Brockwell Medical Group

Quality Report

Brockwell Centre
Northumbrian Road
Northumberland
NE23 1XZ
Tel: 01670 737283
Website: www:brockwell.co.uk

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at the Brockwell Medical Group on 05 February 2016. Overall, the practice is rated as good.

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

- There was an open and transparent approach to safety and there was a good system for reporting and recording significant events. The staff team took the opportunity to learn from all internal incidents.
- The practice had a clear vision to deliver high quality care and promote good outcomes for their patients. The GP team was motivated and committed to exploring possibilities for providing better patient care. This included actively collaborating with their peers to develop new ways of delivering primary care, within their locality. Recent changes in leadership had resulted in action being taken to improve governance and the practice's Quality and Outcomes Framework (QOF) performance.
- Staff demonstrated a strong commitment to supporting patients to live healthier lives and were actively taking steps to achieve this.
- There was a lack of documentary evidence to demonstrate that the practice's staff recruitment procedures had been implemented effectively and that required pre- and post-employment checks, had been completed.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. They had the skills, knowledge and experience to deliver effective care and treatment.
- Staff had developed strong and effective working relationships with other healthcare colleagues, to ensure the needs of vulnerable patients, and patients with complex health conditions, were met.

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- Patients said they were treated with compassion, dignity and respect and that they were involved in decisions about their treatment. Information about the services provided by the practice and how to complain, was available and easy to understand.
- The main practice and the branch surgeries had good facilities and were well equipped to treat patients and meet their needs.

The area where the provider must make improvement is:

- Ensure that the required pre-employment and post-employment checks are carried out.

However, there were also areas where the provider should make improvements. The provider should:

- Use the local clinical commissioning group (CCG's) Safeguarding Incident Reporting Management System to report concerning incidents.
- Improve the practice's QOF performance.
- Continue to take steps to improve telephone access.
- Make sure all staff know how to access the practice's policies and procedures. Ensure all staff know and understand the practice's business continuity plan, and whistleblowing and medicines policies.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

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

There was an effective system for reporting and recording significant events. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. They were working with the local Clinical Commissioning Group to improve their use of the local incident reporting system. Lessons were learned when things went wrong and shared with staff to support improvement. There was an effective system for dealing with safety alerts and sharing these with staff. The practice had good safeguarding arrangements that helped to keep children and vulnerable adults safe. Individual risks to patients had been assessed and were well managed. The practice was clean and hygienic and, overall, there were good infection control arrangements in place. Good arrangements were also in place for making sure the premises were satisfactorily maintained and equipment was safe to use. Arrangements for making sure the required pre-employment and post-employment checks were carried out were not fully satisfactory.

Are services effective?

Good

The practice is rated as good for providing effective services.

Patients' needs were assessed and care was planned and delivered in line with current evidence based guidance. Clinical audits carried out by staff demonstrated their commitment to quality improvement. Staff worked effectively with other health and social care professionals, to help ensure the range and complexity of patients' needs were met. Staff had the skills, knowledge and experience to deliver effective care and treatment. Staff demonstrated a strong commitment to supporting patients to live healthier lives and were actively taking steps to achieve this. This included promoting good health and providing advice and support, to help them manage patients' health and wellbeing. Data from the Quality and Outcomes Framework (QOF) showed the practice's overall QOF performance was lower than the local clinical commissioning group (CCG) and England averages. However, recent changes in leadership had resulted in action being taken to improve the practice's Quality and Outcomes Framework (QOF) performance. The practice had been proactive in improving their referral rates.

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This included the GPs reviewing each other's referrals at a weekly meeting. As a consequence of this, the practice had moved from being one of the highest referrers to one of the lowest in the locality, within a period of three years.

Are services caring?

Good

The practice is rated as good for providing caring services.

Patients' emotional and social needs were seen as being as important as their physical needs. Data from the NHS National GP Patient Survey, published in January 2016, showed patient satisfaction with the quality of GP and nurse consultations was either above, or broadly in line with, the local CCG and national averages. For example: 94% of patients had confidence and trust in the last GP they saw, compared with the local CCG average of 96% and the national average of 95%; 98% of patients said they had confidence and trust in the last nurse they saw or spoke to, compared with the local CCG average of 99% and the national average of 97%. Patients told us they were treated with compassion, dignity and respect, and they felt well looked after. Information for patients about the range of services provided by the practice was available and easy to understand. Staff had made very good arrangements to help patients and their carers cope emotionally with their care and treatment.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

Services were planned and delivered to take into account the needs of different patient groups and to provide flexibility, choice and continuity of care. However, there were some groups of patients for whom reviews had not been held because of difficulties practice staff had experienced obtaining information from the secondary care teams overseeing their care and treatment. However, recent changes in leadership had resulted in action being taken to improve the practice's Quality and Outcomes Framework (QOF) performance. A range of services were offered by staff, and staff were actively taking steps to further improve the care and treatment they provided to patients with long-term conditions. The practice worked closely with local health and social care professionals, and with their peers, to plan how services were provided, to ensure they met patients' needs and offered flexibility, choice and continuity of care.

The practice had introduced a new appointment system in response to patients' concerns about access to same-day appointments. Staff had also worked hard to address any issues that arose as the new appointment system bedded in. The new system made it easier for

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patients to access same-day appointments and advice. Patients were able to book GP appointments on-line. However, results from the NHS GP Patient Survey, published in January 2016, showed levels of patient satisfaction with appointments varied.

The main practice and the branch surgeries provided suitable facilities and they were appropriately equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand.

Are services well-led?

Good

The practice is rated as good for providing well led services.

The practice had a clear vision to deliver high quality care and promote good outcomes for their patients. Staff had devised an overarching mission statement which set out what they wanted to achieve and how they would do this. The GP team was motivated and committed to exploring possibilities for providing better patient care. Clinical staff we spoke to were aware of the developmental work the practice was leading on and were proud to work for the practice.

Overall, the arrangements for governance and performance management were effective. There was evidence of good governance arrangements, for example, in relation to the management of infection control and the holding of regular meetings to share information to manage patient risk. However, we identified that the governance arrangements for monitoring and meeting the QOF performance targets could be more rigorous. But, the new practice management team was actively addressing this, and there was evidence of improvement in the 2015/16 QOF year.

There was a clear leadership structure and staff felt very well supported by the GPs and the practice manager. Regular clinical management, nursing and multi-disciplinary team meetings took place, which helped to ensure patients received highly effective and safe clinical care. The practice actively sought feedback from patients via their Friends and Family Test survey and their patient participation group. They had used this to make significant changes to how their appointment system operated, which meant patients now had access to same-day care.

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The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Good

The practice is rated as good for the care of older people.

Nationally reported Quality and Outcomes Framework (QOF) data, for 2014/15, showed the practice had performed well in relation to providing care and treatment for the clinical conditions commonly associated with this population group. For example, the practice had obtained 100% of the total points available to them, for providing care and treatment to patients who had heart failure. This was 1.1% above the local clinical commissioning group (CCG) average and 2.1% above the England average. The practice offered proactive, personalised care which met the needs of the older patients. For example, all patients over 75 years of age had a named GP who was responsible for their care. The practice held weekly GP clinics at local care homes. These clinics offered regular opportunities for medication reviews, the assessment of acute problems as they arose, and the continued monitoring of older patients with long-term conditions. The adoption of the local high-risk patient pathway had resulted in care plans being put in place to meet the needs of frail and vulnerable older patients. Annual nurse-led clinics for influenza, shingles and pneumococcal vaccinations were provided, to help promote access to this service.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions.

Overall, there were good arrangements in place for providing patients with common long-term conditions with an annual review, so their needs could be assessed, and appropriate care and advice given about how to manage their health. Staff were in the process of setting up a nurse-led model of providing care and support to patients with long-term conditions. Clinical staff were very good at working with other professionals to deliver a multi-disciplinary package of care to patients with complex needs.

Nationally reported QOF data, for 2014/15, showed the practice had performed well in relation to providing recommended care and treatment for the majority of conditions commonly associated with this population group. For example, the practice had obtained 100% of the total points available to them, for providing care and treatment to patients who had been diagnosed with asthma. This was 0.7% above the local CCG average and 2.6% above the England average.

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However, there were also a small number of clinical indicators where the practice's performance fell below the local CCG and England averages. The practice's new management team had introduced measures to improve their QOF performance. This included, for example, the introduction of meetings, to identify and address shortfalls in the recording of QOF data.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people.

There were good systems in place to protect children who were at risk and living in disadvantaged circumstances. For example, the practice maintained a register of vulnerable children and contacted families where a child had failed to attend a planned appointment. Appointments were available outside of school hours and the practice's premises were suitable for children and babies. The practice offered contraceptive and sexual health advice. The practice offered a full range of immunisations for children. Publicly available information showed they had performed very well in delivering childhood immunisations. For example, most of the immunisation rates were above 90%, and one immunisation rate was 100%. Nationally reported data also showed the practice had performed very well in the delivery of their cervical screening programme, with an uptake of 83.91% in comparison with the national average of 81.83%.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students).

The practice had put flexible arrangements in place to meet the needs of working age patients. For example, early morning and late appointments were offered as part of the Doctor First appointment system that had recently been introduced. (Doctor First is a demand led system where patients contacting a practice are assessed by a doctor on a clinical priority basis, and then given an appointment where this is judged appropriate.) One of the GPs ran a clinic which enabled women to access long-acting reversible contraception. Plans were underway to introduce a nurse-led family planning clinic to enable women to book in advance for pill checks and contraceptive injections. An open access family clinic operated at one of the branch surgeries, and could be accessed by patients from other practices. The practice was proactive in offering online services, such as for booking routine appointments and ordering repeat prescriptions. Staff provided a full range of health promotion and screening that reflected the needs of this group of patients.

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People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

There were good arrangements for meeting the needs of vulnerable patients. For example, steps were being taken to reduce unplanned emergency admissions into hospital. Staff had developed a high risk patient register, which they were actively using to provide personalised care planning. Patients admitted into hospital following an emergency had their care plans reviewed by practice staff after being discharged. The needs of vulnerable patients, including those with end-of-life needs, and those who had had contact with the local out-of-hours service during the preceding month, were discussed at monthly multi-disciplinary meetings. The practice maintained a register of patients with learning disabilities which they used to ensure they received an annual healthcare review. Extended appointments were offered to enable this to happen. Systems were in place to protect vulnerable children from harm. Staff understood their responsibilities regarding information sharing and the documentation of safeguarding concerns. Arrangements had been made to meet the needs of patients who were also carers.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).

Patients with mental health needs were provided with advice about how to access various support groups and voluntary organisations. Information included on the practice's website also provided good information about how to access 'talking therapies'. Nationally reported QOF data, for 2014/15, showed the practice had performed less well with regards to providing recommended care and treatment to this group of patients. The practice had obtained 72% of the total points available to them for providing recommended care and treatment to patients with mental health needs. This was 24.5% below the local CCG average and 20.8% below the England average. The practice's new management team had introduced measures to improve their QOF performance. This included, for example, the introduction of meetings, to identify and address shortfalls in the recording of QOF data.

There were good arrangements for meeting the needs of patients who had dementia. Nationally reported QOF data, for 2014/15, showed the practice had performed well in obtaining 100% of the total points available to them, for providing recommended care and treatment to this group of patients. This was above the local CCG average, by 0.9%, and above the England average, by 5.5%. Staff

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kept a register of patients who had dementia, and the practice's clinical IT system clearly identified them to help make sure clinical staff were aware of their specific needs. Clinical staff actively carried out opportunistic dementia screening during long-term conditions clinics, to help ensure their patients were receiving the care and support they needed to stay healthy and safe. GP-led clinics were carried out at local care homes for patients with mental health needs to help make sure they received proactive care and treatment. All staff had attended Dementia Awareness training to help them understand the needs of these patients, and this had resulted in staff taking steps to improve access for such patients.

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What people who use the service say

Feedback from patients was positive about the way staff treated them. We spoke with three patients from the practice's patient participation group. They told us they were treated with compassion, dignity and respect, and felt well looked after. As part of our inspection we asked practice staff to invite patients to complete Care Quality Commission (CQC) comment cards. We received 2 completed comment cards and these contained very positive feedback about the standard of care and treatment provided. Words used to describe the service included: absolutely excellent; extremely professional and helpful; extremely happy with the GP service.

Data from the NHS National GP Patient Survey of the practice, published in January 2016, showed patient satisfaction with the quality of GP and nurse consultations was either above, or broadly in line with, the local Clinical Commissioning Group (CCG) and national averages. However, data from the survey also indicated lower levels of patient satisfaction with telephone access to the practice and access to appointments. For example, of the patients who responded to the survey:

- 94% had confidence and trust in the last GP they saw, compared with the local CCG average of 96% and the national average of 95%.
- 88% said the last GP they saw or spoke with was good at listening to them, compared with the local CCG average of 91% and the national average of 89%.
- 93% said the last nurse they saw or spoke to was good at treating them with care and concern. This was in line with the local CCG average and above the national average of 91%.
- 98% said they had confidence and trust in the last nurse they saw or spoke to, compared with the local CCG average of 99% and the national average of 97%.
- 80% found the receptionists at this surgery helpful, compared with the local CCG average of 89% and the national average of 87%.
- 77% were able to get an appointment to see or speak to someone the last time they tried, compared with the local CCG average of 86% and the national average of 85%.
- 62% who had a preferred GP said they usually got to see or speak to that GP, compared with the local CCG average of 65% and the national average of 59%.
- 62% said they found it easy to get through to this surgery by phone, compared with the local CCG average of 78% and the national average of 73%.

(262 surveys were sent out. There were 122 responses and a response rate of 47%. This equates to 0.7% of the total practice population.)

Areas for improvement

Action the service MUST take to improve

- Ensure that the required pre-employment and post-employment checks are carried out.

Action the service SHOULD take to improve

- Use the local clinical commissioning group (CCG's) Safeguarding Incident Reporting Management System to report concerning incidents.
- Improve the practice's QOF performance.
- Continue to take steps to improve telephone access.
- Make sure all staff know how to access the practice's policies and procedures. Ensure all staff know and understand the practice's business continuity plan, and whistleblowing and medicines policies.

Brockwell Medical Group

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, a practice nurse and a specialist advisor with experience of practice management.

Background to Brockwell Medical Group

Brockwell Medical Group provides care and treatment to 17,045 patients of all ages, based on a Personal Medical Services (PMS) contract. The practice is part of the NHS Northumberland clinical commissioning group (CCG) and provides care and treatment to patients living in Cramlington, Seaton Delaval and Seaton Sluice. The practice serves an area where deprivation is lower than the England average. The practice population includes fewer patients who are under 18 years of age, and over 65 years of age, than the England averages. The practice has a low proportion of patients who are from ethnic minority groups. We visited the following locations as part of inspection:

The Brockwell Surgery, Brockwell Centre, Northumbria Road, Cramlington, NE23 1XF.

The Seaton Terrace Surgery, Westbourne Terrace, Whitley Bay, NE25 0BE.

The Seaton Sluice Surgery, Collywell Bay Road, Seaton Sluice, Whitley Bay, NE26 4QZ.

The main practice and both branch surgeries are located in purpose built health centres and provide access to treatment and consultation rooms that provide disabled access. The practice had nine GP partners (six male and three female), six salaried GPs (four female and two male), five nurses (female), two healthcare assistants (female) and a large team of administrative and reception staff. Practice management responsibilities were being shared between a GP managing partner and a senior member of the administrative team.

Opening hours for the main practice and branch surgeries, and appointment times, were as follows:

The Brockwell surgery:

Monday and Thursday between 8am and 8pm. The practice is closed on Mondays between 1pm and 2pm. (Appointment times start at 8am and finish at 7:50pm.)

Tuesday, Wednesday and Friday between 8am and 6pm. (Appointment times start at 8am and finish at 5:50pm.)

The Seaton Terrace branch surgery:

Monday to Friday between 8:30am and 6pm. The practice is closed on Mondays between 12:45 and 2:15pm. (Appointment times start at 8.30am and finish at 5:50pm.)

The Seaton Sluice branch surgery:

Monday between 8:30am and 12:45pm, and between 2:15pm and 6pm. (Appointment times start at 8:30am and finish at 5:50pm.)

Tuesday to Friday between 8:30am and 1pm, and between 2pm and 6pm. (Appointment times start at 8:30am and finish at 5:50pm.)

When the practice is closed patients can access out-of-hours care via the Northern Doctors Urgent Care Limited On-Call service, and the NHS 111 service.

Detailed findings

Why we carried out this inspection

We inspected this service as part of our 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. This 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.

How we carried out this inspection

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 5 February 2016. During our visit:

- We spoke with a number of staff, including two GPs, the managing GP partner, the operation services manager, a practice nurse, the pharmacist attached to the practice, and staff working in the administrative and reception team.
- We observed how patients were being cared for and reviewed a sample of the records kept by staff.
- We reviewed two Care Quality Commission (CQC) comment cards in which patients shared their views and experiences of the service.
- We spoke with three patients from the practice's patient participation group.

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 are provided for specific groups of people and what good care looks like for them. The population groups are:

- Older people.
- People with long-term conditions.
- Families, children and young people.
- Working age people (including those recently retired and students.)
- People whose circumstances may make them vulnerable.
- People experiencing poor mental health (including people with dementia.)

Requires improvement

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events. Designated lead staff were responsible for making sure the incident reporting system worked satisfactorily, including arranging for items to go on the agenda for discussion and updating the practice's incidents register. All incidents were reviewed and discussed at the practice's monthly team meetings. In 2015, one of the GP partners had carried out a detailed analysis of the strengths and weaknesses of the practice's significant event reporting system using a standardised toolkit. The audit had identified areas for improvement. These had been discussed with staff during practice meetings, and actions for improvement had been agreed.

Staff had identified and reported on nine significant events during the previous 12 months. These reports provided details of what had happened, what staff had done in response and what had been learnt as a consequence. Copies of significant event reports could be accessed by all staff on the practice's intranet system. The sample of records we looked at, and evidence obtained from interviews with staff, showed the practice had managed such events consistently and appropriately. Learning had also been disseminated via staff meetings.

At the time of our visit, the practice was not actively using the local Clinical Commissioning Group's (CCG) Safeguarding Incident and Risk Management System (SIRMS) to report incidents. Staff were due to meet with the local CCG to explore how they could improve their reporting rate. (The SIRMs system enables GPs to flag up any issues via their surgery computer to a central monitoring system, so that the local CCG can identify any trends and issues for improvement across its whole area. This allows the CCG to see a wide view across its constituent practices which it can learn from and then share this learning with them.)

The practice had a satisfactory system for responding to safety alerts. All alerts received by the practice, including those covering medicines, were forwarded to the practice management team, so they could make sure appropriate action was taken in response. All staff we spoke with were aware of the system for handling safety alerts. We were told relevant safety alerts were discussed at monthly practice meetings, as well as the monthly half-day educational sessions, to help ensure staff were clear about what action had been taken.

Overview of safety systems and processes

The practice had a range of systems and processes in place which helped keep patients and staff safe and free from harm. However, it was difficult to confirm that the practice's recruitment checks kept patients safe.

The inspection team found it difficult to confirm that all of the required pre-employment and post-employment checks had been carried out. The new practice management team had identified gaps in their staff recruitment information, and were reviewing their processes for making sure that post-employment checks took place on a regular basis. We looked at four staff files and found they included details of their previous employment. A Disclosure and Barring Service (DBS) check had been carried out for the GP whose file we checked, as part of their inclusion on the Medical Performer's List. However, there was no documentary evidence that a DBS check had been carried out for two of the other clinical staff whose files we looked at. The practice management team assured us that a DBS check had been completed for both staff. We were also unable to find documentary evidence that the identity of each member of staff had been checked, although they had all been subject to an identity check before being issued with an NHS SMART card. Also, there was no documentary evidence confirming that the qualifications of two of the clinical staff had been checked. We were able to confirm that all three clinical staff were registered with their professional body, and there was documentary evidence that the practice had carried out regular checks to confirm the continuing registration of their GP staff. However, there was evidence that this had been also been carried out for the nursing staff. Appropriate indemnity cover was in place for all clinical staff.

The practice had policies and procedures for safeguarding children and vulnerable adults. The managing GP partner acted as the children and vulnerable adults safeguarding lead, providing advice and guidance to their colleagues when needed. Staff demonstrated they understood their safeguarding responsibilities and all had received safeguarding training relevant to their role. For example, all of the GPs had completed Level 3 child protection training.

Requires improvement

Are services safe?

At-risk children and high-risk patients were clearly identified on the practice's clinical IT system, to ensure clinical staff could take this into account during consultations.

The practice's chaperone arrangements helped to protect patients from harm. All the staff who acted as chaperones were trained for the role and had undergone a Disclosure and Barring Service (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 chaperone service was advertised on posters displayed in the practice.

There were good procedures and processes for monitoring and managing risks to patient and staff safety. For example, the practice had arranged for all clinical equipment to be regularly serviced and calibrated, to ensure it was safe and in good working order. We saw evidence other safety checks had been carried out, including checks of the fire alarms, emergency lighting and electrical equipment.

Appropriate standards of cleanliness and hygiene were being maintained at the main practice and the branch surgeries. Staff told us they were in the process of replacing fabric chairs with ones that were washable. However, we found that the floor covering in some areas of the main practice, for example, in the patient waiting area, was showing signs of wear and tear. The managing GP partner told that us that since a decision had now been made not to relocate to another site, steps would be taken to replace carpeted areas with a floor covering that was easier to keep clean.

The practice had a designated infection prevention and control lead, who had completed additional training to help them carry out this role effectively. There were infection prevention and control protocols in place and these were up-to-date. The practice had produced an infection prevention and control annual statement in which they had described their arrangements for protecting patients and staff from harm, including details of recent improvements. For example, a cleaning schedule had been introduced that included twice daily cleaning of the patient check-in screens, at all three locations. All staff had received infection prevention and control training, including 'antibiotic awareness' training for clinical staff delivered by the practice's prescribing lead. An infection prevention and control audit had been carried out in 2015 to help promote good infection control practices.

Overall, the arrangements for managing medicines, including emergency drugs and vaccines, kept patients safe. Blank prescription pads were securely stored to reduce the risk of misuse or theft, and national guidance regarding prescription security was being followed. There was a good system for monitoring repeat prescriptions. Where staff identified that the authorised number of prescriptions had been exceeded, arrangements were in place to make sure that a medicines review took place. The arrangements for overseeing the management of controlled drugs (CDs) had been reviewed, following a recent failure to follow the practice's policy on the disposal of out-of-date CDs. Staff had treated the failure as a significant event, and lessons had been learnt about how to prevent it from happening again. We saw that the out-of-date CDs stock had been properly disposed of and, we found the CDs stored at the practice matched the stock balance entry in the CD register.

Vaccines were stored satisfactorily. Arrangements had been made to monitor the temperatures of the refrigerators used to store vaccines. These included carrying out daily temperature checks and completing temperature logs. However, on one occasion, we saw that a member of staff had recorded that the temperature of one of the vaccine refrigerators had been found to be outside of the range recommended by the vaccine manufacturer (i.e. between +2°C and +8°C). Although staff had recorded a potential reason for this discrepancy on the temperature log sheet we looked at, the practice's guidance regarding monitoring and recording refrigerator temperatures had not been fully implemented on this occasion.

There were suitable arrangements for planning and monitoring the number and mix of staff required to meet patients' needs. Non-clinical staff had been trained to carry out all reception and administrative roles, to help ensure the smooth running of the practice. A designated member of staff held lead responsibilities for making sure that the GP and nurse rotas were kept up-to-date. Locum GP staff were used from time to time to cover shortfalls in the GP rota. An additional GP had recently been recruited, to help ensure the effective implementation of the new Doctor First

appointment system. Nursing staff told us staffing levels were usually sufficient; however, the GP partners were considering employing a locum nurse to cover for staff sickness.

Arrangements to deal with emergencies and major incidents

The practice had made arrangements to deal with emergencies and major incidents. For example, there was an instant messaging system on the computers in all the consultation and treatment rooms, which alerted staff to any emergency. All staff had completed basic life support training. Emergency medicines were available in both the main practice and the branch surgeries, and there was an agreed system for checking these. In the main practice, we found these were kept in a secure area, and staff knew of their location. All of the emergency medicines we checked were within their expiry dates. Staff also had access to defibrillators and oxygen for use in an emergency.

The practice had a business continuity plan for major incidents, such as power failure or building damage. This was accessible to all staff via the practice's intranet system. A copy of the plan was also kept off site by key individuals. A non-clinical member of staff told us they knew what to do in the event of an emergency, but also said they were not sure what was covered in the practice's business continuity plan. A GP partner we spoke with was also unclear about how a major disruption at the practice would be handled.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Staff carried out assessments and treatment in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice had systems in place to keep all clinical staff up-to-date with new guidelines. For example, monthly education sessions had recently been introduced, to provide GPs with the time they needed to keep up-to-date with current guidance and standards.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF), and their performance against national screening programmes, to monitor and improve outcomes for patients. (QOF is intended to improve the quality of general practice and reward good practice).

The QOF data, for 2014/15, showed the practice had obtained 91.9% of the total points available to them for providing recommended care and treatment covered by the scheme. This achievement was 5.7% below the local CCG average and 2.8% below the England average. The practice had an exception reporting rate of 5.7%. This was 3.6% below the local CCG average and 3.5% below the national average. (The QOF scheme includes the concept of 'exception reporting' to ensure that practices are not penalised where, for example, patients do not attend for review, or where a medication cannot be prescribed due to a contraindication or side-effect). The practice had performed well in relation to the majority of the QOF indicators. Examples of good performance included the practice obtaining:

- 100% of the total points available to them, for providing recommended clinical care to patients who had cancer. This was 0.2% above the local CCG average and 2.1% above the England average.
- 100% of the total points available to them, for providing recommended clinical care to patients who had asthma. This was 0.7% above the local CCG average and 2.6% above the England average.
- 100% of the total points available to them for providing recommended clinical care to patients diagnosed with heart failure. This was 1.1% above the local CCG average and 2.1% above the England average.

However, the QOF data also showed there were some clinical and public health indicators where the practice had not performed as well as the local CCG and England averages. For example, the QOF data showed that only 25.6% of patients with rheumatoid arthritis (RA) had received a face-to-face annual review during the preceding 12 months. This was 53.9% below the local CCG average and 58.7% below the England average. A member of the practice management team told us clinical staff had only carried out annual reviews after receiving confirmation, from the hospital teams overseeing each patient's care, that the patient had had the appropriate blood tests and a medicine review. We were told that for some patients it had proved difficult to obtain this information. Because of this, a decision had been made not to update the QOF database until the relevant information had been received for each patient on the practice's RA register. This had affected the performance of the practice in relation to the relevant QOF indicators. However, the QOF data for 2015/16 showed that progress had been made and that, at the time of our visit, 65% of patients on the RA register had had an annual review.

The data also showed the practice had only obtained 72% of the total points available to them for providing recommended care and treatment to patients with mental health needs. This was 24.5% below the local CCG average and 20.8% below the England average. The data also showed that only 12.5% of patients with the clinical conditions specified in the QOF had a documented care plan that had been agreed with their carers in the preceding 12 months. This was 61.8% below the local CCG average and 64.7% below the England average. We discussed the practice's QOF performance for this clinical indicator with them. The operations services manager told us there were 120 patients on the practice's mental health register, and 68% of these met the criteria to be included in the QOF care programme category. They said that, whilst many of the required health care checks for this group of patients had been completed, the GP partners had decided not to update the QOF system until they had received a copy of each person's 'Care Programme' care plan, from the hospital team overseeing their care. We were told the practice had experienced considerable delays in obtaining

copies of these care plans and this had directly impacted on the practice's performance in meeting the QOF mental health indicator. They said that because of this, the practice had recently decided to review and change their approach to meeting the mental health QOF targets.

The practice's new management team had introduced a range of measures to improve their QOF performance. This included the introduction of clinical team meetings, to identify and address shortfalls in the recording of QOF data and to look at potential discrepancies in the way that individual doctors interpreted QOF data sub-groups.

Staff carried out clinical audits to help improve patient outcomes. For example, following receipt of a complaint, the practice had carried out a two cycle audit in relation to the long-term overprescribing of steroid creams to a patient. As a result of this audit, arrangements had been made to ensure patients identified as being at risk of over-using this type of medicine, received a letter suspending their prescription and advising them of the practice's concerns. The practice had also introduced a new interval review template to help support clinical staff in following national guidelines and best practice regarding the prescribing of this medicine. In addition, arrangements had been made to provide patients who were starting to use steroid creams with relevant information produced by the Eczema Society. This audit was clearly linked to an area where staff had reviewed the practice's performance and concluded that improvements could be made. The audit also identified relevant learning points and demonstrated changes had been made to practice.

The practice had also carried out a clinical audit to check whether patients diagnosed with irritable bowel syndrome were receiving care and treatment in line with NICE guidance. The initial audit clearly identified learning points and changes to practice which included providing relevant information to patients and, where appropriate, involving a GP in deciding whether a referral to a dietician would be beneficial. Staff had also carried out a second audit to assess the impact of the changes that had been introduced as a consequence of the initial audit.

Staff had also carried out quality improvement audits and reviews of practice, to help ensure patients had good health outcomes and received safe care. These covered a range of areas, such as the practice's significant event reporting process, their infection prevention and control arrangements and the quality and appropriateness of GP referrals to secondary care services. Staff told us the practice had once been a high referring practice and the GP partners had taken action to address this. This included reviewing each other's referrals at a weekly referral meeting. As a consequence of this, the practice had moved from being one of the highest referrers to one of the lowest in the locality, within a period of three years.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment. They had received the training they needed to carry out their roles and responsibilities. This included training on safeguarding vulnerable patients, basic life support and infection prevention and control. Nursing staff had completed additional training to help them meet the needs of patients with long-term conditions, including, for example, training in travel and child immunisations, cervical screening and spirometry (a test that can help diagnose various lung conditions). Staff made use of e-learning training modules and in-house training, to ensure they kept up-to-date with their mandatory training. Staff had received an annual appraisal of their performance and the GPs received support to undergo revalidation with the General Medical Council.

Coordinating patient care and information sharing

The practice's patient clinical record and intranet systems helped to make sure staff had the information they needed to plan and deliver care and treatment. The information included patients' medical records and test results. Staff shared NHS patient information leaflets, and other forms of guidance, with patients, to help them manage their long-term conditions. All relevant information was shared with other services, such as hospitals, in a timely way. Important information about the needs of vulnerable patients was shared with the out-of-hours and emergency services. Staff worked well together, and with other health and social care professionals, to meet the range and complexity of patients' needs and to assess and plan on-going care and treatment. Community nursing staff reported effective relationships with the practice's clinical team, and in particular commented on their commitment to working with them, to deliver a co-ordinated approach to supporting high risk patients.

Consent to care and treatment

Good

Are services effective?

(for example, treatment is effective)

Patients' consent to care and treatment was sought in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements of the legislation and guidance, including the Mental Capacity Act (2005). When staff provided care and treatment to young people, or adult patients whose mental capacity to consent was unclear, they carried out appropriate assessments of their capacity and recorded the outcome.

Supporting patients to live healthier lives

Staff were committed to supporting patients to live healthier lives through a targeted and proactive approach to health promotion. Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people aged between 40 and 74 years. There were suitable arrangements for making sure a clinician followed up any abnormalities or risks identified during these checks.

The practice had a comprehensive screening programme. The QOF data showed they had performed well by obtaining 100% of the overall points available to them, for providing cervical screening services. This was 0.6% above the local CCG average and 2.4% above the England average. The uptake of cervical screening was higher, at 82.5%, than the national average of 81.83%. The practice also had protocols for the management of cervical screening, and for informing women of the results of these tests. These protocols were in line with national guidance. However, the practice had performed less well by obtaining only 57.1% of the overall points available to them, for providing contraceptive services to women in 2014/15. This was 41% below the local CCG average and 39% below the England average.

Patients were also supported to stop smoking. The QOF data showed the practice had performed well by obtaining 93.1% of the overall points available to them, for helping patients to stop smoking. The QOF data showed that, of those patients aged over 15 years who smoked, 92.2% had been offered support and treatment during the preceding 24 months. This was 1% just below the local CCG average and 1% below the England average. The data confirmed the practice had supported patients to stop smoking using a strategy that included the provision of suitable information and appropriate therapy.

The practice offered a full range of immunisations for children. Publicly available information showed they had performed very well in delivering childhood immunisations. For example, most of the immunisation rates were above 90%, and the rate for immunisation was 100%.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Throughout the inspection staff were courteous and helpful to patients who attended the practice or contacted it by telephone. We saw that patients were treated with dignity and respect. Privacy screens were provided in consulting rooms so that patients' privacy and dignity could be maintained during examinations and treatments. Consultation and treatment room doors were closed during consultations so that conversations could not be overheard. Reception staff said that a private space would be found if patients needed to discuss a confidential matter.

Feedback from patients was positive about the way staff treated them. We spoke with three patients from the practice's patient participation group. They told us they were treated with compassion, dignity and respect, and felt well looked after. As part of our inspection we asked practice staff to invite patients to complete Care Quality Commission (CQC) comment cards. We received 2 completed comment cards and these contained very positive feedback about the standard of care and treatment provided. Words used to describe the service included: Absolutely excellent; extremely professional and helpful; extremely happy with the GP service.

Data from the NHS National GP Patient Survey of the practice, published in January 2016, showed patient satisfaction with the quality of GP and nurse consultations was broadly in line with the local clinical commissioning group (CCG) and national averages. For example, of the patients who responded to the survey:

- 94% had confidence and trust in the last GP they saw, compared with the local CCG average of 96% and the national average of 95%.
- 98% said they had confidence and trust in the last nurse they saw or spoke to, compared with the local CCG average of 99% and the national average of 97%.
- 88% said the last GP they saw was good at listening to them, compared with the local CCG average of 91% and the national average of 89%.
- 88% said the last nurse they saw or spoke to was good at listening to them, compared with the local CCG average of 94% and the national average of 91%.
- 93% said the last nurse they saw or spoke to gave them enough time, compared with the local CCG average of 95% and the national average of 92%.
- 81% said the last GP they saw or spoke to gave them enough time, compared with the local CCG average of 89% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients we spoke with told us clinical staff gave them enough time to explain why they were visiting the practice, and involved them in decisions about their care and treatment. Results from the NHS GP Patient Survey of the practice showed the majority of patient satisfaction levels regarding involvement in decision-making were broadly in line with the local CCG and national averages. Of the patients who responded to the survey:

- 85% said the last GP they saw was good at explaining tests and treatments, compared to the local CCG average of 90% and the national average of 86%.
- 79% said the last GP they saw was good at involving them in decisions about their care, compared to the local CCG average of 86% and the national average of 82%.
- 91% said the last nurse they saw was good at explaining tests and treatments, compared with the local CCG average of 92% and the national average of 90%.
- 85% said the last nurse they saw was good at involving them in decisions about their care. This was broadly in line with the national average, but below the local CCG average of 88%.

Patient and carer support to cope emotionally with care and treatment

Staff were good at helping patients and their carers to cope emotionally with their care and treatment. They understood patients' social needs, supported them to manage their own health and care, and helped them maintain their independence. Notices on display in the patient waiting room told patients how to access a range of support groups and organisations. The practice was committed to supporting patients who were also carers. There were 413 patients who were also carers registered with the practice, which equated to 3.42% of the total patient population. Staff said they used this information to

Good

Are services caring?

help target services at this group of patients. The practice's IT system alerted clinical staff a patient was also a carer, so this could be taken into account when planning their care and treatment. Written information was available for carers to ensure they understood the various avenues of support available to them.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Services were planned and delivered to take into account the needs of different patient groups and to provide flexibility, choice and continuity of care. Examples of the practice being responsive to and meeting patients' needs included:

- Providing all patients over 75 years of age with a named GP who was responsible for their care. The practice held weekly GP clinics at four local care homes. These clinics provided opportunities for medicine reviews, the monitoring of patients with long-term conditions and the prompt assessment of acute health problems. Clinical staff gave us examples of how the clinics had improved the care and treatment patients living in the homes received. Clinical staff had adopted the local high-risk patient pathway, to help improve the care and treatment they provided to their frail and vulnerable older patients. This had resulted in care plans being put in place to meet their needs. Also, annual, nurse-led clinics for influenza, shingles and pneumococcal vaccinations were provided to help promote access to this service.
- Good systems for reducing unplanned, emergency admissions into hospital. For example, staff had developed a high risk patient register, which they were actively using to provide personalised care planning. Patients admitted into hospital, following an emergency. had their care plans reviewed by clinical staff after being discharged. The needs of vulnerable patients, including those with end-of-life needs and those who had had contact with the local out-of-hours service during the preceding month, were discussed at monthly multi-disciplinary meetings to help identify those most at risk. Staff had developed good links with the local community nursing service and the MacMillan nurses.
- The provision of an annual review for patients with common long-term conditions, so their needs could be assessed, and appropriate care and advice given about how to manage their health. Staff told us that a large proportion of the patients on their long-term conditions (LTCs) registers had multiple diseases, and complex health needs. At the time of our inspection, nursing staff were using the Year of Care (YoC) approach to working with diabetic patients. (The YoC model supports patients to self-manage and uses proactive care planning as a central component in achieving this.) Other patients with LTCs were currently being managed via specific disease clinics. Staff were actively taking steps to change to a holistic nurse-led model of providing care and support to patients with LTCs. We were told this would, in future, result in this group of patients receiving two appointments each year, one with a healthcare assistant and a second with a practice nurse, regardless of the number of health concerns they had. Nursing staff were being given additional training to enable them to take on this new role. Retinal screening was provided for patients with diabetes and an anticoagulant monitoring service was provided. This enabled patients to access the treatment they required without the need to attend hospital clinics. Staff had arranged for a physiotherapy service to be provided at the practice twice a week. Clinicians were able to make direct referrals to this service, which made it easier for patients to access this support.
- Good arrangements for meeting the needs of patients who had dementia. Nationally reported QOF data, for 2014/15, showed the practice had performed well in obtaining 100% of the total points available to them, for providing recommended care and treatment to this group of patients. Staff kept a register of patients who had dementia, and the practice's clinical IT system clearly identified them to help make sure clinical staff were aware of their specific needs. Clinical staff actively carried out opportunistic dementia screening, during long-term conditions clinics, to help ensure their patients were receiving the care and support they needed to stay healthy and safe. GP-led clinics were held at local care homes accommodating patients with mental health needs, to help make sure they received proactive care and treatment.
- Giving patients with mental health needs advice about how to access various support groups and voluntary organisations. The practice's website also included information about how to access 'talking therapies'. Staff told us these patients received a written invitation to attend for an annual review. This was followed by a

Good

Are services responsive to people's needs?

(for example, to feedback?)

further two letters if no response was received. If patients still failed to respond to these invitations, staff telephoned them to try to engage them in the review process.

- Providing patients with learning disabilities with access to an extended annual review, to help make sure they received the healthcare support they needed. The QOF data, for 2014/15, showed the practice had obtained 100% of the points available to them, for providing recommended care and treatment to patients who had learning disabilities. This achievement was in line with the local CCG average and 0.2% above the England average.
- Making reasonable adjustments to help patients with disabilities, and those whose first language was not English, to access the practice. For example, disabled toilets had appropriate aids and adaptations. Automatic doors made it easier for patients with mobility issues to gain access. Disabled parking was also provided.
- Making good arrangements to meet the needs of children, families and younger patients. There were systems to identify and follow up children who were at risk. For example, the practice maintained a register of vulnerable children and contacted families where a child had failed to attend a planned appointment. The practice had a named safeguarding lead who attended the monthly safeguarding meetings held at the main site. Appointments were available outside of school hours and at the main practice. Six-weekly post-natal checks were provided and a weekly breastfeeding support drop-in session took place at the main practice. Clinical staff contacted new mothers diagnosed with postpartum depression ten days after giving birth, to check their health and wellbeing. Evening and weekend influenza clinics had been introduced to help working parents to bring their children in for vaccinations. Staff told us they had good contact with the health visitor team, which was located in an adjoining building. The practice was in the process of working towards achieving accreditation under the Department of Health's 'You're Welcome' scheme. (This is a national quality accreditation scheme that assesses whether health services are young person friendly and provide a high standard of care.)
- Making flexible arrangements to meet the needs of working age patients. Early morning and late appointments were offered within the Doctor First appointment system. Patients were able to order prescriptions and book GP appointments on-line. One of the GPs ran a clinic, which enabled women to access long-acting reversible contraception. Plans were underway to introduce a nurse-led family planning clinic, to enable women to book in advance for pill checks and contraceptive injections. An open access family clinic operated at one of the branch surgeries. This could be accessed by patients from any practice in the area.

Access to the service

Opening hours for the main practice and branch surgeries, and appointment times, were as follows:

The Brockwell surgery:

Monday and Thursday between 8am and 8pm. The practice is closed on Mondays between 1pm and 2pm. (Appointment times start at 8am and finish at 7:50pm.)

Tuesday, Wednesday and Friday between 8am and 6pm. (Appointment times start at 8am and finish at 5:50pm.)

The Seaton Terrace branch surgery:

Monday to Friday between 8:30am and 6pm. The practice is closed on Mondays between 12:45 and 2:15pm. (Appointment times start at 8.30am and finish at 5:50pm.)

The Seaton Sluice branch surgery:

Monday between 8:30am and 12:45pm, and between 2:15pm and 6pm. (Appointment times start at 8:30am and finish at 5:50pm.)

Tuesday to Friday between 8:30am and 1pm, and between 2pm and 6pm. (Appointment times start at 8:30am and finish at 5:50pm.)

The practice had recently introduced an appointment system called Doctor First, which provides patients with same-day access to a GP. Staff told us patients wishing to see a doctor would first be contacted by a GP, who would then assess their needs and invite them for a face-to-face consultation, if this was considered to be the most appropriate clinical response. In addition to this, patients were able to book routine appointments on-line, using a link provided on the practice's website.

Results from the NHS GP Patient Survey, published in January 2016, showed good levels of patient satisfaction

Good

Are services responsive to people's needs?

(for example, to feedback?)

with appointment convenience. Patients' satisfaction with appointment waiting times was higher than the national average. However, patients were less satisfied with telephone access and availability of appointments. Of the patients who responded to the survey:

- 90% said the last appointment they got was convenient, compared to the local CCG average of 93% and the national average of 92%.
- 77% said they were able to get an appointment to see or speak to someone the last time they tried, compared to the local CCG average of 86% and the national average of 85%.
- 69% said they usually waited 15 minutes or less after their appointment time, compared to the local CCG average of 74% and the national average of 65%.
- 62% said they found it easy to get through to the surgery by telephone, compared to the local CCG average of 78% and the national average of 73%.

The GP partners had implemented the Doctor First appointment system in the third quarter of 2015, in response to concerns raised by patients about access to same-day care. It was clear to the inspection team that the introduction of the Doctor First system had required a considerable commitment and flexibility from the clinical team, as staff and patients adapted to the new way of providing same-day access to appointments. This period of transition was on-going and staff were still fine tuning the system on a daily basis, to help make sure staff continued to be able to provide a responsive service. One of the patient participation group (PPG) members we spoke with commented that they were now able to see a GP quickly, but that they were still experiencing problems getting through to the practice on the telephone. Another PPG member said it was now much easier to get an appointment, but they said that getting through to the practice on the telephone, especially at busy times, was sometimes difficult. A third PPG member said that, before the introduction of the Doctor First system, they would have experienced difficulties obtaining an appointment, but that this was no longer the case. The two patients who completed CQC comment cards said they were very happy with access to appointments following the implementation of the Doctor First System.

Staff told us the most recent NHS GP Patient Survey results had been collected during the period in which they had implemented the new appointment system, and that this was likely to have had a negative impact on patient satisfaction levels. Staff said they hoped the feedback about access to appointments would improve as the new system bedded in and patients became familiar with using it.

Listening and learning from concerns and complaints

The practice had a system in place for managing complaints. This included having a designated person who was responsible for handling any complaints received by the practice and a complaints policy which provided staff with guidance about how to handle complaints. Information about how to complain was available on the practice's website and was also on display in the patient waiting area. The practice had received 29 complaints during the previous 12 months. This figure included verbal concerns raised with the practice and written complaints. Of these, nine complaints had been raised about problems patients had encountered using the new Doctor First appointment system. We looked at the complaints information provided by the practice and saw that each concern raised had been addressed and, where appropriate, changes had been introduced. For example, two patients with hearing impairments had raised concerns about using the new appointment system. We saw that staff had addressed these concerns by setting up alerts to ensure they were offered easier access to appointments. Some concerns about the new appointments system had resulted in changes to internal practices, and had also involved working with the telephone provider, to address issues about outgoing telephone lines. We saw that where the practice had substantiated a concern raised by a patient, a letter of apology and explanation had been sent to them.

Are services well-led?

Good

(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 clear vision to deliver high quality care and promote good outcomes for their patients. Staff had devised an overarching mission statement which set out what they wanted to achieve and how they would do this. The GP team was motivated and committed to exploring possibilities for providing better patient care. This included looking at new ways of working, in collaboration with two other local practices. They had also met with other GP providers who were successfully delivering new ways of providing primary care to their patients. Clinical staff we spoke to were aware of the developmental work the practice was leading on and were proud to work for the Brockwell Medical Group.

Governance arrangements

The arrangements for governance and performance management did not always operate effectively. Following the departure of the previous practice manager, the GP partners had decided to change the practice's leadership arrangements. In addition to this, the practice was undergoing a period of change following the implementation of the Doctor First appointment system, whilst also preparing for a potential move to different premises. Staff were also heavily involved in planning for another significant potential change to how they delivered services to their patients. The managing GP partner told us that this may have impacted on the effectiveness of some of their systems and processes.

We identified examples of good governance arrangements, for example, in relation to significant event reporting, the management of infection control, and the holding of regular meetings to share information to manage patient risk. Although we identified some weaknesses, we found staff were actively taking steps to address these.

The new practice management team was in the process of reviewing the practice's policies and procedures, and had produced a structured indexing system providing easy access to these. However, some staff we spoke with were not aware of how to access some of the practice's policies and procedures. Also, a member of the clinical team was not aware of the practice's whistleblowing policy.

Leadership, openness and transparency

Clinical staff and the operations services manager, had the experience, capacity and capability to run the practice and ensure good quality care. Our interviews with staff showed they were committed to providing safe, high quality and compassionate care. Recent changes in how the practice had led to a renewed focus on the practice's QOF performance and governance arrangements. The new practice management team and GP partners encouraged a culture of openness and honesty, and there were effective systems in place to support the reporting of notifiable safety incidents. There was a clear leadership structure and staff were satisfied with how they were supported. Following their review of significant events that occurred in 2015, the GPs were concerned about the lack of time available to effectively consider, and learn from, incidents and significant events. To address this, they had introduced monthly half-day education sessions to help promote opportunities for learning and reflection.

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

The practice encouraged and valued feedback from patients and staff. Their patient participation group (PPG) had initially started off as a virtual group. We were told steps were being taken to develop the group, which now had eight members who met from time to time throughout the year. The last minuted meeting took place in July 2015. Staff told us they wanted to develop the group further to help provide the practice with a 'critical friend.' Items on the PPG's most recent agenda included the introduction of the practice's new Doctor First appointment system and improvements to their website. We spoke with some of the PPG members, who told us they felt their views and opinions were welcomed by the practice. Improvements made following feedback from the PPG included improved lighting and disabled parking at one of the branch surgeries. Staff had also gathered feedback from patients through their Friends and Family Test survey.

Continuous improvement

There was a strong focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and had taken a lead in trying to improve how primary care services were delivered within their locality. This included seeking advice and support from peer organisations that had successfully adopted non-traditional models of providing general practice. The practice actively encouraged and supported staff to access

Are services well-led?

Good

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

relevant training. There was a good approach to identifying, and learning from significant events. Staff carried out clinical and quality improvement audits to help improve patient outcomes.

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 **Ensure there is documentary evidence demonstrating that the required pre-employment and post-employment checks have been carried out on staff.** **Regulation 19(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**