Caen Medical Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Caen Medical Centre on 3 February 2016. Overall the practice is rated as outstanding.

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- The practice used innovative and proactive methods to improve patient outcomes, working with other local providers to share best practice. For example, a GP partner was the MacMillan GP facilitator for the area and regional advisor. They shared their knowledge and expertise in this area, providing leadership and facilitation of improvements for patients experiencing the palliative care pathway across the region.
- Feedback from patients who used the service, family members and carers, and stakeholders was continuously positive about the way staff treated them and other patients. Patients said staff went the extra mile and the care they received exceeded their expectations. Feedback from all 48 patients about their care was consistently and strongly positive.
- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they meet patients' needs.It enabled these services to provide clinics for patients at the practice making these more accessible for patients and their carers. For example, strength and balance classes were held for people at risk of falling.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the patient participation group. For example, the appointment system had been completely overhauled and patients reported improved access and support.
- A walk in phlebotomy clinic was held every day between 8:30am to 10:30am, and between 2pm and

Summary of findings

3pm on Tuesday, Wednesday and Thursday. The latter clinic aimed to provide a later service for patients with chronic health conditions who may find it difficult to attend earlier in the day.

- The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand
- The practice had a clear vision which had quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff.

We saw several areas of outstanding practice including:

- Caen Medical Centre has embraced the concept of living well and was facilitating the integration of services to specifically bring care and treatment closer to home for patients. Examples included; developing a community hub bringing services closer to home for patients. The promotion of healthier living which was aimed at reducing the risk of unplanned hospital admissions where ever possible and improved quality of life.For example, older patients at risk of falling were able to attend strength and balance classes every week to improve their stamina and reduce the risk of injury from falls.Holding key roles in some of the 19 local charities identified as being able to support patients who could be at risk of social isolation.Developing a local walking group and driving forward the concept of a 'compassionate community' within Braunton.Patients were signposted and able to access services from within the practice with the aim of avoiding unplanned hospital admissions.
- The practice engaged with young people in using and developing the services at Caen medical Centre ahead of NHS England publishing the initiative entitled "You're welcome" encouraging services to explore young people's needs. The practice undertook a survey with young people in the town and gained some insight into their needs. This work had raised awareness across the team of the young people's attitudes. As a result of this work, the school nurse, in conjunction with the practices GPs, began running a clinic at the local secondary school once weekly.
- The practice held a carers focus group in June 2015, in which 20 carers had been invited and eight attended. Carer's suggestions to increase information on the practice website and in the waiting rooms regarding support available. We saw the practice website and information in the waiting room raised awareness about support services such as Devon Carers.

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?

Good

The practice is rated as good for providing safe services.

- There was an effective system in place for reporting and recording significant events
- Lessons were shared to make sure action was taken to improve safety in the practice.
- When there were unintended or unexpected safety incidents, patients received reasonable support, truthful information, a verbal and written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- Risks to patients were assessed and well managed.

Are services effective?

Outstanding

The practice is rated as outstanding for providing effective services.

- Data from the Quality and Outcomes Framework 2014/15 showed patient outcomes were at or well above average for the locality and compared to the national average.
- A truly holistic approach to assessing, planning and delivering care and treatment to people who used services. We saw several examples of this including the early identification and support of people with mental health needs. The practice was proactive in supporting patients with dementia, through early diagnosis and engaging appropriate care and treatment for them. Risk factors associated with frailty in old age were recognised and evidence based strategies being used to reduce these, for example strength and balance classes were offered to patients at risk of falls.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits demonstrated quality improvement. For example, the practice had utilised national guidance to improve early identification, diagnosis and treatment of patients presenting behaviours and cognitive impairment associated with dementia.
- The continuing development of staff skills, competence and knowledge was recognised as integral to ensuring high-quality care. Staff were proactively supported to acquire new skills and share best practice.

Summary of findings

- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with multidisciplinary teams to understand and meet the range and complexity of patients' needs.
- The systems to manage and share the information that was needed to deliver effective care were coordinated across services and support integrated care for people who used the services provided.

Are services caring?

Outstanding 

The practice is rated as outstanding for providing caring services.

- Data from the National GP Patient Survey July 2015 showed patients rated the practice higher than others for several aspects of care. For example, 100% said they had confidence and trust in the last GP they saw (CCG average 97.2%, national average 95.2%).
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Outstanding 

The practice is rated as outstanding for providing responsive services.

- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they meet patients' needs. This information had informed the development of a community hub bringing services closer to home for patients. GPs held key roles in some of the 19 local charities identified as being able to support patients who could be at risk of social isolation. These included a local walking group which a GP had started and another GP having direct involvement in driving forward the concept of a 'compassionate community' within Braunton. Patients were signposted and able to access services from within the practice with the aim of avoiding unplanned hospital admissions.

Summary of findings

- Innovative patient engagement led to development of services that met patient's needs. Focus groups were held regularly with patients, for example feedback from patients with rheumatoid arthritis led to creating flexible phlebotomy service with later and longer appointments.
- All 12,011 patients registered at the practice had a named GP.
- There are innovative approaches to providing integrated person-centred care. Advanced skills of clinical staff meant that services normally seen in hospital were available for patients. For example, dermoscopy was provided at the practice so that patients with skin conditions or suspect lesion could receive rapid diagnosis and be referred for on-going treatment where needed.
- The practice had forward planning systems in place to ensure that staffing levels were consistent to meet the needs of 3000 temporary residents each year. These patients were people on holiday and families of service personnel from the nearby military base.
- There were a range of appointments and walk in services available; same day service for patients needing to be seen urgently and late appointments Monday to Friday were available for working patients and those with minor illness.
- Patients remarked positively about improvements to the appointment system. The practice had worked collaboratively with the patient participation group to improve patient experience, using feedback to inform the setting up a new system.
- Caen Medical Centre was providing a dermatology service. A GP with Special Interest held clinic, so patients were able to access rapid diagnosis and treatment for conditions such as low risk skin cancer closer to home. Skin cancer rates were higher in Devon than the national average.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?
The practice is rated as outstanding for being well-led.

Outstanding ☆

Summary of findings

- The practice had a clear vision with quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff.
- High standards were promoted and owned by all practice staff and teams worked together across all roles.
- Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice.
- The practice carried out proactive succession planning.
- There was a high level of constructive engagement with staff and a high level of staff satisfaction.
- Peoples individual needs and preferences were central to the planning and delivery of tailored services at Caen Medical Centre.A rolling schedule of focus group meetings with patients and carers was taking place. These have included meeting with bereaved patients in 2015 leading to greater awareness and proactive contact and support for bereaved patients. A young person's focus group was held with 20 young people in February 2016 to evaluate an integrated school based service run by the practice and school nurse, which had been set up as a result of previous feedback from them.

Summary of findings

The six population groups and what we found

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

Older people

Outstanding ☆

The practice is rated as outstanding for the care of older patients.

- Caen Medical Centre had a significantly higher than average elderly population.25.28% of patients were aged over 65 compared with a clinical commissioning group (CCG) average of 24.1% and a national average of 16 %.
- The practice took a truly holistic approach providing proactive, personalised care to meet the needs of the older patients in its population. At the heart of this was the promotion of healthier living which was aimed at reducing the risk of unplanned hospital admissions where ever possible and improved quality of life.For example, older patients at risk of falling were able to attend strength and balance classes every week to improve their stamina and reduce the risk of injury from falls.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. For example, the GPs supported patients living in four nursing homes, one of which was a specialist dementia care service. They visit each service weekly to review patients as well as providing urgent home appointments when needed.
- The practice hosted a quarterly clinic for the national Aortic Aneurysm screening programme (aortic aneurysm is a swelling (aneurysm) of the aorta – the main blood vessel that leads away from the heart, down through the abdomen). Men aged over 65 years were eligible for this screening with the aim of early identification and proactive treatment if they were diagnosed with an aortic aneurysm
- The practice provided facilities for other NHS and private services to bring services closer to home for patients. For example, a chiropody service was provided at the practice twice a week.
- Carers were identified on a practice register and had regular access to a local caring organisation, Devon Carers. The practice provided free accommodation so that carer's clinics could be provided twice a month. The practice provided accommodation free of charge so that the charity was able to run a bimonthly carers clinic, providing support and advice.

People with long term conditions

Outstanding ☆

The practice is rated as outstanding for the care of patients with long-term conditions.

Summary of findings

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- The percentage of patients with diabetes on the practice register, who had received a flu vaccination in the last 12 months was 96.74%. This was slightly higher than the national average of 94.45%.
- The practice hosted the annual diabetic retinal screening service clinics during the winter months, so that patients avoided the inconvenience of having to travel to the main hospital in Barnstaple.
- Structured diabetic education clinics were held in conjunction with the secondary care hospital based diabetic nurse specialist. This provided diabetic patients with complex needs more support to help them achieve a better level of control of their condition.
- Longer appointments and home visits were available when needed. The practice allocated patients a named GP, wherever possible to see them at home for continuity of care. GPs carried out between three to four home visits each day, which could be up to 10 miles or more away on rural roads.
- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.
- Practice nurses had extended their skills so that they were able to treat patients with complex leg ulcers and manage other types of wounds normally treated in secondary care.
- A walk in phlebotomy clinic was held every day between 8:30am to 10:30am and between 2pm and 3pm on Tuesday, Wednesday and Thursday. The latter clinic aimed to provide a later service for patients with chronic health conditions who may find it difficult to attend earlier in the day.

Families, children and young people

Outstanding ☆

The practice is rated as outstanding for the care of families, children and young patients.

- Caen Medical Centre is situated close to a military base and provides healthcare for a temporary population of young families living there.

Summary of findings

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young patients who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations.
- 75.84% of patients diagnosed with asthma register had a comprehensive review in the last 12 months, which was comparable with the national average of 75.35%.
- Patients told us that children and young patients were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- The uptake of women aged 25-64 having had a cervical screening test performed in the preceding 5 years was 81.5% which was higher than the national rate of 74.3%.
- Information displayed encouraged cervical screening, chlamydia and other sexually transmitted infection screening. Chlamydia screening bags were obtainable in the patient toilets.
- Flexible appointments were available for mothers and children. For example, approximately 1400 women benefitted from a flexible and accessible contraceptive service. Appointments, where coils and implant devices could be fitted were available three times a week and appointments outside of school hours.
- We saw positive examples of joint working with midwives, health visitors and school nurses. Midwives were based at the practice and held clinics there every day. An integrated child health surveillance and baby immunisation clinic were held every Monday so that parents had access to a GP, practice nurse and health visitors at the same time.
- There was innovative engagement with young people about development of the services provided or linked with the practice. Focus groups were held with young people and had led to an integrated service run by the school nurse, with support from GPs at the practice, with clinics being held at the local secondary school. This enabled young people to access services and support when they needed it.

Working age people (including those recently retired and students)

Outstanding ☆

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

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, when NHS England

stopped funding the text messaging service the practice looked into other systems. At the time of the inspection, it was negotiating a trial of software which would enable voice and email reminders, and text messages to be sent to patients signed up for this service.

- The practice was responsive to the needs of working patients and had a walk in phlebotomy clinic every day. Flu vaccination clinics had been held at weekends during the winter months, or patients were able to have vaccinations at a time that suited them during extended hours.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.
- The practice supported families of service personnel based at the nearby Chivenor military base. There were systems in place to identify military veterans and ensure their priority access to secondary care in line with the national Armed Forces Covenant.

People whose circumstances may make them vulnerable

Outstanding ☆

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

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

People experiencing poor mental health (including people with dementia)

Outstanding ☆

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

- Data showed that the practice achieved high levels of engagement with patients with complex mental health needs.

Summary of findings

For example, 95.74% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in their record, in the preceding 12 months.

- Staff knew patients well and were proactive in ensuring reasonable adjustments were made. This included offering appointments later in the day and enabling patients to sit in quieter areas away from busy waiting room to avoid experiencing additional anxiety when attending appointments.
- The practice was proactive in identifying any patients who could be undiagnosed with dementia. As a result the dementia register had increased from 94 patients in December 2014 to 130 by January 2016. 97.71% of patients diagnosed with dementia who had had their care reviewed in a face to face meeting in the last 12 months, which was much higher than the national average of84.01%
- All of the staff had completed or in the process of completing an online course to become 'Dementia Friends'. This was helping them to identify patients who were presenting symptoms and behaviour associated with dementia so that they could be referred for assessment and appropriate interventions.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice carried out advance care planning for patients with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

The national GP patient survey results published on July 2015. The results showed the practice was performing in line with local and national averages. 234 survey forms were distributed and 118 were returned. This represented 1% of the practice's patient list.

- 73.39% of patients found it easy to get through to this practice by phone compared to a Clinical Commissioning Group (CCG) average of 84% and a national average of 73.32%.
- 86.25% of patients were able to get an appointment to see or speak to someone the last time they tried (CCG average 91% and national average 76.1%).
- 92.5% of patients described the overall experience of their GP practice as fairly good or very good (CCG average 90% and national average 84.94%).
- 89.79% of patients said they would definitely or probably recommend their GP practice to someone who has just moved to the local area (CCG average 85% and national average 79.11%).

As part of our inspection we also asked for Care Quality Commission comment cards to be completed by patients prior to our inspection. We received 42 comment cards which were all positive about the standard of care received. The majority of these highlighted the care and support as excellent, with staff being very caring.

We spoke with six patients during the inspection. All six patients said they were happy with the care they received and thought staff were approachable, committed and caring.

In January 2016, the practice published the results to date for the Friends and Family. The majority of these were extremely likely or likely to recommend the practice.

Outstanding practice

- Caen Medical Centre has embraced the concept of living well and was facilitating the integration of services to specifically bring care and treatment closer to home for patients. Examples included; developing a community hub bringing services closer to home for patients. The promotion of healthier living which was aimed at reducing the risk of unplanned hospital admissions where ever possible and improved quality of life. For example, older patients at risk of falling were able to attend strength and balance classes every week to improve their stamina and reduce the risk of injury from falls. Holding key roles in some of the 19 local charities identified as being able to support patients who could be at risk of social isolation. Developing a local walking group and driving forward the concept of a 'compassionate community' within Braunton. Patients were signposted and able to access services from within the practice with the aim of avoiding unplanned hospital admissions.
- The practice engaged with young people in using and developing the services at Caen medical Centre ahead of NHS England publishing the initiative entitled "You're welcome" encouraging services to explore young people's needs. The practice undertook a survey with young people in the town and gained some insight into their needs. This work had raised awareness across the team of the young people's attitudes. As a result of this work, the school nurse, in conjunction with the practices GPs, began running a clinic at the local secondary school once weekly.
- The practice held a carers focus group in June 2015, in which 20 carers had been invited and eight attended. Carer's suggestions to increase information on the practice website and in the waiting rooms regarding support available. We saw the practice website and information in the waiting room raised awareness about support services such as Devon Carers.

Caen Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission Lead Inspector**.** The team included a GP specialist adviser, and a practice manager specialist adviser.

Background to Caen Medical Centre

Caen Medical Centre is a semi-rural practice covering an area of approximately 100 square miles. There were 12,011 patients on the practice list and the majority of patients are of white British background. The practice has 2.1% black and minority ethnic patients from Afro Caribbean and Asian (Indian, Pakistani, Bangladeshi and Chinese) backgrounds. All 12,011patients have a named GP and linked administrative staff. There is a higher percentage of babies (0-1 years), working age over 55 years and older people compared to the national averages. The practice has a higher number of patients (1.1%) living in adult social care homes on its list, compared with the national average of 0.5%. Nearly half of the patients at the practice have a long term condition, receive support and are monitored closely. The total patient population falls within the low-range of social deprivation.

The practice is managed by seven GP partners (four male and three female).They are supported by a salaried GP (female). The practice uses the same GP locums for continuity where ever possible. There are four female practice nurses and three female health care assistants. All the nurses specialise in certain areas of chronic disease and long term conditions management.

Caen Medical Centre is a teaching practice, with three GP partners approved as GP trainers. Three GP partners are approved teachers with Health Education South West. The practice normally provides placements for trainee GPs and F2 trainees (qualified doctors in the second year of their foundation training). Placements for trainee paramedics have also recently been made available at the practice. Teaching placements are provided for year three, four and five, medical students. Two trainee GPs were on placement when we inspected.

The practice is open 8:30am to 6:30pm Monday to Friday. Extended opening hours are available on Monday, Tuesday and Wednesday with early morning and late evening appointments with GPs listed on the practice website: Early morning appointments are on Wednesday mornings (7:30am – 8am) and late evening appointments are on Monday and Tuesday (6:30pm - 7:30pm). Appointments can be booked up to 6 weeks in advance.

Opening hours of the practice are in line with local agreements with the clinical commissioning group. Patients requiring a GP outside of normal working hours are advised to contact the out of hour's service provided by Devon Doctors.

The practice has an Personal Medical Service (PMS) contract and provides additional services, some of which are enhanced services:

- Identification of risks associated with alcohol use and providing support to patients.
- Extended hours
- Minor surgery
- Facilitating early diagnosis of dementia
- Influenza, pneumococcal, rotavirus and shingles immunisations for children and adults

Detailed findings

- Patient participation in development of services.

Caen Medical Centre aims to bring services closer to home for patients; Dermoscopy, chiropody, orthoptist. Other NHS services are run at the practice such as the depression and anxiety clinic, which is run by the mental health trust. Nurses from the community nursing service are based at the practice.

Why we carried out this inspection

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

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

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 3 February 2016. During our visit we:

- Spoke with a range of staff (GPs, nurses, administrators and the practice manager) and spoke with six patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed 42 comment cards where patients and members of the public shared their views and experiences of the service.

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

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

We also looked at how well services were provided for specific groups of patients and what good care looked like for them. The population groups are:

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

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

Good

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system.
- The practice carried out a thorough analysis of the significant events.Records showed that 20 significant events had been reviewed in depth in the previous 12 months. Staff verified they were always sent minutes of meetings where these were discussed and if involved, invited to attend the meeting.

We reviewed safety records, incident reports national patient safety alerts and minutes of meetings where these were discussed. Lessons were shared to make sure action was taken to improve safety in the practice. For example, the practice reviewed its referral process when it emerged that a patient reported they had not received a routine appointment from the hospital specialist. It emerged that the Devon central referral point contact number had changed and therefore the referral had not been received. The practice tightened up referral procedures and reviewed documents used to alert GPs to what referrals were appropriate for the central referral service and set up a system for monitoring these. This had avoided the risk of any patient referrals for routine appointments not being followed up.

The practice was proactive in reporting any serious incidents involving other agencies. For example, it reported to the local hospital that a discharge summary for a patient was inaccurate. This instigated an investigation by the hospital, but also showed that the practice knew their patients well and was vigilant in checking these summaries before making any changes to their treatment.

When there were unintended or unexpected safety incidents, patients received support, truthful information, an apology and were told about any actions to improve processes to prevent the same thing happening again.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies were comprehensive and clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding who demonstrated that they had taken swift action when concerns were raised leading to a significant safeguarding investigation being undertaken by the local authority. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training relevant to their role. All GPs were trained to Safeguarding level three for children and had also completed vulnerable adults safeguarding training.
- A notice in the waiting room advised patients that chaperones were available if required. The practice policy was that only nurses acted as chaperones and they had received training for the role and had received a Disclosure and Barring Service check (DBS check). (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The senior practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. The practice policy was to complete infection control audits more frequently. These had been completed every 12 weeks and we saw previous audits identified action to be taken to address any improvements needed. The last one completed in December 2015 demonstrated that previous actions had been addressed and no new actions were identified.
- The arrangements for managing medicines, including emergency drugs and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). The practice carried out regular medicines audits, with the support of the local Clinical Commissioning Group (CCG) pharmacy teams, to ensure prescribing was in line with best

practice guidelines for safe prescribing. Prescription pads were securely stored and there were systems in place to monitor their use. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. The practice had a system for production of Patient Specific Directions to enable Health Care Assistants to administer vaccines after specific training when a GP or nurse was on the premises.

- We reviewed five personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.
- There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office which identified local health and safety representatives. The practice had up to date fire risk assessments last reviewed in May 2015 and carried out regular fire drills. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). Systems were in place, which alerted the practice manager to when risk assessments and policy reviews were next due. For example, the legionella risk assessment was next due to be reviewed in May 2016.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. The practice had forward planning systems in place to ensure that staffing levels were consistent to meet the needs of up to 3000 temporary residents each year. These patients were people on holiday and families of service personnel from the nearby military base.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room. The practice demonstrated that they used emergency events for learning. We saw minutes of a post emergency meeting, which led to improved labelling and organisation of equipment so it could be accessed quickly.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use.

The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep all clinical staff up to date with named GPs taking the lead to monitor specific clinical areas. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patient's needs.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.
- The practice took a truly holistic approach to assessing, planning and delivering care and treatment to people who use services. In particular, there were effective systems to closely monitor vulnerable older patients and those with chronic health conditions. For example in January 2016, the practice carried out a search of all patients over 80 years to ensure there was appropriate monitoring in place. In total there were 819 patients in this group and of these 815 had been reviewed in the previous 12 months and had appropriate support in place.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 92.2% of the total number of points available. This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014/15 showed;

- Performance for diabetes related indicators was similar to the Clinical Commissioning Group (CCG) and national averages. For example, the percentage of patients on the diabetes register, with a record of a foot examination and risk classification within the preceding 12 months (01/04/2014 to 31/03/2015) was 92.51%, which was higher than the CCG average of 88.8% and national average of 88.3%.
- The percentage of patients with hypertension having regular blood pressure tests was 85%, which was similar to the national average of 83.65%.
- Performance for mental health related indicators was better than CCG and national averages. For example, the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months was much higher at 95.74% compared with the national average of 88.47%.

Clinical audits demonstrated quality improvement.

- There had been seven clinical audits completed in the last two years, seven of these were completed audits where the improvements made were implemented and monitored. For example, a steroid injections audit looked at the outcomes and complications experienced by patients. In the first cycle, 19 steroid injections had been given to 17 patients. 89% of injections had a favorable and positive outcome, relieving the patient's symptoms. There were no complications or side- effects from the procedures. Between the first and second audit the number of patients outcomes assessed increased by more than 50% with 52 procedures for 39 patients reviewed in the second cycle. 85% of injections had achieved a successful outcome in totally relieving the patient's symptom. Data showed that there were clinical reasons, why patients did not experience total relief of pain which included being referred for surgery to relieve symptoms that could not otherwise be treated without it. There were no complications or side effects for all the patients (100%). The GPs had plans in place to continue auditting this area of treatment for patients.
- The practice participated in local audits, national benchmarking, accreditation, peer review and research.
- Findings were used by the practice to improve services. For example, recent action taken as a result included:

Educational meetings had reviewed NICE guidelines and the team had considered the latest information about screening patients for diabetes. The practice had identified that they had a lower prevalence of diabetes than they would have expected and had been looking into this before we inspected.. The first cycle of the audit had taken place to identify any patients who could be classed as

pre-diabetic so that they received appropriate support and follow up. A search of patient registers was undertaken, but this did not identify any additional patients who could be in the pre-diabetic range

The practice provided information about actions taken regarding identification of patients for the dementia register and had been scrutinising this over the last year. In January 2015 the practice adopted the Dementia Quality Toolkit, which provides guidance for GPs and aims for early assessment, diagnosis and support of patients with dementia. The practice had run this tool three times during the year to help identify any patients who were undiagnosed but could be presenting symptoms and behaviours associated with it. Any patients identified had been referred to their named GP who then carried out a review with the patient. This had seen the practice dementia register increase from 94 patients in December 2014 to 130 by January 2016. Data showed that 97.7% of patients diagnosed with dementia who had had their care reviewed in a face to face meeting in the last 12 months, which was much higher than the national average of 84.01%.

Information about patients' outcomes was used to make improvements such as; increasing staff awareness of patients potentially living with dementia and impact on their carers. All of the staff had completed or were in the process completing e-learning to become 'Dementia Friends'. Staff told us that this was helping them to recognise and provide appropriate support for any patient whose mood, behaviour and memory had changed or identifying when carers could be under increased stress.

The practice used the Devon Predictive model to identify and monitor those patients most at risk of unplanned hospital admissions. This information was used to inform the practice register of vulnerable patients, who could be at risk of social isolation and/or deteriorating health due to chronic conditions. Care plans were in place for all of the patients on this register and were being reviewed every three months or more often when needed.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- There was a buddy system in place covering GPs when they were on leave or away training. This buddy was familiar with the patients on the GPs list and able to respond to their needs. Holidays were co-ordinated to avoid the GP and their buddy GP being off at the same time.
- The team of GPs had specialist skills and took the lead in specific areas of practice. For example, GPs held advanced qualifications, which included a GP with special interests in dermatology.
- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. The induction records were role specific and prompted the assessor to identify any further training needs for the inductee.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, practice nurses took the lead in reviewing patients with long-term conditions. They held diplomas in respiratory disease and diabetes management. Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings. Nurses involved in baby immunisation had completed an update in the last six months which had updated their knowledge about changes in the immunisation schedule.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support during sessions, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. All trainee GPs, paramedics and medical students were allocated a supervisor during their placement at the practice. All staff had had an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire procedures, basic life support and information governance awareness. Staff had access to and made use of e-learning training modules and in-house training.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Coordinating patient care and information sharing

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

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

The practice had worked hard to remain co-located with community nursing staff. We spoke with community nursing staff who reported that the GPs were effective and responsive in communicating and co-ordinating information about vulnerable patients. They told us they were always invited to attend the daily meeting with GPs and practice nurses, which allowed them to quickly raise any concerns about any patients they were supporting.

Staff worked together and with other health and social care services to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. We saw evidence that multi-disciplinary team meetings took place on a monthly basis and that care plans were routinely reviewed and updated.

A GP partner was the MacMillan GP facilitator for the area and Regional advisor for End of Life Care. The practice followed the gold standards framework for end of life care, holding monthly multidisciplinary meetings where risks were reviewed and actions agreed. The practice undertook a review of its end of life care to establish how effective this was. The practice shared the findings and ran an education session with GPs and the multidisciplinary primary care group to consider ways of promoting more personalised care. A second review in 2016 found improvements had taken place, for example the total number of 'home' deaths experienced by patients had increased to 64% from 58% demonstrating that their wishes to remain at home were being followed wherever possible. Documentation had improved regarding symptom control, psychological, social support and the need to assess and encourage appropriate nutrition and fluid intake for patients. Further work was required around advanced care planning with patients and was in the process of being worked on at the time of the inspection.

Consent to care and treatment

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young patients, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored through records audits. For example, the second cycle of the end of life review showed that the use of treatment escalation plans, including decisions about resuscitation was greater. Recorded discussions with family and carers were more detailed giving a better picture of what had been covered and agreed.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support.

- These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation.Patients were then signposted to the relevant service.
- The practice promoted awareness of cancer risks, for example by supporting the Breast Cancer UK awareness event held in the village. A higher percentage of women over 50 years registered with Caen Medical Centre had attended breast screening with 79.9% compared with the CCG average of 77.5% and national average 72.2%.
- Dietary and smoking cessation advice was available from practice nurses and patients were signposted to a local support group.

The practice's uptake for the cervical screening programme was 81.5% which was higher the Clinical Commissioning Group (CCG) average of 77.0% and the national average of

Outstanding ☆

Are services effective?

(for example, treatment is effective)

74.3%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

Childhood immunisation rates for the vaccinations given were comparable to CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 76.7% to 98.5% and five year olds from 91.3% to 97.5%. Flu vaccination rates for risk groups such as diabetics was 96.74% compared with the national average of 94.45%.

Patients had access to appropriate health assessments and checks. Up until recently, this included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified. However, funding for these checks was due to be stopped on 29 February 2016 by the local authority. As a result the practice no longer offered this service on site by the time we inspected. The practice could refer patients to services outside of Devon County Council's boundaries should they wish to receive this service.

Outstanding ☆

Are services caring?

Our findings

Kindness, dignity, respect and compassion

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

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

The majority of the 42 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with six members of the patient participation group (PPG). They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Care Quality Commission comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey (July 2015) showed patients felt they were treated with compassion, dignity and respect. The practice was at or above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 93.3% said the GP was good at listening to them compared to the Clinical Commissioning Group (CCG) average of 92% and national average of 88.6%.
- 92.9% said the GP gave them enough time (CCG average 90.9%, national average 86.6%).
- 100% said they had confidence and trust in the last GP they saw (CCG average 97.2%, national average 95.2%)
- 91.6% said the last GP they spoke to was good at treating them with care and concern (CCG average 89.7%, national average 85.1%).
- 90% said the last nurse they spoke to was good at treating them with care and concern (CCG average 93.4%, national average 90.4%).
- 87.2% said they found the receptionists at the practice helpful (CCG average 90.5%, national average 86.8%)

Care planning and involvement in decisions about care and treatment

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

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

- 93% said the last GP they saw was good at explaining tests and treatments compared to the Clinical Commissioning Group (CCG) average of 90.4% and national average of 86%.
- 92.4% said the last GP they saw was good at involving them in decisions about their care (CCG average 87.3% and national average 81.4%)
- 83.6% said the last nurse they saw was good at involving them in decisions about their care (CCG average 88% and national average 84.8%).

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available. Patient information leaflets were also available in different languages, for example Chinese.

Patient and carer support to cope emotionally with care and treatment

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

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 3.3% of the practice list as carers, using codes on the patient records system to denote when a patient was also a carer. Accommodation was provided free of charge to a charity -

Outstanding ☆

Are services caring?

Devon Carers – which enabled them to run bi-monthly carers clinics at the practice. Carers were able to access regular support and advice through this service. Staff told us that they worked hard to identify carers. Data from the Public Health Devon Joint Strategic Needs Assessment profile for Braunton showed that the number of adult carers aged over 18 years receiving a carer assessment or review in Braunton was 1.17 adult carers per 1000 population aged 18 or over compared to0.68 for Devon overall.

Written information was available to direct carers to the various avenues of support available to them. The practice held a carers focus group in June 2015, in which 20 carers had been invited and eight attended. Carer's suggestions to increase information on the practice website and in the waiting rooms regarding support available had been acted upon. For example, the practice website and information in the waiting room raised awareness about Devon Carers, a charity supporting carers in the county. Participants at the focus group agreed that they would like to meet again in the next 12-18 months.

A bereavement focus group in 2015 provided feedback to the practice and led to changes including proactive contact and support for bereaved patients. Staff told us that if families had suffered bereavement, their named GP contacted them or sent them a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

The practice had systems in place to identify military veterans and ensure they received appropriate psychological and welfare support in line with the national Armed Forces Covenant.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.

- The GP partnership had utilised the joint strategic plan for the area and had identified the needs of patients registered at the practice. This information had informed the development of a community hub bringing services closer to home for patients.
- Innovative patient engagement led to development of services that met patient's needs. For example, a focus group was held with patients with rheumatoid arthritis and led to improvements in the phlebotomy service providing flexibility of later and longer appointments.
- The practice was providing dermatology GPwSI (GPs with special interests) services. A GPwSIs worked closely with the dermatology service at the local hospital and provided appointments for patients at the practice. This included early screening of patients with suspicious skin lesions, which could be cancerous enabling them to receive prompt treatment.
- Caen Medical Centre had a higher than average elderly population. 25.28% of patients were aged over 65 compared with a clinical commissioning group (CCG) average of 24.1% and a national average of 16 %.The practice took an early intervention approach to managing frailty for these patients to reduce health risks wherever possible.For example, strength and balance classes were held once a week for patients who were at risk of falling.
- The practice also demonstrated that reasonable adjustments were in place and action was taken to remove barriers when patients found it hard to use or access services.They recognised that older patients using the practice tended not to engage with new technologies so had taken this into account when designing new services.For example, in addition to online services the practice continued to offer patients the option to complete paper and telephone requests for appointments and repeat prescriptions.
- Approximately, 1400 women of child bearing age benefitted from a flexible and accessible contracteptive service. Appointments, where coils and impant devices could be fitted were available three times a week and appointments outside of school hours.
- The nursing team were highly skilled and able to provide services which brought care and treatment closer to home for patients. For example, patients with complex wounds and leg ulcers were able to be treated at the practice avoiding the need to attend the local hospital for this.
- The practice provided accommodation so that patients had local access to a number of additional clinics run by other private and NHS providers. These included physiotherapy, chiropody, orthoptometry, counselling and children/adult mental health services.
- National and local screening programmes were run at the practice, including a quarterly clinic to screen men over 65 years who could be at risk of abdominal aortic aneurysm and annual retinal screening for all patients with diabetes.
- There were longer appointments available for patients with a learning disability and/or mental health needs. Staff understood patients needed flexibility and support during these appointments, for example providing quieter areas to wait enabling them to avoid sitting in a crowded waiting room.
- Home visits were available for older patients and patients who had difficulties attending the practice.
- Same day appointments were available for children and those with serious medical conditions.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately.
- There were disabled facilities, a hearing loop and translation services available.

Access to the service

The practice was open 8:30am to 6:30pm Monday to Friday. Extended opening hours were available on Monday, Tuesday and Wednesday early morning and late evening appointments with a GP were listed on the practice website: Early morning appointments were provided on Wednesday mornings (7:30am – 8am) and late evening appointments were on Monday and Tuesday (6:30pm - 7:30pm). Appointments could be booked up to 6 weeks in advance and urgent same day appointments were also available for patients that needed them.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

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

- 86.75% of patients were satisfied with the practice's opening hours compared to the Clinical Commissioning Group (CCG) average of 77.6% and national average of 78.53%.
- 73.39% of patients said they could get through easily to the practice by phone (CCG average 84.4% and national average 73.32%).
- 93.4% of patients said they always or almost always see or speak to the GP they prefer (CCG average 91% and national average 85.2%).

Six patients told us on the day of the inspection that they were able to get appointments when they needed them. They told us that the practice had taken appropriate action when patients in a survey had highlighted that it was difficult to sometimes get through to the practice by telephone. The number of telephone lines had increased from six to ten. All reception staff were now also answering telephone calls when there was highest patient demand between 8.30-9am and on-line appointment booking had been promoted with patients.

Listening and learning from concerns and complaints

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

- The complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system.Posters and leaflets summarising the procedures for complaints were displayed in prominent areas of the waiting room.

We looked at 14 complaints received in the last 12 months and found these were satisfactorily handled, dealt with in a timely way, openness and transparency with dealing with the complaint. Lessons were learnt from concerns and complaints were discussed on a monthly basis and action was taken as a result to improve the quality of care. For example, the practice had reviewed it's consent process for all minor surgical procedures to ensure that patients were fully informed about the risks and benefits and that this was documented.

Are services well-led?

Outstanding ☆

(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 patients.

- The practice had a mission statement which was displayed in the waiting areas and on the website. This was to work in 'partnership with patients for healthier living'. All staff knew and understood the values.
- The patient's charter was on display in the waiting room and also in the practice leaflet.
- The practice had a robust strategy and supporting business plans which reflected the vision and values and were regularly monitored. There was a higher percentage of older people registered at the practice and one area of the strategy focussed on reducing the risks of social isolation. For example, a mapping exercise was carried out to identify all the local charities the practice worked with or could work with and was signposting patients to these services to help reduce isolation.

Governance arrangements

Caen Medical Practice had achieved the Royal College of GPs Quality Practice award in 2006 and had been working towards renewing this until it ceased. The practice had an overarching governance framework, with embedded systems which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- A GP partner was the clinical governance lead and there was a governance policy in place which outlined expectations of clinical staff, for example to undertake clinical audits and to operate effective risk management.
- Leadership of the nursing team was strong and there was senior nursing representation at strategic management meetings and policy development.
- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff
- A comprehensive understanding of the performance of the practice was maintained
- A programme of continuous clinical and internal audit which was used to monitor quality and to make improvements
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions

Leadership and culture

The partners in the practice had the experience, capacity and capability to run the practice and ensure high quality care. They prioritised safe, high quality and compassionate care. The partners were visible in the practice and staff told us they were approachable and always took the time to listen to all members of staff. This also included GPs in training and doctors on placement as part of their post qualification training.

The provider was aware of and complied with the requirements of the Duty of Candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for knowing about notifiable safety incidents

When there were unexpected or unintended safety incidents:

- The practice gave affected patients reasonable support, truthful information and a verbal and written apology
- They kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure in place and staff felt supported by management.

- Staff told us the practice held regular team meetings across all staff groups every six weeks.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident in doing so and felt supported if they did.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

Are services well-led?

Outstanding ☆

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

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

The practice encouraged and valued feedback from patients, the public and staff. The practice proactively sought patients' feedback and engaged patients in the delivery of the service.

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. There was an active PPG which met regularly, reviewed the results of patient surveys and submitted proposals for improvements to the practice management team. Six members of the PPG told us that the chairs in the entrance lobby had been changed, information about the phlebotomy clinic was displayed more prominently and details of each GP's usual working days were published on the practice website. However, members of the PPG told us that the most significant area of improvement had been the increased number of appointments available to book on line and changes to the telephone system.
- The practice had gathered feedback from staff generally through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.

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 part of local pilot schemes to improve outcomes for patients in the area. In 2011 the practice chose to use NHS Scotland's "Walk the Talk" toolkit to engage young people in using and developing the services at Caen medical Centre. The practice was proactive in doing this before NHS England published a similar initiative entitled "You're welcome" encouraging services to explore young people's needs. The practice undertook a survey with young people in the town and gained some insight into their needs. They discussed the survey results with the local secondary school, and the multidisciplinary team which included the school nurse. This work had raised awareness across the team of the young people's attitudes. As a result of this work, the school nurse, in conjunction with the practices GPs, began running a clinic at the local secondary school once weekly. A further focus group was held with young people at the school a few days before the inspection to evaluate the services provided.

The practice had strong links with other agencies such as the hospice and local palliative care team. A GP partner was the MacMillan GP facilitator for the area and Regional advisor. They shared their knowledge and expertise in this area, providing leadership and facilitation of improvements for patients experiencing the palliative care pathway across the region. These improvements included the development of a regional template and guidance in using treatment escalation plans. These are discussed and agreed with patients receiving end of life care so that their wishes are followed.

Integration and bringing care closer to home. A GP partner had met with the local parish council to progress plans for the village to become a 'compassionate community'. The practice had extensive links with local charities providing advice, financial and practice support for carers, people with dementia, vulnerable families and ex service personnel. For example, the chairperson of the Royal Air Force Association (RAFA) befriending service was enabled to raise awareness of this at the practice through patient newsletters. This was an important third sector support service in North Devon, where ex service personnel lived after leaving the nearby military base.