Bramblehaies Partnership

Quality Report

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

Bramblehaies Partnership was inspected on Wednesday 5 November 2014. This was a comprehensive inspection covering Bramblehaies Medical Practice.

Bramblehaies Partnership provides primary medical services to people living in Cullompton and surrounding villages in Devon covering approximately 180 square miles.

The practice provides services to a diverse population. At the time of our inspection there were approximately 6,500 patients registered at the service with a team of four GP partners. GP partners held managerial and financial responsibility for running the business. In addition there was one additional salaried GPs, four registered nurses, two health care assistants, a practice manager and team of administrative staff. We spoke with 11 staff in total.

Patients who use the practice have access to community staff including district nurses, community psychiatric nurses, health visitors, physiotherapists, mental health staff, counsellors, chiropodist and midwives.

The practice is rated as good. Our key findings were as follows:

- Patient comments were positive about the care and support they experienced at the practice. In particular, the staff were said to be compassionate and supportive in promoting good health and well being.
- Patients reported having good access to appointments at the practice and had a named GP which improved their continuity of care. The practice was clean, well-organised, had good facilities and was well equipped to treat patients.
- The practice valued feedback from patients and had an active patient participation group (PPG) and 'Friends of Bramblehaies' that saw their

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suggestions put into place. The practice was ready to start the 'Friends and Family Test' with patients to receive daily feedback about their experiences of care and treatment there.

- The practice was well-led and had a clear leadership structure in place whilst retaining a sense of mutual respect and team work. There were systems in place to monitor and improve quality, identify business risk and systems to manage emergencies.

We saw several areas of outstanding practice including:

- Patients with long term conditions were benefitting from specialist equipment that had been purchased so that blood screening was carried out at the practice for patients. Instead of receiving results the next day, results were available immediately and discussed with patients. Immediate changes to their medicine dose could then be made in response and additional advice and support given where needed.
- A named GP and nurse monitored the health and well being of vulnerable patients with a learning disability and/or complex mental health needs. This promoted a trusting rapport with patients. The expertise of a national charity had been used to make all information at the practice accessible for vulnerable patients with a learning disability. Information leaflets and posters were in easy read and picture formats. This had increased patient involvement in the management their health and well being.
- The practice was successful in engaging patients with mental health needs to ensure their health and well being was closely monitored. Longer appointments, at quieter times of the day and with named staff were taking place. Information received about the practice prior to and during the inspection demonstrated the practice performed better compared with other practices. These areas included cervical screening for women with complex mental health needs and annual health checks of patients with a learning disability.

However, there were also areas of practice where the provider needs to make improvements.

Importantly, the provider must:

- Have effective operating systems for the handling pathology results, scanned correspondence to mitigate the potential risks of inappropriate or unsafe care and treatment of patients.

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 safe.

Staff understood their responsibilities to raise concerns, and report incidents and near misses. When things went wrong, reviews and investigations were thorough and lessons learnt were communicated to support improvement. Risks to patients who used services were assessed and systems and processes to address these risks were mostly implemented well enough to ensure patients were kept safe. Infection control arrangements had been audited and the practice was able to show whether improvements were effective and sustained. The practice managed the complex needs of patients well and responded in a timely way when urgent care and treatment was required.

Are services effective?

Requires improvement

The practice is rated as requiring improvement for providing effective services.

Patients were potentially at risk of not receiving prompt, co-ordinated care across the GP and nursing team at the practice. This was because the IT system for recording actions taken on receipt of pathology results and scanned correspondence was not consistently followed across the team. Systems were in place to ensure that all clinicians were up-to-date with both NICE guidelines and other locally agreed guidelines, which was influencing and improving practice and outcomes for their patients. We saw data that showed that the practice is performing highly in a number of areas when compared to neighbouring practices in the CCG.

Are services caring?

Good

The practice was rated as good for providing caring services.

Data showed patients rated the practice higher than others for some aspects of care. Twenty two CQC comment cards reviewed and discussion with eight patients on the day all provided positive feedback. A common theme was that the staff were compassionate and supportive in promoting the health and well being of patients. This was borne out in the way staff engaged with patients with complex communication needs. Staff we spoke with were aware of the importance of providing patients with privacy and information was available to help patients understand the care available to them.

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Are services responsive to people's needs?

Good

The practice was rated as good for providing responsive services.

The practice was proactive in carrying out health checks before further prescriptions were issued to vulnerable patients. Patients confirmed this system worked well. The practice supported patients living in seven adult social care homes, several of which specialised in caring for people with a learning disability and/or complex mental health needs. A named nurse and GP were monitoring the health and mental well being of patients, which promoted good rapport and continuity for them. The expertise of a national charity specialising in supporting people with learning disabilities had been used so that patient information was accessible in an easy read format. The practice also had a member of staff who acted as a champion for patients with learning disabilities and had undertaken additional training to fulfil this role.

Flexible arrangements were in place for working age patients, which extended the opportunities for health screening to take place at one appointment. For example, the way patients were invited to attend health screen checks had been reviewed, making it a more personalised and successful service. Extended evening appointments for 20 minutes were offered and had resulted in an increased uptake of patients aged 40-74 years old being screened. Potential health risks for some patients had been identified and early interventions such as information about leading a healthy lifestyle or signposting to other services had taken place.

Patients reported good access, including same day routine appointments with a named GP and continuity of care. Urgent appointments were also available the same day. There was a clear complaints policy and procedure demonstrating that the practice responded quickly to issues raised and brought them to resolution. There was evidence of shared learning from complaints with staff and other stakeholders. Improvements as a result of the learning from complaints included greater awareness of the importance of handling sensitive information.

Are services well-led?

Good

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

The practice had a clear vision and strategy to deliver this. Staff were clear about the vision and their responsibilities in relation to it. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and regular governance meetings had taken place. There were systems in place to monitor and improve quality and identify risk. The practice had an active patient participation group (PPG) and fundraising charity, which was

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consulted about developments. Suggestions for improvement of services were acted upon and the PPG felt the relationship with GP partners was an inclusive one. Arrangements were in place to start obtaining daily feedback from patients for the 'Friends and Family Test'. Staff had received inductions, regular performance reviews and attended staff meetings and events.

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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 data showed the practice had good outcomes for conditions commonly found amongst older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example in dementia and end of life care. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs and home visits. Patients newly discharged from hospital were contacted within three days to check on their well being. Social isolation was recognised as a risk for older people and the practice worked closely with local charities and other agencies to provide additional support to improve the quality of life for people. For example, patient were signposted to walking and lunch clubs. A carers clinic was held every month at the practice in conjuction with Devon social services to support patients caring for relatives.

People with long term conditions

Outstanding

The practice is rated as outstanding for the population group of people with long term conditions.

The practice was effective in developing an in house blood monitoring service. Specialist equipment had been purchased and staff using it had received appropriate training. Patients had access to instant results so were able to access support when needed and make immediate changes to their medicines safely. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. When needed, longer appointments and home visits were available. All these patients had a named GP and structured annual reviews to check their health and medication needs were being met. For those people with the most complex needs the named GP and nursing team worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

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

Sick children arriving for help were seen quickly by the duty GP as a priority, and kept isolated if considered to be infectious. Children living in disadvantaged circumstances and who were at risk were

quickly identified and measures to reduce these risks were put in place, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations because reminders were sent to parents. Parents told us that their children and young people were treated in an age appropriate way and recognised as individuals. Appointments were available outside of school hours and the premises was suitable for children and babies. The practice signposted young people dealing with grief to a local charity for additional practical, emotional and social support. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health.

Working age people (including those recently retired and students)

Outstanding ☆

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

The needs of the working age population, those recently retired and students, had been identified and the practice was responsive in the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening which reflects the needs for this age group. The way patients were invited to attend health screen checks had been reviewed, making it a more personalised and successful service. Extended evening appointments for 20 minutes were offered and had resulted in an increased uptake of patients aged 40-74 years old being screened. Potential health risks for some patients had been identified and early interventions such as information about leading a healthy lifestyle or signposting to other services had taken place.

Carers registered with the surgery who also fell in to the working age group, were referred to the practice by a local carers group. They had been offered a comprehensive carers' health and well-being check. A carers clinic was held every month at the practice in conjuction with Devon social services to support patients caring for relatives.

People whose circumstances may make them vulnerable

Outstanding ☆

The practice is rated as outstanding for the population group of people living in vulnerable circumstances.

Accessible information in easy read and picture formats had been developed in conjunction with a national charity to promote equality for patients with a learning disability. The practice had a learning disability champion to raise awareness about patient communication needs across the team.The practice had a policy on

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patient dignity requiring staff to treat people from all backgrounds with respect and provide for their needs. Any person arriving at the practice in need of medical attention would be seen at the practice if this was the appropriate place of care, regardless of social, demographic or personal circumstance. Although small in number, the practice was sometimes used by traveller families. The practice kept in touch with the families via mobile contact numbers to ensure test results were followed up.

Patients with a learning disability were known to the practice and their health and well being closely monitored. Carers confirmed that the team were attentive and supportive to their relatives with a learning disability. Data showed that 100% patients with a learning disability had received an annual health check. The team worked closely with seven adult social care homes where some patients lived. GPs had attended case conferences with social services when patients needed safeguards in place to protect them.

People experiencing poor mental health (including people with dementia)

Outstanding ☆

The practice is rated as outstanding for the population group of people experiencing poor mental health (including people with dementia).

The level of health checks and support people experienced exceeded national averages. Longer appointments and home visits were available. Staff knew their patients well enough to detect early signs of mental health relapse and worked closely with them and their family to keep them safe. All these patients had a named GP and structured annual reviews to check their health and medication needs were being met. For example, 95% of patients had experienced a discussion about their lifestyle, about their drinking and smoking habits. Cervical screening had taken place for 100% female patients with complex mental health needs.

The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice supported patients living in an adult social care home with a link GP. Advance care planning, including treatment escalation plans had been reviewed with patients and/or their advocates for 87% patients with dementia.

The practice had sign-posted patients experiencing poor mental health to various support groups and third sector organisations. The

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practice had a system in place to follow up on patients who had attended accident and emergency or were hospitalised where there may have been mental health needs. Staff had received training on how to care for people with mental health needs and dementia.

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What people who use the service say

The 2014 national GP survey results for the Bramblehaies Partnership based on 191 responses, stated that 87.2% patients rate the practice as amongst the best. Responses were better in most areas compared to the clinical commissioning group (CCG) and national average. In the survey, there were four areas for improvement highlighted by patients, which the patient participation group (PPG) has monitored. These focussed on communication when appointments were running behind, raising awareness for patients about how to use of services such as A&E and the GP practice appropriately and making information more accessible in larger print. The practice had followed these areas up and made improvements, such as having a white board in the seating area to inform patients about any delays in waiting time for appointments.

During the inspection, we spoke with eight patients, two of whom were members of the patient participation group (PPG). The practice had provided patients with information about the Care Quality Commission prior to the inspection. Our comment box was displayed and comment cards had been made available for patients to share their experiences with us. We collected 14 comment cards, which contained detailed positive feedback about the Bramblehaies Partnership.

The overarching theme from patients in their responses was that staff had a caring attitude and listened. Staff were described by patients as being kind, compassionate and responsive when they saw them. Patient comments included examples of how the practice responded quickly when they were in need of urgent care. Working patients commented positively about the availability of early appointments, which avoided disruption to their working day.

These findings were reflected during our conversations with eight patients. Patients told us about their experiences of care and praised the level of care and support they consistently received at the practice. For example, a GP had phoned a patient the night before to check if they were ok as they had not seen them for a while. Patients stated they felt safe and always involved in making decisions about their treatment and support. All eight patients were happy, very satisfied and said they received good treatment. Patients told us that the GPs were excellent and closely monitored their health with reminders for vaccinations and screening such as blood tests. Patients said they were often given advice about diet and lifestyle to help them stay healthy.

Young patients told they were treated with respect. Parents said the GPs talked to their children at their level and this helped reduce any anxieties their child might have had about visiting the practice.

Patients were happy with the appointment system and said it was easy to make an appointment. Patients said they rang the practice and were offered a same day appointment if they needed it. Patients felt listened to and said they had no complaints. Information about how to make complaints was clearly displayed and patients told us they were confident that if they did have any concerns they would be acted upon.

Patients said it easy to get repeat prescriptions arranged and this worked well with all the local chemists in the area.

In addition to the PPG there was a friends of the practice group set up as a charity, with the sole purpose of fundraising. The PPG members felt that the relationship with GP partners was good and they worked closely with them to fund raise and improve facilities at the practice. The building was highlighted by patients as being accessible for people using mobility aids, safe, clean and tidy. PPG members said recent fundraising had been for new front doors, which were being fitted to make the entrance more accessible.

Summary of findings

Areas for improvement

Action the service MUST take to improve

Have effective systems for handling pathology results, scanned correspondence to mitigate the potential risks of inappropriate or unsafe care and treatment of patients.

Outstanding practice

The practice had flexible arrangements for working age patients, which resulted in an increased take up health checks for patients over 40 years. The practice had reviewed how contact was made with patients and compared it's performance against other practices to make improvements. Evening and longer appointments for 20 minutes were being offered. Potential health risks were identified and patients received information promoting healthy lifestyle choices and were given help where needed.

Patients with long term conditions were benefitting from specialist equipment that had been purchased so that blood screening was carried out at the practice for patients. Instead of receiving results the next day, results were available immediately and discussed with patients. Immediate changes to the dose could then be made in response and additional advice and support given where needed.

A named GP and nurse monitored the health and well being of vulnerable patients with a learning disability and/or complex mental health needs. This promoted a trusting rapport with patients. The expertise of a national charity had been used to make all information at the practice accessible for vulnerable patients with a learning disability. Information leaflets, posters were in easy read and picture formats. This had increased patient involvement in the management their health and well being.

The practice was successful in engaging patients with mental health needs to ensure their health and well being was closely monitored. Longer appointments, at quieter times of the day and with named staff were taking place. Information received about the practice prior to and during the inspection demonstrated the practice performed better compared with other practices. These areas included cervical screening for women with complex mental health needs and annual health checks of patients with a learning disability.

Bramblehaies Partnership

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 advisor, a Practice Manager specialist advisor and an Expert by Experience.

Background to Bramblehaies Partnership

Bramblehaies Partnership is a GP practice providing NHS primary care services for approximately 6,500 patients. The practice is situated in the town of Cullompton and covers a wide rural area of 180 square miles, and has low deprivation levels. There is a predominantly older population using the practice and slightly above the national average number of patients in the working age population. The practice supports patients living in nine adult social care services (one of which is a nursing home) and an independent hospital for brain injured patients. The practice has a higher than national average list of patients with learning disabilities and has worked extensively with a national charity to improve accessibility for patients.

The practice has a total of four GP partners who are supported by one salaried GP, four qualified nurses and two healthcare assistants. The clinical team comprises of 3 male and 9 female staff. There is an administrative team consisting of a practice manager, office supervisor, secretary, support staff and receptionists. The opening hours are: 8.30am to 7.30pm Monday to Thursday and 8.30am to 7pm on Friday. Appointments are available 8.30 to 11.30 starting again in the afternoon from 2.30pm (Wednesday), 3pm (Monday and Friday), 3.30pm (Thursday) and 4pm (Tuesday) until closing each day. Emergency Out of Hours cover is delivered by another provider.

Bramblehaies Partnership is registered with one location at Bramblehaies Medical Practice. The practice does not have a dispensary and patients are able to collect their medicines from a choice of pharmacies based in Cullompton.

We carried out our announced inspection at the practice on Tuesday 4 November 2014.

Why we carried out this inspection

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.

This provider had not been inspected before and that was why we included them.

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

Detailed findings

How we carried out this inspection

Before inspecting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. This included information from NHS England, NHS Northern, Eastern and Western Devon CCG, Devon Healthwatch and the local council Health and Scrutiny Board. We looked at the 2014 patient survey and corresponding action plan the practice had in place. We carried out an announced inspection on 4 November 2014. During our visit we spoke with staff (GPs, nurses, healthcare assistants, managers and administrative staff). We spoke with eight patients who used the service. We observed how patients were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients. We reviewed 14 comment cards where patients and members of the public shared their views and experiences of the service.

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

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

We also looked at how well services 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
- The working-age population and those recently retired (including students)
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Good

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses. The practice sent us five recent examples of these. For example, a serious event audit (SEA) record for September 2014 showed that the practice had reviewed an incident where the incorrect size of compression stockings were supplied to a patient. Records showed that the practice had involved the patient in reviewing this SEA and made changes as a result. Practice nurses confirmed that patients were first assessed using a doplar machine to test blood flow before being measured for compression stockings during an appointment with them.

We reviewed other safety records and incident reports and minutes of meetings where these were discussed for the last two years. NHS England told us the practice shared SEAs and serious incidents requiring investigation (SIRIs) with them, so was considered to have a good reporting culture. Staff confirmed that actions taken as a result were then reviewed at a later date to ensure change was embedded in practice and sustained. This showed the practice had managed these consistently over time and so could evidence a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events that had occurred during the last two years and these were made available to us. Significant events were discussed at practice meetings agenda with a dedicated meeting occurring every two months to review actions from past significant events and complaints. There was evidence that appropriate learning had taken place and findings were disseminated to relevant staff. Staff including receptionists, administrators and nursing staff were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so. For example, the practice shared the learning from an audit which looked at the handling of a urine sample. The patient still had symptoms of a urine infection so the sample should have been sent to the laboratory for analysis. The practice policy had not been followed on this occasion. Three staff we spoke with confirmed that they knew about the event and confirmed their awareness of the policy. We saw patient urine samples had been sent off for analysis as per policy.

We saw incident forms were available on the practice intranet. Once completed these were sent to the practice manager who showed us the system they used to oversee these were managed and monitored. We tracked three incidents and saw records were completed in a comprehensive and timely manner. Evidence of action taken as a result was shown to us. For example, one related to the delayed referral for investigation and treatment of a patient at hospital. The GPs we spoke with were open about their learning and showed us all of the documentation relating to this matter. Information was shared with other stakeholders, which helped facilitate the investigation and led to an action plan being developed to improve clinical practice.

National patient safety alerts were disseminated by email to practice staff and accessible on the practice intranet. Staff we spoke with were able to give examples of recent alerts relevant to the care they were responsible for. They also told us alerts were discussed at weekly meetings between doctors and the nursing team to ensure all were aware of any relevant to the practice and where action needed to be taken.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. The team had clear oversight of patients who could be at risk of unplanned admissions to hospital, receiving palliative care or had complex care needs. Minutes of quarterly meetings were seen demonstrating that the team worked in close collaboration with other health and social care professionals to manage and review the risks for vulnerable patients. GPs said that if they or the nursing team became aware of a new concern, they would act on this information immediately and alert the appropriate agencies. We met eight patients, two were adults with long term conditions and a parent with a child. They described positive experiences with the practice, which they felt promoted

their safety. They told us the practice was responsive in providing treatment and additional support at times of crisis, which they said had reduced the risk of unplanned admissions to hospital.

Practice training records made available to us showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Contact details were easily accessible.

The practice had a dedicated GP lead for safeguarding vulnerable adults and children who had been trained to enable them to fulfil this role. This GP said they were trained to level 3 for safeguarding children and had also completed adult safeguarding training. All staff we spoke with were aware who the lead was and who to speak to in the practice if they had a safeguarding concern. On the training matrix we saw there were some training gaps for GPs around adult safeguarding training, which the practice manager was addressing with each individual.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. Three examples were discussed with the safeguarding GP lead and lead nurse, both of which demonstrated that the practice worked collaboratively with the safeguarding board, parents and other health and social care professionals to protect the children involved. GPs had attended child protection meetings and minutes were obtained. Staff explained that patient records flagged concerning information and highlighted potential risks for vulnerable adults and children using a coded system. The safeguarding lead explained that the practice had identified vulnerable adults and worked closely with other health and social care professionals to protect people.

A chaperone policy was in place and visible on the waiting room noticeboard and in consulting rooms. The practice policy highlighted that only nurses and healthcare assistants carried out chaperone duties. Chaperone training had been undertaken by all nursing staff. Four staff we spoke with understood their responsibilities when acting as chaperones including where to stand to be able to observe the examination.

Medicines Management

Safe systems were in place for the generation of repeat prescriptions. Patients had a number of ways to request their repeat prescriptions, in person, over the telephone, on line or by leaving a written request at reception. Staff had arranged with some patients for their repeat prescriptions to be generated automatically. Repeat prescriptions had an annual review date after which staff could not generate a repeat prescription unless the doctor had reviewed the prescription. Safeguards were in place to make sure that high risk medicines were identified and regularly monitored. Prescription pads were held securely and records held to show how these were used.

Medicines were stored securely at the practice and were only accessible to authorised staff. Medicines were stored at the required temperatures. Staff monitored the temperatures of medicines refrigerators to make sure these medicines were safe to use. The practice had a supply of emergency medicines. These were checked regularly by a named nurse to make sure they were in date and safe to use.

The practice held a small stock of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard operating procedures that set out how they were managed. We checked the arrangements in place and saw these were secure.

There were arrangements in place for the recording of controlled drugs. A main register was kept, which clearly showed when controlled drugs were taken out and given. The entries showed who was given the medicine, the dose, the remaining medication returned and when it was destroyed by an authorised person. The local area medicines team were responsible for this and the practice liaised with them to make sure out of date medicines would be disposed of safely.

Directions in line with legal requirements and national guidance were in place for nurses administering vaccines. There were up to date copies of these directions, which staff demonstrated they followed. There was a refrigerator in each of the treatment rooms for any items requiring

cold-storage and temperatures were monitored to ensure these medicines were stored correctly. One refrigerator was hard wired and the other had a clear sign over the socket to warn staff not to switch it off or remove the plug. Nurses responsible for carrying out this task showed us the stock control system in place and vaccines used for patients were within date. A patient participation group member told us that their members had helped the team with the flu vaccination campaign, directing patients into the venue and providing teas and coffees. We met other patients who attended appointments for flu vaccination during the inspection. Patients said that the nurse had first checked whether they had any allergies before giving the vaccination. All of the patients said the nurse had answered their questions and given them information about the vaccine before leaving. This promoted patient health and safety.

Cleanliness & Infection Control

Eight patients we spoke with told us the practice was always clean and tidy and this was borne out by our observations. Fourteen patients in comment cards fed back that they had no concerns about cleanliness or infection control.

The practice had a lead nurse responsible for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received updates. Nursing staff said they had carried out a comprehensive audit of the practice 2014. They showed us this audit and the previous one from 2013. Practice meeting minutes showed the findings of the audits were discussed with staff and changes made as a result. For example, a protocol for cleaning privacy curtains and blinds every in treatment rooms was developed and being followed by the cleaning staff every six months.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. For example, two nurses told us they cleaned equipment used to test patients blood pressure and lung capacity after every patient.

Policies in place covered areas such as personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. Staff were able to describe how they would use these in order to comply with the practice's infection control policy. There was also a policy for needle stick injury, which linked with occupational support for staff in the event of an injury. Staff told us they had been made aware of the latest guidance about needles and were using safer equipment outlined in this document.

Hand hygiene techniques signage was displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). Records showed that the practice had been risk assessed by an external contractor. Action plans had been put in place following the assessment to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly for patient use and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. Calibration of medical equipment was undertaken by an external contractor annually and we saw the inspection report and certification for 2014.

Staffing & Recruitment

We looked at three staff records, all of which contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service (DBS). The practice had a recruitment policy setting out the standards it followed when recruiting clinical and non-clinical staff. The chaperone policy followed at the practice meant that only nurses or healthcare assistants had this additional duty and a DBS had been obtained for all of them.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. For example, two nurses said they were never expected to work outside of their scope of

practice. They shared examples of how their professional competencies linked with health promotion clinics being delivered. For example, a nurse had completed a four day course on compression bandaging (a form of treatment for patients with ulcerated legs) through the hospital tissue viability department. This included assessment of their competency to carry out this treatment for patients. We saw there was a rota system in place for all the different staffing groups to ensure there was enough staff on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave. Newly appointed staff had this expectation written in their contracts.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe. The practice manager showed us records demonstrating that actual staffing levels and skill mix were in line with planned staffing requirements. There was a duty GP system in place and part of the role included responding to urgent needs from patients. This included making home visits where necessary. Nursing staff had a broad range of responsibilities and tended to see patients with more complex needs. Some of the nursing responsibilities had been delegated to three healthcare assistants and included health screening, taking blood pressures and blood for testing. Training records and discussion with these staff verified that they had undertaken further training and assessed as competent before carrying these out. For example, a healthcare assistant confirmed they had completed a blood taking course at the hospital phlebotomy department. They said they felt well supported by the nurses and shadowed them until they felt confident and were assessed as competent to take blood from patients for testing.

Monitoring Safety & Responding to Risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Identified risks were included on a risk log. Each risk was assessed, rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at GP partners' meetings and within team meetings.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example:

- For patients with long term conditions there were emergency processes in place. All of the reception team had been trained to recognise potential emergencies. Patient records highlighted potential risks such as allergies and reminders to ensure annual checks had been done. The practice had a priorty triage system in which the duty doctor carried out an assessment of the patient. Staff gave us examples of referrals made for patients that had a sudden deterioration in health. For example, reception staff notice that an older patient whilst waiting for an appointment had become acutely ill and was attended to. The duty GP gave the patient oxygen and inserted a needle so that medicines could be given quickly whilst they waited for an ambulance to arrive to take them to hospital.
- There were emergency processes in place for identifying acutely ill children and young people and staff gave us examples of referrals made. GPs said that they did not hesitate in contacting the consultant at the local paediatric assessment unit if they had concerns about an acutely ill child.
- Emergency processes were in place for acute pregnancy complications. Nursing staff described how they had looked after a pregnant patient who was bleeding and at risk of loosing their unborn child. The patient was quickly transferred via emergency services to the Royal Devon & Exeter hospital for treatment.
- Staff gave examples of how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment. For example, named staff monitored a patient with complex mental health needs. The staff knew this patient well and were able to describe triggers and behaviours which would indicate that their mental well being was deteriorating. Staff explained they worked closely with the crisis and home treatment team to get support for this patient that resulted in early treatment, which avoided the patient being admitted to hospital.

Good

Are services safe?

- The practice monitored repeat prescribing for patients receiving medication for mental health needs. For example, some patients attended the practice to be given prescriptions for medicines to assist in recovery from addiction. Staff explained that patients were given a limited number of medicines to maintain safety for the person. Staff knew the patients well and said they would involve other health and social care professionals promptly if they were concerned about a person's mental well being.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support and had recently had an annual update in October 2014. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). All staff asked knew the location of this equipment and records we saw confirmed these were checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use. The lead practice nurse carried out regular audits of this equipment to ensure that procedures for maintaining the equipment were being followed. This provided the practice with an additional layer of assurance that emergency equipment was fit for purpose.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to.

Fire safety policies and procedures should be improved. A fire risk assessment had been undertaken that included actions required to maintain fire safety. Records showed the majority of staff were up to date with fire training. GPs had not received fire training for over a year. Records showed that regular fire drills were undertaken. There were minor gaps in the fire safety policy and procedures. For example, there were no action notices giving clear instructions on what to do immediately on finding a fire and role of the fire warden was unclear. This did not follow current fire safety guidance.

Risks associated with service and staffing changes (both planned and unplanned) were required to be included on the practice risk log. For example, a full time GP was on maternity leave. The practice identified a number of risk factors linked with this changed such as the impact on continuity of care for patients due to the increased use of locum GPs. The practice had chosen to use known locums to cover this leave to reduce the impact for patients and maintain continuity of care.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence and from local commissioners. The GP partners hold a journal club to review new guidelines and discuss the implications for the practice's performance and where patients were discussed and required actions agreed. The staff we spoke with and evidence we reviewed confirmed these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate. For example, GPs told us they had recently discussed the latest NICE guidelines published in September 2014 about current antidepressant treatment for adults. GPs used standardised questionnaires to assess the mental health of a patient and prescribed treatment according to the outcome of NICE guidelines.

The GPs told us they lead in specialist clinical areas such as minor surgery, emergency medicine, diabetes, heart disease and asthma. The practice nurses supported this work which allowed the practice to focus on specific conditions. GPs and Nurses we spoke with were very open about asking for and providing colleagues with advice and support. For example, GPs told us they met informally with the Nurses to discuss issues and share best practice guidelines at lunchtime as well as using formal meetings.

Data from NEW Devon Clinical Commissioning Group (CCG) of the practice's performance for prescribing pain relief was comparable to similar practices. The GPs said they utilised an IT system for repeat prescribing, sought guidance from the optimisation team at the CCG and knew the practice was consistently within budget for medicines.

National data showed the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of patients with suspected cancers referred and seen within two weeks.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture at the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making. We met eight patients with diverse needs who all said GPs referred them to specialists without hesitation when a second opinion was required. The practice supported patients who lived in several care homes, some of which specialised in the care of people with learning disabilities. The practice had worked closely with a national charity to make all the patient information accessible for patients with learning disabilities. This included easy read and picture formats for leaflets about leading a healthy life style.

Management, monitoring and improving outcomes for people

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. These roles included data input, clinical review scheduling, child protection alerts management and medicines management. The information staff collected was then collated by the practice manager and to support the practice to carry out clinical audits.

The practice showed us clinical audits that had been undertaken in the last year. For example, an audit of patients prescribed pain relief medicine which is applied to the skin. This was a controlled medicine (medicines that require extra checks because of their potential for misuse). The GPs wanted to ensure that there was a specific indication for prescribing this medication to patients and reviewed 19 records. They also wanted to ensure the decision making was from assessment of the patient against a standardised pain scale and had been recorded. Initial findings found some gaps in recording the rationale to support decisions and led to an action plan being put in place to change how GPs approached this. The audit was then repeated after three months to ensure that changes to practice were embedded across the GP team. This showed that audits carried out followed the full cycle to provide assurance that changes to practice was sustained.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). QOF is a national performance measurement tool. For example we saw an audit regarding the prescribing of analgesics and non steroidal anti-inflammatory drugs. Following the audit the GPs carried out medication reviews for patients who were

Requires improvement

Are services effective?

(for example, treatment is effective)

prescribed these medicines and altered their prescribing practice, in line with the guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes.

Nurses were also subject to clinical audit cycles. For example, cervical smears were audited and nurses have to be revalidated every 3 years to carry these out. The lead nurse confirmed that the results of smear tests for female patients were always checked. 'Inadequate' smear test results led to the patient being recalled and additional audits being triggered for the individual nurse who carried out the test. This ensured the cervical screening service was constantly monitored for patients.

The practice also used the information they collected for the QOF and their performance against national screening programmes to monitor outcomes for patients. For example, 95% of patients with diabetes had an annual medication review, which included screening the patient for known risk factors such as peripheral disease and kidney failure. The practice also met all the minimum standards for QOF regarding asthma, chronic obstructive pulmonary disease (lung disease). This practice was not an outlier for any QOF or any other national targets. In some of these targets the practice was better than expected and this included carrying out alcohol use screening for 95% of patients diagnosed with complex mental illness.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of Nurses and GPs. The staff we spoke with discussed how as a group they reflected upon the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement. For example, the practice had purchased specialised equipment and trained a healthcare assistant to take blood samples to monitor the effects of anti clotting medication. Normally this was done at the hospital and results available to the following day. Instead, patients at Bramblehaies received an instant result and were then able to make the necessary changes to the dose of their medicine. Another benefit for patients was the access they had to immediate advice and support if this was needed. An external quality assurance scheme was used to ensure that the results were within range, safe and accurate to then prescribe the correct does of medicine for each patient. Records showed that audits comparing the practice performance and testing against other practices had been done every three months.

Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP went to prescribe medicines. This showed GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes comparable to other services in the area. For example, data showed that GPs at the practice were better than average at reviewing all patients on the palliative care register with other health and social care professionals who might be supporting them in the community.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. Staff said they received support for their professional development. A good skill mix was noted amongst the GPs, for example one held a diploma in women's health. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. GPs told us they informed the practice manager when they had been appraised. Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by the GMC can the GP continue to practice and remain on the performers list with the NHS England.

All of the staff interviewed confirmed that annual appraisals were undertaken. These identified learning needs from which action plans were documented. The practice manager sent us a spread sheet covering four years of appraisals, which summarised the outcomes from these each year across the team. This provided the practice with a clear overview of the skill base and where

professional development was needed. Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses. For example, a healthcare assistant with delegated responsibilities to do vitamin B12 injections had completed a course, which included an assessment of competency.

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. These duties included immunisation of babies and children, cervical screening and management of patients with long term conditions. Three nurses were working and explained that the administration team had information about their scope of practice which was linked to completed training and assessment of competence. They confirmed that they were never asked to work outside of their professional competence, so worked within safe boundaries when caring for patients. All of the nurses were responsible for management of patients with long-term conditions such as asthma, chronic pulmonary disease, diabetes and coronary heart disease. Records showed they had completed appropriate training and held additional qualifications to fulfil these roles.

Working with colleagues and other services

Close working with other community services was evident. For example, a fortnightly meeting took place with the extended primary care team at the local hospital, district nurses, palliative care specialists and community mental health workers. The purpose of the meeting was to monitor patients with complex needs who could be more at risk. This also included patients receiving palliative care who might need additional support from the hospice or for further advice from the palliative care consultant.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their records. These were used to co-ordinate holistic care for patients receiving palliative care and demonstrated that the team works collaboratively with the local hospice to meet patient needs.

The practice used an electronic patient record system, into which results from investigations such as blood testing, letters from consultants and discharge letters from hospital were scanned in. Specific staff oversaw this process each day and created a task within the system for the patient's GP to review the results. There was a duty system in place for GPs to ensure that patient's results were reviewed every day and action taken where necessary.

Information Sharing

Practice systems to manage information must be improved to reduce the potential risk of patients not receiving prompt care. Records were kept on an electronic system which collated all communications about the patient including scanned copies of communications from hospitals. We found there was inconsistency in the way abnormal pathology and other investigation results were signed off by GPs at the practice. Three different GPs had not followed the practice procedure. For example, an abnormal pathology result received in February 2014 was not recorded as having been seen by the individual GP or recorded actions taken on receipt of this information. A second example of 24 abnormal results received in October 2014 for different patients were not signed off by a GP, which again did not document the actions taken on receipt of these. A third example was an x-ray result received on 8 October 2014, which had no accompanying record to demonstrate whether a GP had looked at the result or discussed this with the patient.

The code of conduct for GPs at the practice stated that pathology results and scanned correspondence must be actioned within five days of receipt. The GP specialist advisor tracked the action taken for five patients through their clinical records and spoke with their GP. Prompt action had been taken for all of these patients, which included recalling the patient for further investigation or commencing treatment. It did, however demonstrate that some staff did not fully understand important safeguards within the electronic patient system. The IT system had a task facility, which when used correctly provided an audit trail showing how abnormal results and scanned correspondence from hospital appointments was followed up for patients. We discussed this matter at feedback as we were concerned that there was a risk that important information about patients was not accessible to all the GPs and nurses until the responsible GP signed off and recorded the actions taken in light of the information. This could impact on continuity of care and treatment of patients. The timescale for action within the code of conduct did not reflect what was happening in practice. GPs said that the duty GP or patient's GP reviewed the results the same day it was received. We followed how results were handled on the day of the inspection and saw these were promptly reviewed by the duty GP. Within 48

hours of the inspection, the practice submitted a revised code of conduct with shorter timescales and a revised protocol for viewing and processing results and correspondence.

The practice used several electronic systems to facilitate continuity of care and treatment for patients. For example, there was a shared system with the local out of hours provider to enable patient information to be shared in a secure and timely manner. GPs showed us the system, which allowed them to upload special notes directly onto this system. An example shared with us involved the care of a patient prescribed complex pain medication. Information was shared with the out of hours provider so that the medication was managed safely to avoid risks such as potential overdose. The practice had a list of patients who were vulnerable, at risk due to long term conditions and those receiving palliative care. Electronic systems were also in place for making referrals to secondary care services.

For emergency patients, there was a practice policy of providing a printed copy of a summary record for the patient to take with them to the Accident and Emergency Department. The practice had signed up to the electronic Summary Care Record and had plans to have this fully operational by 2015. Summary Care Records provide healthcare staff treating patients in an emergency or out-of-hours with faster access to key clinical information. Information about this system was published on the practice website for patients and clearly explained the circumstances when information would be shared with other health or social care professionals.

Consent to care and treatment

Staff were aware of the Mental Capacity Act 2005 and the Children's and Families Act 2014 and their duties in fulfilling it. GPs and Nurses we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment). One of the patients we spoke with was a parent and confirmed that all of the staff communicated well with their children. They verified they themselves were always present with the child during the appointment.

Patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity. The staff understood patients needed to be able to retain and process information given for valid consent. For example, an older patient with mental health needs was deemed to have capacity until they started to neglect their personal hygiene and stopped eating. The GP said they involved the community mental health team, which then resulted in the patient being sectioned under the Mental Health Act 1983 and admitted to hospital for assessment. Another example shared with us highlighted longer term planning with older patients. A GP linked to care homes had reviewed treatment escalation plans (TEP) with patients and their advocates. Staff said a copy of the TEP was held on the patient records at the practice as well as the care home where the patient lived.

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, the practice policy was for a patient's verbal consent to be documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

Health Promotion & Prevention

The practice had met with the Public Health team from the Local Authority and the CCG to discuss the implications and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the local area. This information was used to help focus health promotion activity.

It was practice policy to offer all new patients registering with the practice a health check with the health care assistant or practice nurse. The GP was informed of all health concerns detected and these were followed-up in a timely manner. We noted a culture amongst the GPs and nurses to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic smoking cessation advice to smokers.

Requires improvement

Are services effective?

(for example, treatment is effective)

The practice also offered NHS Health Checks to all its patients aged 40-75 every week. The practice had reviewed it's performance with these and took advice from another practice about how it was achieving higher rates of checks for this patient group. As a result, staff said they had introduced a telephone appointment system where staff spoke with the patient and arranged a date for the health check. This approach was proving successful and had been effective in early identification of long term health conditions. For example, an assessment of drinking habits highlighted that a patient was significantly at risk due to alcohol addiction. Help was offered to the patient quickly as well as further health screening, which resulted in greater awareness for the patient who cut down how much alcohol they were drinking each day/week.

The practice had numerous ways of identifying patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept a register of all patients with learning disabilities and all the patients were offered an annual physical health check . Practice records showed 100% had received a check up in the last 12 months. Similar mechanisms of identifying at risk groups were used for patients who had mental health needs and those receiving end of life care. For example, 95% of patients with complex mental health needs had been assessed with regard to lifestyle choices such as alcohol consumption. These groups were offered further support in line with their needs.

The practice's performance for cervical smear uptake of patients with complex mental health needs was 100% which was better than the national average. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend annually. There was a named nurse responsible for following-up patients who did not attend screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. For example, parents told us that the practice sent out regular reminders so their children were up to date with the immunisations. Staff said the reminders also include telephone prompts to the child's parent.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

The verbal and written feedback we received from 22 patients in total had common themes about their positive experiences at the practice. They highly praised all of the staff who work at the practice and described a culture that was centred on the needs of patients. Patients talked of staff being professional, friendly, helpful and caring. One patient said they were always asked their opinion and their views listened to and acted upon. Patients told us staff were respectful, polite and made them feel valued as people. For example, one patient said their GP called them by name, knew their interests and family connections which made them feel good about coming to the practice. Another patient told us that when they rang up for an appointment staff wished them a happy birthday, which they said had made their day.

Privacy and dignity were respected. At the reception desk we observed interactions between reception staff and patients. These were polite, professional and demonstrated staff were caring and knew their patients well. There was appropriate screening in consultation and treatment rooms. Patients said chaperones had been offered and sheets used to protect dignity during intimate examinations. There were notices informing patients of their right to have a chaperone should they want one.

Care planning and involvement in decisions about care and treatment

The practice participates in the annual national Quality and Outcomes Framework (QOF). This is a nationally recognised voluntary annual reward and incentive programme for GP surgeries in England. Information we reviewed from the QOF monitoring, indicated that 88 % of patients with a documented care plan had been involved in decisions about the content.

Patients told us they felt involved in the decisions about the care and treatment they received and were able to decline treatment. None of the eight patients we spoke with said they had ever felt rushed whilst seeing the GP's or nurses. All eight patients said they felt the GP really took time to listen and acted on their wishes. Staff also worked closely with patient advocates to ensure that decisions made were in the best interest of the person they were treating. For example, a patient with a long term condition said that their GP had telephoned the evening before the inspection to check on their well being as they had not seen them for a while. This then led to an appointment being made the following day for the patient.

We did not speak to any patients whose first language was not English. Staff told us there were facilities to access a telephone and face to face translation service should it be required. The team had a clear overview of patients on the practice list who might need translation services and these included Latvian and Lithuanian people.

The practice and consulting rooms had level access. We saw patients using walking aids were able to move without any restrictions between the waiting and consultation rooms.

Everyone working at the practice was expected to sign a confidentiality agreement as part of their contract of work. Patients we spoke with were not concerned about confidentiality. They were aware their information sometimes needed to be shared by the GP or nurse with other healthcare professionals. The training matrix showed that staff underwent training on information governance (sharing confidential information).

Patient/carer support to cope emotionally with care and treatment

Practice survey information for 2013-14, which we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 91% of patients commented that they would recommend the practice. The eight patients we spoke with and 14 comment cards we received were also consistent with this survey information. For example, these highlighted staff responded compassionately when extra support was required. A patient who experienced pregnancy complications had received on-going support from their GP to help them come to terms with the loss and told us that because of this they were able to eventually return to work.

The team recognised the risk of social isolation, particularly for older people and those with no family members close by. For example, older people were given information about a local luncheon and walking club enabling them to mix with people from the community. Patient participation group (PPG) members said the practice charity also held coffee mornings to raise funds, which in turn helped to bring the community together.

Good

Are services caring?

Notices in the patient waiting room, on the TV screen and patient website also signposted people to a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer and ensured their health was assessed as well as the demands of caring for their relative explored with them.

Staff told us families who had suffered bereavement were called by their usual GP. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or signposting to a support service. At the time of bereavement the practice routinely sent sympathy cards to patients experiencing the loss of a loved one, which patients said they appreciated.

Twenty two patients commented in writing and in person that the staff did their utmost to give clear explanations and support. For example, a new parent said staff acknowledged the anxieties they had about their baby, which they found very reassuring. They said the staff had made them feel comfortable about raising any future concerns if they had any about their child.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Patients told us that the practice responded to their individual health needs well. They said that preferences, such as to see a doctor of the same sex, were responded to where possible. All of the patients had a named GP. Eight patients we spoke with consistently commented that their GP had an in-depth knowledge about theirs and the needs of their family. Patients told us that the practice was reliable, particularly at times of crisis or when in urgent need.

Twenty two patients commented that the prescription system was good. Some patients used the on line request service, whilst others called in to collect their prescription and take it to a local chemist. The practice had arrangements in place for more vulnerable patients so that prescriptions were sent automatically to the chemist of choice. The chemist then delivered the medicines direct to the patient. All patients said the process was efficient and took a couple of days. Reminders were sent to patients and health checks carried out before further prescriptions were issued. Patients confirmed this system worked well.

Secondary care referral to hospitals or other health providers were made promptly. Patients were able to pick their own routine appointment time through a choose and book system. For urgent referrals to other services GPs completed a template, patient services staff processed it and an appointment was booked.

The practice had an active patient participation group (PPG), which worked collaboratively with a charity to raise funds for the development of the practice. Plans were in place for the implementation of the 'Friends and Family test', which would be operating from December 2014. This test allows practices to collect feedback daily from patients attending for appointments.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning it's services. For example, the practice was promoting equality in the way it supported patients with a learning disability and/or complex mental health needs. One of the nursing team staff and a GP partner closely monitored the mental well being of a young person who was at risk of self harm. It was clear from the discussions with these staff that they knew the patient well and supported them in a positive way.

The partner GPs were knowledgeable about changes in the local population in terms of ethnicity and diversity of patients registering with the practice. For example, the practice also had a higher percentage of patients with learning disabilities. Some of the patients live in care homes and named GPs were linked to these for continuity of care. The practice had worked with a national charity specialising in support of people with learning disabilities to ensure all of the patient information was accessible in an easy read format. The practice also had a member of staff who acted as a champion for patients with learning disabilities and had undertaken additional training to fulfil this role.

Equality and diversity training had been completed by all of the nursing and administrative staff via e-learning. Staff we spoke with confirmed they had completed this training in the last twenty four months and that equality and diversity was regularly discussed at appraisals and team events.

Access to the service

Flexible arrangements were in place for working age patients, which extended the opportunities for health screening to take place at one appointment. For example, the way patients were invited to attend health screen checks had been reviewed, making it a more personalised and successful service. Extended evening appointments for 20 minutes were offered and had resulted in an increased uptake of patients aged 40-74 years old being screened. Potential health risks for some patients had been identified and early interventions such as information about leading a healthy lifestyle or signposting to other services had taken place.

Feedback cards completed by 22 patients had a recurring theme highlighting that they were able to get an appointment when they needed it. Eight patients we spoke with told us the appointment system was accessible, by telephone or bookable in person. The practice had plans in place to offer an online appointment system in January 2015. We saw reception staff answered the telephone to patients in a friendly way and were accommodating in getting them appointments to see the GPs or nurses.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice used a triage system and offered telephone appointments for patients. Patients told us their GP usually telephoned them back after morning surgery, which they felt was a good alternative to attending in person for minor issues.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. Advice from a national charity had been taken to make the complaints policy more accessible for patients with a learning disability. The policy was in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints at the practice. Information about making a complaint was clearly displayed in several areas around the practice.

The practice demonstrated evidence of learning from patient complaints. Examples seen had a positive impact on patient experience of care and treatment. For example, a complaint about handling on-going symptoms of a patient was looked at. Records showed staff had been made aware that if a patient still complained of discomfort but their urine sample tested as negative for a second time the sample must be sent to the lab to rule out any other causes. Staff were able to describe the process and showed they were aware of this procedure.

None of the eight patients we spoke with, or 22 patients who gave written comments had ever made a complaint. Patients said they would either speak to the receptionists, the GP or practice manager.

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

There was clear leadership at the practice. Partner GPs provided clear business and clinical leadership in areas such as safeguarding and specialist care. Staff told us they felt they were well supported and enjoyed working at the practice. The changes and challenges staff faced at the practice related to it's town and semi rural location and on-going financial constraints with the NHS budget. Care and welfare meetings, reflective practice, access to counselling services and de-briefing after serious incidents were embedded measures supporting staff. All of the staff told us they felt very well supported.

Staff morale was high at the practice. Staff said they felt valued and were encouraged to do the best for patients. The practice team was managed in an open and transparent way at the practice.

Governance Arrangements

All 11 staff we spoke with understood their role and responsibilities and demonstrated appropriate accountability in the way they supported and treated patients in their care. There were clear lines of accountability with regard to making specific decisions, especially decisions about the provision, safety and adequacy of the care provided and these were aligned to risk.

Senior GPs had lead roles, for example one GP was responsible for the protection of patients. Policies and procedures underpinning Adult and Children safeguarding at the practice were kept under review by this GP and referenced national guidance and current local safeguarding processes. The adult safeguarding procedure lacked information about the practice policy regarding disclosure and barring checks for staff or use of disciplinary procedures in the event of concerns being raised about staff. Administrative staff held specific responsibilities for example with regard to alerts from the Medicines and Healthcare products Regulatory Agency (MHRA). These were escalated to the GP prescribing lead and were then discussed to raise awareness across the clinical team about potential risks and necessary actions to take.

Practice nurses told us they were supported through the local practice nurse forum and links with the modern matron and other specialist nurses at the Royal Devon & Exeter hospital. The senior partner GP and practice manager carried out appraisals of the nurses. Training needs were identified and support given to staff to undertake additional training to increase their skill base. For example, a senior nurse had completed a leadership in practice course which provided them with the skills to lead the nursing team. Nursing staff increased their skills and expertise in supporting patients to manage long term conditions. An example of this was the quarterly meetings held with the diabetic nurse specialist to review patients with complex and unstable diabetes.

There were management systems in place to monitor the quality of the service provided. Regular reports were provided to the Northern, Eastern and Western Clinical Commissioning Group (CCG). This included performance information, clinical and strategic management. Referrals were monitored and there was a quarterly system in place for GPs to check each others referrals, for example, for appropriateness.

There were clear lines of reporting at the practice, which was clearly monitored through quality and safety processes. For example, one of these processes included senior GP partner oversight of emerging risks with vulnerable patients. The team had a clear overview of the most vulnerable patients, in particular those receiving palliative care. Immediate, medium and longer term actions were in place to mitigate potential risks and promote patient safety, health and welfare.

Leadership, openness and transparency

The practice participates in the annual national Quality and Outcomes Framework (QOF). This is a nationally recognised voluntary annual reward and incentive programme for GP surgeries in England. The practice has to achieve targets called indicators in four main sections, called domains. These include clinical care which looks at long term conditions such as asthma and coronary heart disease to make sure the staff are caring for these patients adequately. QOF results for the cycle 2012-13 were achieved by the practice.

GPs met every day to discuss practice issues informally with nursing staff and there were regular formal meetings to promote good communication and team work. These included monthly meetings to review risks and issues arising for patients receiving palliative care, at risk of unplanned admission or with complex care needs, weekly

Are services well-led?

Good

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

clinical governance and business meetings between GP partners and the practice manager. There were also separate practice nurse meetings for nursing staff to catch up, share information and feedback.

Practice seeks and acts on feedback from users, public and staff

The importance of patient feedback was recognised and there was an active patient participation group (PPG), which worked in collaboration with a charity set up by the practice for fundraising. Two members of the PPG said that the GP partners and practice manager listened and acted on suggestions made. They explained that the GP partners always explained any potential barriers for change, which usually related to matters outside of their control such as NHS budget constraints. Plans to expand the practice had been openly discussed with the PPG and the practice was proactive in engaging the help of members during the recent flu vaccination campaign. The PPG members had provided tea, coffee and morale support for patients attending the clinic which other patients said they appreciated. The charity linked to the practice was led by a GP who had worked there before their retirement. Fund raising was focussed on improving the physical environment, for example the doors leading into the practice were about to be replaced with automatic ones to provide better access for patients with limited mobility.

Management lead through learning & improvement

We saw evidence that the practice undertook a range of audits and professional groups had specific objectives to achieve. GPs and nurses are subject to revalidation of their qualifications with their professional bodies. We saw a cycle of audit taking place at individual level. For example, one audit showed that a GP had carried out a review of their prescribing practice to determine if this was in line with patient needs and national guidance. This showed the GP was responsive to patient needs in their prescribing practice and potential risks were always explored with the patient. Another example seen was the revalidation of nurses in cervical screening every 3 years. Nurse held records of anonymised cervical screening results, which were peer reviewed. All 'inadequate result' cervical smears carried out for patients, were reviewed by the lead nurse. Mentoring and support was provided for nurse's to improve their skills and accuracy with such testing.

A random selection of five staff files showed that annual appraisal were carried out. Training needs were identified, present conduct discussed and future plans agreed upon. Nursing staff files contained evidence of professional training and reflection on specific issues. Clinicians were appraised by clinicians and administration staff appraised by administration staff. Competencies were assessed by a line manager with the appropriate skills, qualifications and experience to undertake this role.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **Patient information systems were not consistently followed when documenting actions taken with pathology results. Patients were potentially at risk of not receiving prompt, co-ordinated care across the GP and nursing team at the practice.**