Broadway Surgery

Quality Report

Wellsbourne Health Centre
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Website: N/A

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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	Inadequate
Are services safe?	Inadequate
Are services effective?	Inadequate
Are services caring?	Requires improvement
Are services responsive to people's needs?	Requires improvement
Are services well-led?	Inadequate

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Broadway Surgery on 11 February 2016. Overall the practice is rated as inadequate.

Our key findings across all the areas we inspected were as follows:

- Patients were at risk of harm because systems and processes were not in place to keep them safe. For example there was no evidence that appropriate recruitment checks on staff had been undertaken prior to their employment.
- Effective arrangements for managing medicines, including emergency drugs, vaccines and high risk medicines were not in place.
- Not all staff were clear about how to report incidents, near misses and concerns.
- Not all staff who acted as chaperones had received training for the role. Also there was no evidence to show that all staff had received up to date training on basic life support.
- Not all staff who acted as chaperones had received a Disclosure and Barring Service check (DBS check).
- Staff had not received any training on infection control.
- The practice was unable to demonstrate effective management of complaints since 2014.
- The practice had not undertaken any audits of clinical practice to ensure improved outcomes for patients. There was no evidence of any quality improvement.
- There was a large variation in practice performance against the quality and outcomes framework (QOF) and national prescribing indicators compared to the clinical commissioning group (CCG) and national averages.

Summary of findings

- Immunisation rates were relatively low for all standard childhood immunisations.
- Patients' views were mixed. Patients told us that staff were helpful, caring and considerate. They commented that they felt listened to and well supported by their GP. However, the national survey showed that the number of patients who would recommend their surgery was significantly less than the national and CCG average.
- There was no evidence that feedback from patients including the national survey or the friends and family test had been analysed and reviewed.
- The practice had insufficient leadership capacity and limited formal governance arrangements.

The areas where the provider must make improvements are:

- Introduce robust processes for reporting, recording, acting on and monitoring significant events, incidents and near misses.
- Ensure that action is taken to address identified concerns with medicines management and infection control.
- Ensure recruitment arrangements include all necessary employment checks are undertaken for all staff.
- Put systems in place to ensure action is taken to effectively manage the care and treatment of patients with long term conditions.
- Carry out complete clinical audits cycles to ensure quality improvements have been achieved.
- Ensure that concerns raised in feedback from staff and patients are addressed including lower levels of satisfaction in relation to the ability to get an appointment and patients overall experience of the practice.
- Address areas of low performance against the quality and outcomes framework.
- Improve the uptake of cervical screening and childhood immunisations.
- Implement formal governance arrangements including systems for assessing and monitoring risks and the quality of the service provision including the quality of the experience of patients in receiving those services.
- Provide staff with appropriate policies and guidance to carry out their roles in a safe and effective manner which reflect the requirements of the practice.
- Ensure there is leadership capacity to deliver all improvements.
- Ensure all staff who undertake chaperone duties receive appropriate training.
- Ensure all staff have up to date basic life support training.
- Ensure that there are sufficient numbers of suitably qualified staff, particularly in relation to practice nursing staff.

The areas where the provider should make improvement are:

- Ensure accurate training records are kept including the level of safeguarding training attained by GPs and induction checklists
- Ensure written information about services is provided in other languages.
- Ensure the practice is able to demonstrate effective management of complaints.

I am placing this practice in special measures. Practices placed in special measures will be inspected again within six months. If insufficient improvements have been made so a rating of inadequate remains for any population group, key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

The practice will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service.

Summary of findings

Special measures will give patients who use the practice the reassurance that the care they get should improve.

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?

Inadequate

The practice is rated as inadequate for providing safe services and improvements must be made.

- Staff were not clear about reporting incidents, near misses and concerns. Although the practice carried out investigations when there were safety incidents, it was not clear whether lessons learned were communicated to staff so that safety was improved.
- Patients were at risk of harm because systems and processes were not in place to keep them safe. For example, there was no evidence that appropriate recruitment checks on staff had been undertaken prior to their employment.
- Effective arrangements for managing medicines, including emergency drugs and vaccines were not in place.
- Not all staff who acted as chaperones had been formally trained for the role or had received a Disclosure and Barring Service check (DBS check).
- Staff had not received any formal training on infection control
- The practice did not have a system for monitoring high risk medicines.

There were not enough staff to keep patients safe. For example, there were not enough practice nurses to meet patient needs.

Are services effective?

Inadequate

The practice is rated as inadequate for providing effective services and improvements must be made.

- Data showed patient outcomes were low compared to the locality and nationally. For example the percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control was 51% compared to the CCG average of 74% and the national average of 74%
- Patient outcomes were hard to identify as little or no reference was made to audits or quality improvement and there was no evidence that the practice was comparing its performance to others; either locally or nationally.
- There was limited multi-disciplinary team working.

Are services caring?

Requires improvement

The practice is rated as requires improvement for providing caring services.

Summary of findings

- Data from the National GP Patient Survey showed patients rated the practice lower than others for several aspects of care.
- Patients we spoke with said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- Information for patients about services was available. However, not everybody would be able to understand or access it. For example, there were no information leaflets available in Polish despite there being a large number of Polish patients on the practice list.

Are services responsive to people's needs?

Requires improvement

The practice is rated as requires improvement for providing responsive services.

- There was no evidence that the practice had reviewed the needs of its local population in the last year or that it had a plan to secure service improvements.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- Patients could get information about how to complain.

Are services well-led?

Inadequate

The practice is rated as inadequate for being well-led.

- The practice did not have a clear vision and strategy.
- Leadership and management capacity was limited and staff did not always feel supported by the GP partners.
- The practice had a number of policies and procedures to govern activity, but key policies were missing for example, a policy for ensuring that medicines were kept at the required temperatures.
- The practice did not hold regular governance meetings and issues were discussed on an ad hoc basis.
- The practice had not actively sought feedback from patients since 2014 and did not have a patient participation group. There was no evidence that feedback from other sources for example, the friends and family test, comments and suggestions boxes had been analysed and reviewed. The practice had not undertaken its own survey of patient views.

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

Inadequate

The practice was rated as inadequate for safe, effective 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 for conditions commonly found in older patients were below average. For example, the percentage of patients with chronic obstructive pathways disease (COPD) who had had a review, undertaken by a healthcare professional, including an assessment of breathlessness in the preceding 12 months was 55% compared to the clinical commissioning group (CCG) average of 88% and national average of 89%.

However, there were some examples of good practice:

- The practice offered personalised care to meet the needs of the older patients in its population.
- It worked closely with the community nurses and social workers in relation to the care provided to older patients.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.

People with long term conditions

Inadequate

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

- Practice performance against the diabetes indicators in the QOF were below the CCG and national average. For example, performance for diabetes related indicators was 71% which was below the CCG average of 88% and the national average of 88%. However, on the day of the inspection we saw that performance had improved and was now in line with the average.

However, there were some examples of good practice;

Patients had a structured annual review to check that their health and medication needs were being met.

- The practice nurse took a lead role in chronic disease management and patients at risk of hospital admission were identified as a priority.
- Longer appointments and home visits were available when needed.

Summary of findings

Families, children and young people

Inadequate

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

- Immunisation rates were relatively low for all standard childhood immunisations. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 64% to 68% and five year olds from 42% to 45%.
- The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control was 51% compared to the CCG average of 74% and the national average of 74%.
- The practice's uptake for the cervical screening programme between 2014/15 was 72%, which was below the national average of 82%.

However, there were some examples of good practice;

- 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 patients who had a high number of A&E attendances.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- There was a twice weekly benefits advice clinic provided on the practice premises.
- The practice had baby changing facilities.
- The practice liaised regularly with the health visitors, midwives and social workers.

Working age people (including those recently retired and students)

Inadequate

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

- The practice offered extended opening hours for appointments every Wednesday between 6.30pm and 7.30pm.
- Appointments could only be made by telephone or in person.
- Patients could not book appointments or order repeat prescriptions online.

People whose circumstances may make them vulnerable

Inadequate

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

Summary of findings

- The practice did not provide an enhanced service for patients with a learning disability.
- We saw that not all patients with a learning disability had a care plan.
- The practice did not routinely work with multi-disciplinary teams in the case management of vulnerable patients.
- The practice informed 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 hour

People experiencing poor mental health (including people with dementia)

Inadequate

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

- 80% of patients diagnosed with dementia had had their care reviewed in a face-to-face review in the preceding 12 months compared to the national average of 84% (04/2014 to 03/2015).
- 62% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the record, in the preceding 12 months compared to the national average of 88% (04/2014 to 03/2015)
- The practice had told patients experiencing poor mental health about how to access various local support groups and voluntary organisations.

Summary of findings

What people who use the service say

The national GP patient survey results published in July 2015. The results showed the practice mainly performed below local and national averages. Four hundred and forty-one survey forms were distributed and 83 were returned. However this only represented 4% of the practice's patient list.

- 80 %found it easy to get through to this surgery by phone compared to a clinical commissioning group (CCG) average of 83**%** and a national average of 85%.
- 65% were able to get an appointment to see or speak to someone the last time they tried, compared to the CCG average 88%, and the national average 85%.
- 77% described the overall experience of their GP surgery as fairly good or very good, compared to the CCG average 85%, and the national average 84%.
- 58% said they would definitely or probably recommend their GP surgery to someone who has just moved to the local area, compared to the CCG average 79%, and the national average 78%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 34 comment cards the majority of which were positive about the standard of care received. Patients commented that staff were helpful, caring and considerate. They commented that they felt listened to and well supported by their GP. Most patients said they could get an appointment when they wanted one and appreciated the fact that GPs would telephone them if requested. Four patients commented that they had to wait too long to get an appointment.

We spoke with five patients during the inspection. All five patients said they were happy with the care they received and thought staff were approachable, committed and caring. They said they could get an appointment when they needed one.

Areas for improvement

Action the service MUST take to improve

- Introduce robust processes for reporting, recording, acting on and monitoring significant events, incidents and near misses.
- Ensure that action is taken to address identified concerns with medicines management and infection control.
- Ensure recruitment arrangements include all necessary employment checks are undertaken for all staff.
- Put systems in place to ensure action is taken to effectively manage the care and treatment of patients with long term conditions.
- Carry out complete clinical audits cycles to ensure quality improvements have been achieved.
- Ensure that concerns raised in feedback from staff and patients is addressed including lower levels of satisfaction in relation to the ability to get an appointment and patients overall experience of the practice.
- Address areas of low performance against the quality and outcomes framework.
- Improve the uptake of cervical screening and childhood immunisations.
- Implement formal governance arrangements including systems for assessing and monitoring risks and the quality of the service provision including the quality of the experience of patients in receiving those services.
- Provide staff with appropriate policies and guidance to carry out their roles in a safe and effective manner which reflect the requirements of the practice.

Summary of findings

- Ensure there is leadership capacity to deliver all improvements.
- Ensure all staff who undertake chaperone duties receive appropriate training.
- Ensure all staff have up to date basic life support training.
- Ensure that there are sufficient numbers of suitably qualified staff, particularly in relation to practice nursing staff.

Action the service SHOULD take to improve

- Ensure accurate training records are kept including the level of safeguarding training attained by GPs and induction checklists
- Ensure written information about services is provided in other languages.
- Ensure the practice is able to demonstrate effective management of complaints.

Broadway Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist adviser and a practice manager specialist adviser.

Background to Broadway Surgery

Broadway Surgery is located in the Whitehawk area of Brighton and provides primary medical services to approximately 2250 patients. The practice had recently taken an additional 300 patients as a result of the closure of a practice nearby.

There are two part-time GP partners. One GP provided eight sessions a week and the other two sessions per week.

There is one part-time practice nurse, one part-time health care assistant and one part-time phlebotomist. There is a practice manager, an administrator and two receptionists.

Data available to the Care Quality Commission (CQC) shows the practice serves a higher than average number of patients aged between 5 and 29 when compared to the national average. The number of patients over the age of 75 is below the national average. The practice population has a significantly higher than average income deprivation score. There is also a higher than average number of patients with long standing health condition and with health related problems in daily life.

The practice is open on Monday, Tuesday Wednesday and Friday from 9am to 1pm and 3pm to 6pm and on Thursday from 9am to 1pm. It is closed on a Thursday afternoon. Between 8am-9am and 6pm- 6:30pm and on Thursdays from 1pm to 6.30pm, a telephone service is offered by the on call duty GP. Extended hours appointments are offered every Wednesday between 6.30pm and 7.30pm. Appointments can be booked over the telephone, or in person at the surgery. Patients are provided with information on how to access the duty GP or the out of hours service by calling the practice.

The practice runs a number of services for its patients including; chronic disease management, asthma and diabetes reviews, new patient checks, and holiday vaccines and advice.

At the time of the inspection the practice had not formally notified us that one partner had joined in June 2015. The practice was in the process of submitting the relevant applications.

Why we carried out this inspection

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

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

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 11 February 2016. During our visit we:

- Spoke with the two GPs, the practice manager, a practice nurse, a health care assistant, a phlebotomist and an administrator/receptionist.
- Spoke with five patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members
- Reviewed the treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We also looked at how well services were provided for specific groups of people and what good care looked 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 whose circumstances may make them vulnerable.
- People experiencing poor mental health (including people living with dementia).

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

Inadequate

Are services safe?

Our findings

Safe track record and learning

The practice did not have an effective system in place for reporting and recording significant events.

- We saw that the practice had a form and policy for reporting serious incidents, accidents and near misses. However, not all the staff we spoke with were aware of the policy or the form. Staff told us they would inform the practice manager of any incidents.
- The practice provided us with a log of three incidents that had occurred over the last year which included the date and details of the incident, the outcome and the learning points to be discussed. However, the practice was unable to locate the completed incident forms for these events or provide any evidence of where the learning points had been discussed.

Overview of safety systems and processes

The practice did not have clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse:

- Arrangements were in place to safeguard children and vulnerable adults from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs did not attend safeguarding meetings but always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training relevant to their role. The GPs told us they were trained to safeguarding level three for children, however they were unable to provide certificates on the day of the inspection, in order to confirm this to be the case.
- A notice in the waiting room advised patients that chaperones were available if required. However not all staff who acted as chaperones had been trained for the role or had received a Disclosure and Barring Service check (DBS check). (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). The practice could not be sure that staff who undertook chaperone duties were of good character or were able to discharge this duty appropriately.
- The practice did not always maintain appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. There was an infection control policy in place. However, it was noted on the day of the inspection that there was no soap dispenser or soap in the female toilets and that the sharps bins in one of the consulting rooms were not dated. The practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. The practice nurse had not had any additional training for their lead role in infection control.. Whilst we saw that all staff had signed to say they had read and understood some written guidance on hand washing techniques they had not received any training on infection control. Also infection control was not covered as part of the practice induction. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.
- The practice did not have effective arrangements for managing medicines, including emergency medicines and vaccines, for keeping patients safe. There was no policy for ensuring that medicines were kept at the required temperatures, and which described the action to be taken in the event of a potential failure. When we looked at the temperature recording charts for the medicines fridges we saw that they had been recorded as being above the required maximum temperature on certain days and that no action had been identified to address this. This meant that the practice could not be sure the medicines held in the fridge had not been compromised. We saw that whilst prescription pads were securely stored, there were no systems in place to monitor their use. We also observed that whilst medicines in the treatment rooms were kept in a locked cupboard the key to the cupboard was not kept securely. The medicines could have been accessed by patients or visitors without the practice knowing.
- The practice carried out regular medicines audits, with the support of the local clinical commissioning group pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. These

identified that the practice prescribing was not in line with best practice guidelines for a number of medicines including antibiotic and hypnotic medicines. The practice did not have an action plan in place for medicines optimisation in areas where it had been identified as an outlier.

- The practice had arrangements in place for undertaking medication reviews with patients when the authorised number of repeat prescriptions had been passed. However this system had lapsed during the last six months. The GPs told us that this was because the practice had been under pressure caused by taking on over 300 new patients as a result of the closure of a practice nearby.
- The practice did not have a system for monitoring high risk medicines. For example, one patient on a high risk medicine that should have had a blood test every three months had not had one for more than six months. The practice could not be sure the patient was safe to continue receiving their prescription.
- Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. The practice had a system for production of Patient Specific Directions to enable health care assistants to administer vaccines after specific training, when a doctor or nurse was on the premises.
- We reviewed six personnel files and found appropriate recruitment checks had not been undertaken prior to employment. For example, proof of identification, references, and the appropriate checks through the Disclosure and Barring Service. We were unable to find contracts of employment for the staff whose files we reviewed. The practice could not demonstrate that the employment process ensured staff were suitable for the roles to which they were employed.
- There were systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Monitoring risks to patients

Risks to patients were not always assessed and managed.

- The practice premises were owned by an external company and managed by NHS Property Services that had procedures in place for monitoring and managing risks to patient and staff safety. There were up to date fire risk assessments and the practice carried out regular fire drills. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. Risk assessments in relation to the safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings) were undertaken by NHS Property Services.
- There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. However there were no formal arrangements in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. Staff told us that at times there were insufficient staff to meet patient needs, particularly in relation to practice nurse and GP availability. This had been made worse by the need to take on additional patients as a result of the closure of a practice nearby. This meant that the practice had not had sufficient staff to ensure the safe delivery of care, treatment and monitoring for patients with long term conditions. For example, the percentage of patients with asthma, on the register, who had had an asthma review in the preceding 12 months that included an assessment of asthma control was 51% compared to the CCG average of 74% and the national average of 74%. Also patients had to wait four weeks to see a practice nurse.

Arrangements to deal with emergencies and major incidents

The practice did not have adequate arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- The practice was unable to provide evidence that all staff had received up to date annual basic life support training.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.

Inadequate

Are services safe?

- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use. However, not all of the appropriate medicines were available including benzyl penicillin, glucagon and glucose. The practice told us that arrangements would be put in place immediately to ensure these were available.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs told us that they assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs. However, the practice did not undertake any monitoring to ensure that these guidelines were followed.

Management, monitoring and improving outcomes for people

The practice did not use the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 78% of the total number of points available, with 15% exception reporting. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). The national average for exception of patients was just over 9% making the exception rate for this practice significantly higher than average. This practice was an outlier for QOF (or other national) clinical targets with performance mostly below the clinical commissioning group (CCG) and national average. Data from 2014/15 showed:

- Performance for diabetes related indicators was 71% which was below the CCG average of 87% and the national average of 88%. Although on the day of the inspection we saw that performance had improved in line with the average.
- Performance for asthma related indicators was 67% compared to the CCG average of 97% and the national average of 98%.
- The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control was 51% compared to the CCG average of 74% and the national average of 74%.
- The percentage of patients with hypertension having regular blood pressure tests was 69% compared to the CCG average of 81% and national average of 83%.
- Performance for mental health related indicators was 69% compared to the CCG average of 89% and national average of 92%.
- The percentage of patients with COPD (lung disease) who had had a review, undertaken by a healthcare professional, including an assessment of breathlessness in the preceding 12 months (04/2014 to 03/2015) was 55% compared to the CCG average of 88% and national average of 89%.
- The percentage of patients diagnosed with an enduring mental health problem who had a comprehensive, agreed care plan documented in the record, in the preceding 12 months (04/2014 to 03/2015) was 62% compared to the CCG average of 83% and the national average of 88%.

The practice told us that the low performance was due to the nature of the practice population and also due to the fact that they did not have sufficient practice nursing staff to undertake the management of long term conditions. They told us they had tried to recruit additional practice nurses but had been unable to attract any candidates. They also told us that they had found it difficult to cope with the increase in demand from having to register an additional 300 patients as a result of a nearby practice closing.

The practice had not undertaken any clinical audits, and was therefore unable to demonstrate quality improvements or improvements to patient outcomes.

Effective staffing

Staff had most of the skills, knowledge and experience to deliver effective care and treatment. However not all staff had received the training they required.

- The practice had an induction checklist for all newly appointed staff. It covered such topics as, fire safety, health and safety and confidentiality. However when we reviewed staff files we were unable to locate induction checklists for all recently appointed staff. There was no evidence that infection control was covered during induction.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff for

Inadequate

Are services effective?

(for example, treatment is effective)

example, for those reviewing patients with long-term conditions. Staff administering vaccines and taking samples for the cervical screening programme had received specific training.

- The learning needs of staff were identified through a system of appraisals. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included access to on line training, external courses and in-house training and support for revalidating GPs. All staff who had been in post for over a year had received an appraisal within the last 12 months.
- Staff received training that included: safeguarding, equality and diversity and the Mental Capacity Act. However not all staff who acted as chaperones had received training for the role. Also there was no evidence to show that all staff had received up to date training on basic life support.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results. Information such as NHS patient information leaflets were also available.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff shared information with other health and social care services to ensure understanding of the range and complexity of patients' needs and to assess and plan on going care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. There were regular multi-disciplinary meetings for patients who were on the palliative care register. However for other patient groups, there was no evidence of multi-disciplinary working.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young patients, staff carried out assessments of capacity to consent in line with relevant guidance.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were then signposted to the relevant service.

The practice's uptake for the cervical screening programme between 2014/15 was 72%, which was below the national average of 82%. There was a policy to offer written reminders for patients who did not attend for their cervical screening test.

Childhood immunisation rates for the vaccinations given were relatively low. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 64% to 68% and five year olds from 42% to 45%. The practice notified the health visitors of children who did not attend for immunisations. There was no evidence that the practice was taking action to improve uptake.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74.

Requires improvement

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

Thirty out of the 34 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and considerate. They commented that they felt listened to well supported by their GP. Less positive comments related to comments from four patients who felt that they had to wait too long to get an appointment.

Results from the national GP patient survey showed that the majority of patients felt they were treated with compassion, dignity and respect. However, the practice was mostly lower than the average for its satisfaction scores on consultations with GPs. For example:

- 76% said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 87% and national average of 89%.
- 80% said the GP gave them enough time (CCG average 84%, national average 87%).
- 88% said they had confidence and trust in the last GP they saw (CCG average 95%, national average 95%).
- 72% said the last GP they spoke to was good at treating them with care and concern (CCG average 84%, national average 85%).
- 92% said the last nurse they spoke to was good at treating them with care and concern (CCG average 91.1%, national average 90%).
- 88% said they found the receptionists at the practice helpful (CCG average 89%, national average 87%)

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback on the comment cards we received was also positive and aligned with these views.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were mixed when compared to the local and national averages. For example:

- 90% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 85% and national average of 86%.
- 73% said the last GP they saw was good at involving them in decisions about their care (CCG average 80%, national average 81%).
- 87% said the last nurse they saw was good at involving them in decisions about their care (CCG average 84%, national average 85%).

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations.

Written information was available to direct carers to the various avenues of support available to them including the local carers support organisation.

Staff told us that if families had suffered bereavement, their usual GP contacted them and have them advice on how to find a support service.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We were unable to identify whether the practice 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. However the practice did offer the following:-

- Extended hours every Wednesday between 6.30pm and 7.30pm.
- Longer appointments were available for patients who had complex needs.
- Home visits were available for older patients and patients who would benefit from these.
- Same day appointments were available for children and those with serious medical conditions.
- There were disabled toilet facilities and a baby changing facilities.

Access to the service

The practice was open on Monday, Tuesday Wednesday and Friday from 9am to 1pm and 3pm to 6pm and on Thursday from 9am to 1pm. It was closed on a Thursday afternoon. Between 8am-9am and 6pm- 6:30pm and on Thursdays from 1pm to 6.30pm, a telephone service was provided by the on call duty GP. Extended hours appointments were offered every Wednesday between 6.30pm and 7.30pm. Appointments could be booked over the telephone, or in person at the surgery. Patients were provided information on how to access the duty GP or the out of hour's service by calling the surgery.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was comparable to local and national averages.

- 71.4% of patients were satisfied with the practice's opening hours compared to the CCG average of 72.5% and national average of 74.9%.
- 80%% patients said they could get through easily to the surgery by phone (CCG average 76**%**, national average 73%).
- 65% patients said they always or almost always see or speak to the GP they prefer (CCG average 66%, national average 60%).

Patients told us on the day of the inspection that they were able to get appointments when they needed them. However it was noted that patients had to wait four weeks for a practice nurse appointment.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns.

- The complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system in the form of a leaflet given out to patients by the receptionists.

The practice did not hold records of complaints received in the last 12 months. However, records from 2013/2014 showed that lessons were learnt from concerns and complaints and action was taken to as a result to improve the quality of care. For example, in response to complaints about appointments running late receptionists booked double appointments for patients with multiple health issues. The practice was unable to demonstrate effective management of complaints since 2014.

Are services well-led?

Inadequate

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

Our findings

Vision and strategy

The practice had a set of aims and objectives which were set out in its statement of purpose which were based on achieving the best outcomes for patients. However there was no supporting business plan which set out and monitored the future direction of the practice. The Quality and Outcomes framework (QOF) showed that outcomes for patients were mainly below the national and clinical commissioning group average. There was no evidence that the practice had a plan in place to improve outcomes for its patients.

Governance arrangements

The practice did not have an effective governance framework in place to support the delivery of good quality care.

- Practice specific policies were in place and were available to all staff. Although, some key policies were missing for example, a policy for ensuring that medicines were kept at the required temperatures.
- There were no arrangements in place to ensure a comprehensive understanding of the performance of the practice was maintained.
- There were no arrangements in place for identifying, recording and managing risks, issues and implementing mitigating actions. This had led to significant issues that threatened the delivery of safe and effective care, for example inadequate arrangements for the safe management of medicines and poorer outcomes for patients in a number of areas.
- The practice had not submitted notifications to the CQC as required, for example a notification and application to add a GP partner.

However,

- Staff were aware of their own roles and responsibilities

Leadership and culture

The partners in the practice had limited capacity to run the practice and ensure high quality care. Although they were compassionate and caring it was not clear whether safe, high quality care was prioritised. Staff told us that one of the partners was not always visible in the practice and that they were not always approachable or took the time to listen to all members of staff. There were no meetings for practice staff. The practice had been without a practice manager since December 2015 and the new practice manager had only been in post for two weeks. They had limited previous practice management experience.

The provider was aware of and complied with the requirements of the Duty of Candour. Staff told us there was a culture of openness and honesty although not all of them were aware of the procedures for reporting incidents. There were systems in place for knowing about notifiable safety incidents.

There was a clear leadership structure in place, however staff did not always feel supported by management.

- Staff told us there were no practice team meetings.
- Staff were not involved in discussions about how to run and develop the practice, or identify opportunities to improve the service delivered by the practice.

Seeking and acting on feedback from patients, the public and staff

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. It had attempted to set up a patient participation group (PPG) in July 2014 with the help of the local Brighton PPG champion. However, this had been unsuccessful. There was no evidence that feedback from other sources e.g. Friends and Family Test, comments and suggestions boxes had been analysed and reviewed. The practice had not undertaken its own survey of patient views. The practice did not routinely gather feedback from staff although all staff had an annual appraisal.

Continuous improvement

The practice was unable to demonstrate any focus on continuous learning and improvement. The practice was not part of local pilot schemes to improve outcomes for patients in the area.

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 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **How the regulation was not being met:** The provider was unable to demonstrate that appropriate recruitment procedures were in place to ensure that staff were of good character or had the qualifications, competence, skills and experience which are necessary for the work to be performed by them, and were in good health as specified in Schedule 3. Regulation 19(1)(a)(b)(c) (2)(a)(b) (3)(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 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:** The provider did not have sufficient numbers of suitably qualified, competent, skilled and experienced practice nursing staff. This was in breach of regulation 18 (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

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 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** Staff undertaking chaperone duties had not received appropriate training therefore the provider had not ensured that persons providing care or treatment to service users had the competence, skills and experience to do so. The provider was unable to provide evidence that all staff had received up to date annual basic life support training. The provider did not have arrangements in place to ensure the safe management of medicines including the storage of vaccinations at the correct temperature, the issuing of blank prescriptions, undertaking medication reviews with patients and the prescribing of high risk medicines. Sufficient specific medication was not available in case of emergencies. The provider did not have effective arrangements in place for assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated. Not all sharps bins were dated and there was no soap in the female toilets. Staff had not received training on infection control. This was in breach of regulation 12(1)(2)(c)(f)(g)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. . . . .

This section is primarily information for the provider

Enforcement actions

Regulated activity

Diagnostic and screening procedures

Family planning services

Maternity and midwifery services

Surgical procedures

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

How the regulation was not being met:
The provider did not have systems and processes such as regular audits of the clinical services provided for assessing, monitoring and improving the quality and safety of the service.

The provider did not have systems in place to assess, monitor and mitigate risks relating to health safety and welfare of patients. Not all staff were aware of the practice's policies for reporting incidents. Staff did not always receive information about the outcome of incidents nor was this information always shared with others to promote learning.

The provider was unable to demonstrate that feedback from patients or staff had been sought, analysed or that action plans had been developed to address issues where they were raised. It was unable to demonstrate that improvements had been made.

The provider did not maintain accurate records in relation to staff employed. Records in relation to the management of the practice were not kept.

Regulation 17 (1)(2)(a)(b)(d)(e)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.