The practice operated an open and inclusive culture where staff and patient feedback was valued and acted upon. Informal staff meetings were held on a daily basis. It was clear that communication between staff was effective. There were management systems in place which identified and managed risks, enabled learning and improved overall performance.

Our findings

Leadership and culture

Staff were able to tell us about the values and ethos of the practice and these encompassed ideas such as placing the patient at the centre of their work, compassion, dignity, respect and equality. The clinical and non-clinical staff in the practice were clear about what decisions they were required to make and knew what they were responsible for. There were clear limits of authority for each role. For example, the receptionist demonstrated they knew when not to issue repeat prescriptions and delegated responsibility to the GP. The practice nurse knew when the GP was required to refer patients to consultants for further treatment or investigations. The practice nurse also demonstrated where they were allowed to refer patients to other services. For example, referring to the chiropodist or family centre. All staff we spoke with knew when to refer patients to the safeguarding vulnerable adult's team.

Governance arrangements

The practice prided itself on its open, no blame culture and its strong team work ethos. Staff were aware of their roles and accountabilities. Staff had designated responsibilities and took the lead role in areas such as infection control, safeguarding, staff recruitment, complaint handling and maintenance of the building. This provided a level of autonomy for the staff team who took responsibility for tasks associated with their particular job role. For example, the practice nurse was responsible for ensuring that vaccinations were provided safely by the surgery. The practice nurse was responsible for maintaining the cold chain at the practice which included monitoring the vaccine fridge storage temperatures. They also checked the expiry dates on vaccines and determined when supplies of vaccine were ordered. All of the staff felt valued in their role and were aware of how to raise concerns, comments and suggestions. They understood their responsibility to report concerns and poor practice.

Systems to monitor and improve quality and improvement

The practice uses the Quality and Outcomes Framework (QOF) to determine its performance against national targets. QOF is a voluntary annual reward and incentive programme for all GP surgeries in England, detailing practice achievement results. It is not about performance management but resourcing and then rewarding good

Are services well-led?

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

practice. The practice achieved 96% in the clinical domain overall in the QOF for 2013 which shows that the practice is working towards or meeting government targets for quality care in the delivery of primary medical services.

Patient experience and involvement

The practice acknowledged that it had experienced difficulties in relation to engaging with patients in a formal manner due to the demographics and population of the practice area. There were posters in reception encouraging patients to join the patient participation group (PPG). The PPG is a group of patients who are registered with the practice who have no medical training, but have an interest in the services provided. The aim of the PPG is to represent patient's views and work in partnership with the practice to improve common understanding. The practice had recently recruited 11 patients to join the PPG which were to be known as the 'Friends of Broadway Surgery'. The inaugural meeting was planned for July 2014. To recruit participants the practice worked directly with community development workers, who attended the practice to encourage patients to join. The practice manager had conversations with the local Brighton PPG champion and attended a meeting of their PPG to get ideas. They discussed ways of encouraging patient participation in the group. As a result of discussions the practice manager wrote directly to a number of patients to encourage support.

Staff engagement and involvement

We heard how all practice staff met regularly in an informal way due to the small size of the team and layout of the practice. Staff told us processes were in place to support them and promote their positive wellbeing. Recruitment practices, including induction programmes, reinforced organisational processes and values. There was a strong team based work ethic, characterised by a cooperative, inter-disciplinary approach to delivering care. Staff teams had clearly defined tasks and roles as well as clear communication processes.

The practice was small and friendly and met mainly in an informal manner on a daily basis. Feedback from patients was discussed openly at the meetings. The practice manager operated an 'open door' policy and staff felt that management were approachable and caring. The practice manager provided praise and encouragement when staff were performing well in their role and this was reflected formally in staff appraisals. When challenge was needed it was provided in a positive and constructive manner. Staff told us they received an annual appraisal and we saw records that confirmed this. Staff had a job description and clear lines of accountability. Their values and visions focused on providing high quality care to patients of the practice.

Learning and improvement

The practice staff told us about the training they had received. Most recently staff had completed a course in managing medical emergencies. Nursing staff told us about learning and development they routinely undertook to maintain their skills and knowledge, as well as their registration. All staff received an annual appraisal which reviewed their performance and helped identify further learning they may need.

Identification and management of risk

We heard from staff about a range of audits undertaken by the practice manager which ensured safe working practices and a safe environment. We saw from information provided to us that the provider also contributed to external audits for hygiene and infection control and the Quality Outcomes Framework. Where risk was identified management systems were put in place to reduce the likelihood of recurrence. Management systems were underpinned by effective policies and procedures.

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 was effective at meeting the needs of older patients. We found the practice was safe, effective, caring, responsive and well led for older patients. The proportion of older patients registered with the practice was lower than other practices in the local area and in general in England. However, we found older patients received a good quality service that was consistent, flexible and coordinated.

Our findings

The practice had been purpose built to provide level access and accessible facilities to older patients. There was a wheelchair available at the practice for use of patients with mobility difficulties.

There were effective arrangements in place to identify vulnerable and frail older patients registered with the practice. Patients were offered regular health checks with the practice nurse in order to maintain their health and avoid unplanned hospital admission. The GP regularly visited a number of older patients with mobility problems at home. Home visits could be requested when necessary.

We saw the practice provided information to older patients about support networks in the local area and nationally. Patients were signposted to local day centres and lunch clubs in order to avoid social isolation. The practice promoted healthy lifestyles and prevention of ill health.

There were arrangements in place to support patients at the end of their life. The practice worked with other health and social care professionals to ensure continuity of care. The practice met regularly with community nurses, McMillan nurses and other professionals.

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

Patients with long term conditions were well supported to manage their health, care and treatment. They were signposted to sources of support and information about their condition. The practice monitored the prevalence of long term conditions across the practice population and worked closely with the Clinical Commissioning Group (CCG) to improve services to patients.

Our findings

Broadway Surgery worked with the local CCG to improve services to patients with long term conditions. Each patient had a care and treatment plan that was monitored and reviewed regularly.

Prescribed medication was reviewed at least annually to ensure its efficacy in treating the condition. Appropriate referrals were made to secondary care when the need arose. The practice monitored the care patients received to ensure it was effective in reducing the number of unplanned hospital admissions.

The practice displayed health promotion materials in the waiting area and sign-posted patients to other local services and support groups. Patients could meet the practice nurse for individual health promotion and support. An example of effective health promotion and support was demonstrated by the practice nurse, when a newly diagnosed patient was supplied with practical advice and information about their condition. The practice obtained useful information from Diabetes UK, which particularly met the patient's individual lifestyle choice and specific needs.

We spoke with the practice nurse about patients with long term conditions and how their health was managed. They told us they carried out routine health checks, blood tests and/or spirometry (lung function tests) at regular intervals. Patients who had multiple long term conditions were asked to attend a single appointment. This enabled one health check review to assess all the patient's needs, rather than asking the patient to attend multiple appointments for individual conditions.

The practice had arrangements in place to ensure that vulnerable patients were offered vaccinations against shingles, influenza and pneumonia. Housebound patients were offered a service at home.

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 was effective at meeting the needs of mothers, babies and younger patients. Broadway Surgery worked closely with other health care organisations to improve the health and wellbeing of their younger population. Vulnerable patients and those from disadvantaged backgrounds were provided with appropriate care, treatment and support.

Our findings

The practice had a larger population of younger people, young mothers and one parent families than neighbouring practices. Many young mothers lived alone in social housing and were not effectively supported by family networks. Therefore, there was a greater need for support from statutory agencies including Social Services and other health and social care professionals.

Broadway Surgery shared premises with other health and social care professionals who provided family support and child health advice. The practice worked closely with the neighbouring child health centre to safeguard children from abuse and exploitation. Information about children identified as being at risk, or families with concerns, were circulated to nurses and GPs at the practice. Vulnerable patients and those from disadvantaged backgrounds were provided with appropriate care and support. The practice had robust systems in place to ensure the close monitoring of children, young people and families living in disadvantaged circumstances. This included 'looked after' children, children of substance abusing parents and young carers.

All staff received appropriate safeguarding training to protect young patients and children from the risks of abuse. Staff of all levels demonstrated they understood signs and symptoms of abuse and knew what to do to raise concerns.

The practice provided information leaflets and displayed posters in the waiting area about child safeguarding and domestic violence and who to contact if patients had concerns.

The Brighton and Hove area had very high rates of sexually transmitted disease. Broadway Surgery worked closely with other organisations to try and improve the sexual health of younger patients. The practice had been particularly successful in promoting chlamydia testing for under 25's. The practice offered free self-testing kits and full

information to its younger patients. Results were provided directly to the patient by text message. This had proven popular with younger patients who sought advice from the surgery about the results.

The GPs at the practice did not prescribe contraception to children under the age of 16 without a parent's consent. Young patients below this age were signposted to local family planning centres.

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

We found the practice was safe, effective, caring, responsive and well led for working age patients. The practice acknowledged that access to appointments for working age patients was limited by the practice opening hours. However, the practice prioritised late afternoon/ early evening appointments for working patients. Telephone triage was provided to patients who felt they needed to see a GP when no appointments were available. Patients who needed to be seen were invited to sit and wait at the end of surgery.

Our findings

The practice acknowledged that the opening hours of the practice made it difficult for working patients to be provided with an appointment. Therefore, appointments in the late afternoon and early evening were prioritised for patients who were at work during the day.

Patients were provided with access to a GP by telephone over the lunchtime period in case of emergency and telephone triage was offered to patients who felt they needed an appointment on the day. When necessary patients were asked to sit and wait for an appointment at the end of surgery.

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

The practice was responsive to the needs of vulnerable patients. The practice effectively assessed and monitored the practice population needs, including patients in vulnerable circumstances. The practice was particularly responsive in providing care and treatment in patients' homes for those who found it difficult to attend the practice.

Our findings

The practice had a large transient population. This meant that the practice had a high turnover of patients with many patients registering for care and treatment for short periods of time before moving elsewhere. Many of the practices patients were from ethnic minority backgrounds, many of whom did not speak English as a first language.

The practice was responsive to the needs of vulnerable patients. The practice participated in recognised national benchmarking programmes such as the Quality Outcomes Framework (QOF). This supported regular annual health checks for patients with learning disabilities. The practice supported the communication needs of patients with learning disabilities by providing pictorial formats and drawn diagrams to aid patients understanding. Signers and interpreters were used when necessary.

Patients whose first language was not English, were supported by the practice. Staff could arrange interpretation services when needed. A longer consultation time could be arranged to facilitate the use of an interpreter.

Patients were invited to share feedback with the practice. The practice had taken steps to establish a Patient Participation Group (PPG) in order to further involve patients in improvements to services. The practice had used creative ways of encouraging involvement in the PPG including the use of community development workers, who attended the practice to encourage patients to join in.

Clinicians supported patients who wished to be accompanied to consultations, examinations or procedures by friends or relatives of their choice. The practice provided a formal chaperone service.

The practice identified people in carer roles and provided resources, information and advice to support them. This

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

included signposting to other services available locally. The practice had developed effective working relationships with the community nursing team, who provided additional support to housebound patients at times of crisis.

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

We found the practice was safe, effective, caring, responsive and well led for patients experiencing poor mental health. The practice worked collaboratively with local mental health organisations to provide support for patients with mental health conditions.

Our findings

The practice worked collaboratively with other health and social care professionals to meet the needs of patients experiencing poor mental health. They worked alongside community health teams and voluntary services to ensure that patients received appropriate support.

The practice had been identified as a practice where there was a higher than normal use of 'Benzodiazepines'. Benzodiazepines are medicines used to treat anxiety, insomnia and other nervous conditions. Continued use of Benzodiazepines had been linked with physical and emotional dependence in a few patients. We discussed the use of this medication with the GP who explained that the practice worked with specialists in Sussex Partnership NHS Trust to reduce patient's dependence on this sort of drug. Each patient who was being prescribed Benzodiazepines was on a reduction programme. The practice had success in significantly reducing the use of such medication.