

Care Quality Commission

Inspection Evidence Table

BRUNE MEDICAL CENTRE

Inspection date: 5 February 2019

Date of data download: 13 December 2018

Overall rating: Good

Please note: Any Quality Outcomes Framework (QOF) data relates to 2017/18.

Well-led

Rating: Good

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme in place, including a succession plan.	Y
Explanation of any answers and additional evidence: The Government has produced guidelines on delivering good integrated care seeing this as the way forward for healthcare reducing gaps and inefficiencies and is an essential part of delivering improved outcomes for people. Southern Health and The Willow Group were inextricably linked and dedicated to continual development of the integrated care model to provide effective and efficient care for patients. Leaders had an inspiring shared purpose and strove to deliver and motivate staff to succeed. There were comprehensive and successful leadership strategies in place to ensure delivery and to develop the desired culture. There was a clear leadership structure, which was a unique model within the sector. Southern Health NHS Trust (Southern Health- who were joint providers of care with The Willow Group) and The Willow Group had worked together to embed primary care within secondary care. Leadership was facilitated jointly by Southern Health and The Willow Group to provide a seamless care pathway across the system for patients. Southern Health and The Willow Group shared leadership and governance including integrated care and community hospitals. This meant the Willow Group had access to NHS Trust executives, for example the Medical Director, Chief Operating Officer and Director of Nursing. The Clinical Director was Clinical Director for both Southern Health and The Willow Group. The Head of Nursing was responsible for the leadership of nurses within The Willow Group and the area matrons for Southern Health. This meant there was effective and consistent leadership across the care system.	

There were four sites, (Brune Medical Centre, Waterside Medical Centre, Forton Medical Centre and Stoke Road Medical Centre) each site had its own management lead. The Willow Group systems and processes were integrated with Southern Health. For example, serious incidents were reported through the Southern Health reporting system and were monitored as a whole for the business unit. Investigations were of a high standard. For example, a wound care investigation included a root cause analysis/thematic review which resulted in a new wound care template which was used consistently across the trust and the practice providing better care for patients. The risk register was also integrated as Southern Health monitored risks for the business unit, which included The Willow Group and community hospitals. All Willow Group staff were employed by Southern Health who provided human resources (HR) and finance services to the Group.

Challenges were addressed jointly across the care system resulting in clear care pathways for patients with efficiencies in the system reducing the need for multiple appointments. For example, the long-term conditions hub and complex care team described below.

The practice was clear about their challenges which included the difficulty in recruiting GPs, a risk of change fatigue and an aging population with complex needs in an area of social deprivation. They also recognised financial pressures and had worked hard on engaging with staff to ensure staff from four sites felt and worked as one organisation. In the light of identified challenges, the practice had considered succession planning. This was based around the new GP consultant model described below which sets out how care will be provided to patients in the future. The model considered current resources available and what will be required in the future to deliver a seamless care pathway for patients.

Vision and strategy

The practice had a clear vision and credible strategy to provide high quality sustainable care.

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Y
There was a realistic strategy in place to achieve their priorities.	Y
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence: There was clear statement of vision and values, driven by quality and safety. It had been translated into a credible strategy and well-defined objectives that were regularly reviewed to ensure that they remained achievable and relevant. The vision, values and strategy had been developed through a structured planning process with regular engagement from internal and external stakeholders, including people who use the service, staff, commissioners and others.	
The practice's vision and values and mission statement were displayed on noticeboards in the waiting area and on the website. Staff described the vision and values as creating continuity for patients. Governance leads told us the practice had moved from 'fire-fighting' to reflection and learning. Examples	

of learning are described below.

The practices' long-term plan for to provide integrated care reflected the government's five-year plan for primary care.

Culture

The practice had a culture which drove high quality sustainable care.

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y

Explanation of any answers and additional evidence: There were high levels of staff satisfaction across all different types of staff groups. Staff were proud of the organisation as a place to work and spoke highly of the culture. There were consistently high levels of constructive engagement with staff, including all equality groups. Staff at all levels were actively encouraged to raise concerns.

The senior management team saw staff wellbeing as a priority. There was an employee assistance program in place for staff to access confidential support with both work and private issues. A series of positive psychology workshops had been held which staff told us had been very popular. The idea was to offer staff a range of innovative services to improve their health and wellbeing and for staff to have the best possible service by aligning sessions and activities to the vision and values of the organisation. Staff were offered focus groups and games on such topics as positivity, engagement, relationships and achievement. The psychology sessions were delivered in response to staff feedback and was reported in the staff newsletter under 'You said...we did.'

There was a culture of openness and transparency. The practice held a variety of meetings and apart from partners meetings, all minutes of meetings were openly available for staff on the intranet to review. This meant staff had access to information about developments, changes and plans for the practice.

Following feedback from a staff away day a social committee had been developed. Staff reported this had been positive in breaking down perceived barriers between managers and staff and allowed staff to take ownership, organising events they were interested in. Events organised by staff for staff included a family barbecue, a moonlight Alzheimer's walk and a pottery event.

The practice received 72 compliments in the quarter ended 29 November 2018, these were emailed to staff to support good morale.

Examples of feedback from staff or other evidence about working at the practice

Source	Feedback
Staff	Staff told us that management were transparent and encouraged staff to share views which were always listened to. They were offered training to support their role such as medical terminology courses and Makaton courses. Makaton is a language program using signs and symbols to help people communicate.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

	Y/N/Partial
There were governance structures and systems in place which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
<p>Explanation of any answers and additional evidence: Governance and performance management arrangements were proactively reviewed and reflected best practice. There was a GP assigned to support governance for the practice, who had a dedicated session each week to ensure pro-active governance.</p> <p>A clear set of key performance indicators (KPIs) were monitored weekly for The Willow Group by the business leadership team. This ensured the leadership team were able to closely observe and take appropriate action where necessary. The business unit (which included The Willow Group and community hospitals) monitored patient flow, routine appointment availability, patients with multiple appointments, cancellations or 'did not attends,' registered carers and veterans and Quality Outcome Framework (QOF).</p> <p>The practice had a framework of meetings in place to maintain good governance. The minutes were available to staff on the intranet. Examples of meetings included governance, practice, patient participation group (PPG), vulnerable families, gold standards framework on end of life care, nurse, operational management, pharmacy, multi-disciplinary and administrative. Staff told us they read minutes to keep up to date. We reviewed minutes of governance meetings which demonstrated that for example; complaints and concerns were discussed, and appropriate actions taken. Changes in policy and National Institute for Clinical Excellence (NICE) guidelines were discussed including audit schedules and reports.</p> <p>The intranet was also used to make regular announcements to staff, for example, changes in patient access, scam emails and sepsis awareness. Staff told us they appreciated being kept up to date and were able to apply the knowledge from the updates to their working practices.</p> <p>Staff were aware of their roles and responsibilities. The practice held quarterly target meetings which discussed scenarios and responses for staff to engage with. This provided further assurance for management that staff understood these.</p>	

Managing risks, issues and performance

There were effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems in place which were regularly reviewed and improved.	Y
There were processes in place to manage performance.	Y
There was a systematic programme of clinical and internal audit.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence: The practice identified and addressed risks in conjunction with its partner Southern Health. The practice risk register was part of Southern Health's risk register and they were monitored and managed as part of a joint governance process. Key risks identified were the difficulty in GP recruitment and the future plan to meet increasing patient needs.	

Appropriate and accurate information

There was a demonstrated commitment to using data and information proactively to drive and support decision making.

	Y/N/Partial
Staff used data to adjust and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Our inspection indicated that information was accurate, valid, reliable and timely.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
Explanation of any answers and additional evidence: The practice closely monitored and worked on improving Quality and Outcomes Framework (QoF) data, to support good outcomes for patients. The lead GP for QoF had a session each week dedicated for this purpose. For example, there had been a health campaign promoting cervical smears. This included noticeboards, social media discussion and text messages sent to patients.	

Engagement with patients, the public, staff and external partners

The practice involved the public, staff and external partners to sustain high quality and sustainable care.

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence: We saw evidence of engagement with a wide range of stakeholders. Patient engagement was valued. The practice used patient feedback cards to collate views and potential issues for action. In December 2018 the practice had written to all patients explaining the services they had developed such as the long-term conditions hub, telling patients what they had done to improve the service such as installing a new telephone system and explaining what they were doing to increase access to routine appointments. There was also a practice social media page which allowed private messaging for patient feedback. The long term conditions hub was located at Forton Medical Centre and ensured that all patients with multiple long term conditions were able to have all their needs met in one appointment. For example, on the same day they were able to have a diabetic review, a blood test, a blood pressure check and an electrocardiogram (ECG).	

Feedback from Patient Participation Group.

Feedback

During the inspection we spoke to the chair and three other members of the patient participation group (PPG). The practice engaged with the PPG over a decision to provide GP care across three sites and have a dedicated long-term condition hub at the fourth site. The practice held extraordinary general meetings with the PPG and an open day to gain patient understanding and feedback. The practice listened to patients and the PPG and worked with them to provide an outcome which benefitted both patients and the provider. These discussions were reported to have been facilitated in an open and transparent manner. Working across three locations instead of four, meant GPs were not spread out so thinly and were less likely to be lone working at any location. Patients were able to benefit from the long-term conditions hub providing a one stop shop for all their needs. The PPG held a mystery shopper event to ascertain impact from the new arrangements and fed back to the practice. This feedback was positively received and the practice considered further actions from the feedback.

The long-term conditions hub had been highlighted on local television as a good model of care. Footage showed positive feedback from patients about how their needs were met.

The PPG worked actively for the benefit of patients, petitioning patients to ensure the only bus route to serve one of the sites was retained.

Any additional evidence

A systematic approach was taken to working with other organisations to improve care outcomes, tackle health inequalities and obtain best value for money.

The practice engaged with community services such as local food bank. There were food collection points

at the four locations where staff could donate food. GPs in the practice were able to issue food vouchers to their patients to enable them to collect food from the food bank.

Patients received wider access to care through engagement with Southern Health. Patients under the care of community nurses provided by Southern Health who requested a home visit from the practice, were reviewed to see if the community nursing team could alternatively meet their needs. This avoided a duplication of care and two visits from two different teams.

Services worked collaboratively and in partnership to review and develop care plans to support patients with a swallowing difficulty. For example; the practice engaged with the Clinical Commissioning Group (CCG) and social services to review and address a swallowing difficulty issue identified by their care homes team

Rigorous and constructive challenge from people who use services, the public and stakeholders was welcomed. The practice listened to feedback from staff. Nursing staff had reported to the practice they often stayed later to complete incident forms which were time consuming and slow to upload. A new process was developed which involved governance staff uploading the data provided in paper format by nurses. This freed up clinical time for nurses but also supported clinical discussion. The practice engaged with staff and patients by sending round regular newsletters, holding coffee mornings and holding 'feedback Fridays' (a dedicated time for staff provide feedback and be listened to).

There was also consistent engagement with patients sending out regular newsletters. Patients received a letter explaining the new model of care developed by establishing the long-term condition hub. At Christmas staff were involved in singing a Christmas carol in Makaton (a form of signed communication) which was displayed on the website to wish patients a happy Christmas. This ensured some patients with communication needs were able to access the Christmas message and feel involved. Patient newsletters included a 'You said, we listened, we actioned' section informing patients how their feedback had been responded to and what changes had been made for example, installation of the new telephone system.

The practice engaged with patients using the long-term condition hub using a patient activation measure tool. This was a tool which required patients to complete a questionnaire indicating how motivated they were to engage in improving their long-term health. The practice then used the patient score to determine how to support the patient to improve their health.

Continuous improvement and innovation

There were evidence of systems and processes for learning, continuous improvement and innovation.

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence: The leadership team drove continuous improvement and staff were accountable for delivering change. Safe innovation was celebrated. There was a clear proactive approach to seeking out and embedding new and more sustainable models of care. The practice was located in an area of social deprivation and there was a history of challenge to recruiting GPs. In addition, the GP workforce nationally is declining with one in five GPs approaching retirement. To address these issues and promote sustainable future care for patients, a new model of care, called the consultant GP model, was being developed. This was expected to be operational in the	

next three to five months. Operational development days had been planned to ensure the whole operations team were involved in developing the new model. The aim was to base this around a ward model e.g. a consultant GP decision maker supported by a whole team of care providers This could include pharmacists, physiotherapists, CPNs or advanced nurse practitioners.

Examples of continuous learning and improvement

There were arrangements in place to support continuous improvement and learning, for example, through staff development. A structure programme of audits leading to improvements in outcome for patients.

The practice participated in a local initiative that took a holistic approach to the care of individuals. This led to a 22% reduction in hospital admissions.

Whilst developing new models of care, the practice continued to look to the future for new developments. The practice was part of a primary care network working with seven other local practices. A monthly meeting was held which included practice managers, local counsellors, PPG members and GPs to discuss new models of care based on a combined health and social care model. The was referred to as 'the engine room.'

As a result of a serious incident the practice undertook a review of wound care. This led to investigation training for two staff, revision of the documentation for wound care, staff training and improved governance. Since the new template and processes had been in place and followed by staff there had been no further serious incidents related to wound care.

A full cycle clinical audit program was in place to monitor and improve services provided and clinical care. This led to improvements in the care provided.

The practice had a research GP who had two sessions a week dedicated to research. They were undertaking research with the University of Southampton.

A structured programme of learning was in place to ensure skills and knowledge were up to date.

The practice had implemented a quality improvement program, which was monitored and updated and included target dates for completion. For example, the practice wanted to improve identification of patients who were also carers. They launched a social media campaign and sent patients text messages asking them to update their status. There was also a message on the patient check in screen asking patients (which we saw during inspection), when they checked in for an appointment, whether they were also a carer. It was noted that numbers of carers identified were increasing monthly. A quality improvement week was planned to look at care pathways, the function of the telephone hub and whether a patient could see a practitioner other than a GP.

The practice was acutely aware of patient feedback and social media campaigns regarding difficulty for patients in contacting the practice by telephone and in accessing routine appointments. There was a patient survey action plan which had been developed to address the concerns. The practice had engaged with a local member of parliament (MP) who agreed to visit the practice to understand the issues and how the practice was addressing them. The practice had invested in a new telephone system to improve telephone access. The new system advised patients where they were in the queue. There was also a reporting facility which allowed the practice to identify how many patients were in the queue and the longest wait time. This assisted the practice to identify peaks and troughs to plan resourcing of the telephony hub. Although the issue remained on the risk register for monitoring, patient, staff and PPG feedback demonstrated an improvement for most patients in accessing the practice via telephone.

Patient feedback in relation to the availability of routine appointments was also being addressed by the

practice. There were protected appointments available daily which could be given to patients who had been triaged and identified as needing an appointment that day. There were also protected appointments available which individual GPs could book for their patients if they required a follow up appointment with the same doctor to ensure consistency of care. Appointments could be booked up to four weeks in advance. These were released daily. Most were released at 9.30am and were mostly all booked by lunchtime. Following feedback from patients some were released at 4.30am allowing patients to book online before going to work. Appointments were also available within the practice with a pharmacist or advanced nurse practitioner, care navigators were trained to determine if patients' needs could be met with an appointment with clinicians other than GPs. Anyone who required an urgent same day appointment was always seen either through a GP appointment at one of the four sites or through the same day access service provided at a local community hospital. There was a long-term plan to address availability of appointments through the GP consultant model being developed. GPs had worked hard to ensure that care navigators offered a variety of appointments to patients to ensure their needs could be met. The practice continued to monitor concerns particularly in relation to telephone access and appointments and this demonstrated a peak in October 2018 which had reduced to just one or two by December 2018. Staff told us there was a huge reduction in complaints since the new telephone system had been installed.

The practice had quality assurance systems in place. A quality assessment tool was used monthly, checks were carried out on three clinicians, three administrative staff and three patients. Checks included, for example, 'Are fridge temperatures in line with policy and discrepancies addressed.' Staff were asked, for example, about how to report an incident and patients were asked if they had any worries about their care. Responses were recorded and actioned and where appropriate.

The senior management team held monthly meetings and kept a rolling action plan. This was reviewed and updated monthly and completed actions 'greyed out.' This helped to ensure the smooth operation of the practice

We saw that all actions identified at the last Care Quality Commission inspection had been appropriately addressed ensuring systems and processes were in place for continued improvement. For example, 'continue to identify patients who are also carers.' There were several actions in place to identify carers and these were ongoing meaning the numbers of carers identified was continually growing.

Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique we can be 95% confident that the practice's performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

The percentage of practices which show variation depends on the distribution of the data for each indicator, but is typically around 10-15% of practices. The practices which are not showing significant statistical variation are labelled as no statistical variation to other practices.

N.B. Not all indicators in the evidence table are part of the GP insight set and those that aren't will not have a variation band.

The following language is used for showing variation:

	Variation Band	Z-score threshold
1	Significant variation (positive)	$Z \leq -3$
2	Variation (positive)	$-3 < Z \leq -2$
3	No statistical variation	$-2 < Z < 2$
4	Variation (negative)	$2 \leq Z < 3$
5	Significant variation (negative)	$Z \geq 3$
6	No data	Null

Note: for the following indicators the variation bands are different:

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average.

It is important to note that z-scores are not a judgement in themselves, but will prompt further enquiry, as part of our ongoing monitoring of GP practices.

Guidance and Frequently Asked Questions on GP Insight can be found on the following link:
<http://www.cqc.org.uk/what-we-do/how-we-use-information/monitoring-gp-practices>

Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease
- **PHE:** Public Health England
- **QOF:** Quality and Outcomes Framework
- **RCP:** Royal College of Physicians.
- **STAR-PU:** Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.