Brannam Medical Centre

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
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

We carried out an announced comprehensive inspection at Brannam Medical Centre on 18 November 2014. Overall the practice is rated as good. We found the practice to be good for providing safe, effective, caring, responsive and well led services. It was also good for providing services for all the population groups.

Our key findings were as follows:

Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.

The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the Patient Reference Group. Improvements had been made so that patients with reduced mobility including wheelchair users could access the practice easily. Patients had a variety of ways to make appointments and found the practice to be flexible in meeting their needs.

The practice had a system in place for completing clinical audit cycles in order to monitor safety and effectiveness of practice. Audits had been done for the benefit of patients. There was a culture of willingness to challenge. There were a range of audits that had been reviewed and repeated annually. Audits were routinely done on the whole practice list, not just those on individual lists of the GP doing the audit.

Staff compiled a weekly list of vulnerable patients who needed follow-up, having missed for example, international normalisation ratio (INR) which checks whether the anti-coagulant medicine is being given at the correct therapeutic dose. The GP would then decide what action was needed to ensure the patient's safety.

There was a drop-in clinic for patients under the age of 21, for contraception and general advice. No

Summary of findings

appointment was necessary and it was open to non-registered patients. Homeless patients referred on to other services could collect details of other medical appointments or messages from the practice.

The practice had good facilities and was well equipped to treat patients and meet their needs. The practice used innovative and proactive methods to improve patient outcomes, working with other local providers to share best practice. For example a skin cancer surgery clinic had been offered since November 2013 at Brannam Medical Centre for low risk excisions, by a GP registered with a special interest in dermatology.

The practice had a clear vision which had quality and safety as its top priority and were proud to maintain continuity of care for patients through the GPs personal lists. A business plan was in place, was monitored and regularly reviewed and discussed with all staff. High standards were promoted and owned by all practice staff with evidence of team working across all roles.

We saw several areas of outstanding practice including:

A nurse and GP were on duty every afternoon, running a 'never full' system. Anyone who asked for a rapid access appointment was seen on the day and this included patients with minor injuries.

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

Provide staff training in the Mental Capacity Act 2005 and its relevance for their work in respect of patients who may lack capacity to give informed consent to care and treatment.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. The practice used every opportunity to learn from internal and external incidents, to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Reliable systems were in place to provide and maintain good practice in infection control and cleanliness throughout the practice. Medicines were safely stored and administered. Staff understood their responsibilities with respect to protecting children and safeguarding vulnerable adults.

Are services effective?

Good

The practice is rated as good for providing effective services. The practice was proactive in checking outcomes and considering the best way of providing the service. Professional guidance was discussed at Monday lunch time meetings where the responsible GP for an individual disease area would present a summary before discussion.

A high percentage of patients had their annual review – 95% of patients with diabetes, 85% for obstructive pulmonary disease (COPD), and 78% for asthma. National data showed the practice was above average in keeping a register of patients with a learning disability and those in need of palliative care. Care plans for patients with complex needs were drawn up at the weekly multi-disciplinary meeting.

The practice had a system in place for completing clinical audit cycles. Audits had been done for the benefit of patients as well as meeting Quality and Outcomes Framework requirements. There was a culture of willingness to challenge. There were a range of audits that had been reviewed and repeated annually. Audits were routinely done on the whole practice list, not just those on individual lists of the GP doing the audit.

The nurses were well organised with specific roles and responsibilities and staff were supported in role development.

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Are services caring?

Good

The practice is rated as good for providing a caring service. Patients who spoke with us all felt GPs, nurses and other staff were friendly, approachable and professional. They felt supported and well cared for, and had been treated with compassion, dignity and respect. They said they had enough time with the GP to talk about their health concerns.

A patient who had been with the practice for a long time told us their husband passed away some time ago and they had felt well supported and cared for. Staff told us that GPs phoned bereaved relatives and would visit if this was appropriate. Staff also gave practical advice about death certificates and funeral directors.

Are services responsive to people's needs?

Good

The practice is rated as good for providing a responsive service.

There was no telephone triage system for allocating GP appointments. Instead an innovative system had been introduced called the rapid access clinic. A nurse and GP were on duty every afternoon, running a 'never full' system. Anyone who asked for a rapid access appointment was seen on the day and this included patients with minor injuries.

Patients told us they had got an appointment on the day when they had needed one and they had been able to see their own GP within two days.

Patients were offered the option of a telephone consultation with their GP, which was well used, as 12% of patient contact was by phone. The practice was considering the potential for email consultations or Skype.

A third of the practice population lived in rural areas, covering a wide area. GPs made home visits when necessary although journey times meant that each visit could take an hour.

Patients said it had been easy to get an appointment and staff would provide treatment and care other than the clinic that was running if a patient needed to be seen. Staff said the rapid access clinic was well used and was a way of effectively connecting with homeless patients, as they found it helpful that they could be seen without having to make an appointment.

There was active review of complaints and how they are managed and responded to, and improvements are made as a result. We looked at four complaints received in the last year and found these were satisfactorily handled and dealt with in a timely way. One had been a patient expressing anxiety, but had been logged as a

Summary of findings

complaint so the practice manager could evidence what had been done. This was excellent practice, showing openness and transparency in dealing with problems that arose and reliability in dealing with them.

Are services well-led?

Good

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

The practice had a clear vision to provide a family GP service with each GP having personal lists to provide continuity of care including health promotion. The partners were keen to be involved with innovations and volunteered to take part in pilot schemes. For example, Brannam Medical Centre was one of four pilots introducing an on-line system for recording and sharing information and helping to establish it. Electronic prescribing had been introduced and electronic discharge was being piloted.

There was a clear leadership structure with named members of staff in lead roles. We spoke with ten members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. Staff and GPs attended team away days where the practice two, five and ten year plan had been discussed. Staff told us this was a really good practice for team work, role development and training. A team health audit had been carried out by the treatment room staff. This identified that health care assistants (HCAs) at times felt isolated as their rooms were away from the main treatment room. The practice took action in response by providing each with a nurse mentor for support and guidance, as well as providing a weekly meeting with the treatment room lead nurse to discuss any concerns. The HCAs also now ran some of their clinics from the main treatment room.

The patient reference group (PRG) met quarterly. The practice manager always attended along with one or two GPs. PRG members told us they had been asked by the practice for feedback about the level of service they wanted, for example, the speed of response. They were pleased overall with the standard of communication and said that GPs and managers had a democratic and respectful way of relating to patients.

Summary of findings

The six population groups and what we found

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

Older people

Good

All patients had a named GP. The practice has run personal lists for over forty years with every patient registered in the practice having a named GP. The practice was proud of maintaining the personal connection with patients. Diabetic patients, becoming housebound in later life, would suffer an extra loss if they had to change nurse, so, although practice nurses had not done home visits, it was under discussion.

Home visits and rapid access appointments were offered to those with enhanced needs including dementia.

The practice was auditing the number of patients over 75 who had not been seen in the last year with a view to inviting them in for a health check. So far, just 33 out of 1493 had been identified.

Weekly multi-disciplinary meetings were held to discuss patients with complex needs including end of life care in line with the gold standards framework (GSF). The practice manager told us that these GSF meetings had been held up as an exemplar local model by external health care professionals attending the meetings. Patients with chronic diseases eg COPD/asthma were provided with self-management plans by lead nurses. At the time of this inspection the practice was part of a three month pilot, sharing an emergency care practitioner (ECP) with two other Barnstaple practices. The GP triaged visit requests and decided whether to send the ECP to assess. The ECP was generally able to visit more quickly than the GP and may be able to prevent hospital admission.

A GP coordinated how care in care homes is managed. He had no specific MCA training but felt confident in this area and has had to make best interest decisions. He had reviewed care home patients including those in specialised dementia care. He worked to identify those patients who were likely to develop complex needs and undertook an early visit to patients admitted to a care home for this reason. The GP reviewed medication and attached special patient messages for the Out of Hours services.

Patients were put in touch with volunteer groups via the complex care team. Health Care Assistants, who carried out carer's checks, had information on support groups. There were also contacts with local churches and Age Concern.

Summary of findings

People with long term conditions

Good

There was a system to identify patients at risk of developing long term conditions. Once identified, patients were offered NHS health checks and new patient checks. There was a recall system to follow up of patients who for example had raised blood pressure without diagnosis of hypertension, or significant life style recording eg drinking habits. Opportunistic screening was offered, as was screening for dementia in at risk groups. Patients' good health was promoted supported by the provision of a health trainer within the practice as well as weight management and smoking cessation clinics.

There was a well organised recall system for chronic disease clinics. Clinics were held jointly where this would be beneficial to patients. For example, patients might attend for consecutive diabetes and chronic obstructive pulmonary disease (COPD) appointments with lead nurses.

All patients with a long term condition were recalled annually for a medication review with their GP. The current figures for the percentage of patients who had an annual review were diabetes 95%, COPD 85% and asthma 78%.

Links with palliative care teams were strong, through the weekly multi-disciplinary meeting under the Gold Standards Framework (GSF). This gave the opportunity for the patient's usual GP to discuss individual patients with external health care professionals. A designated receptionist acted as practice GSF administrator, communicating regularly with the members of the team, including the hospice nurse and complex care team.

There was a system for reviewing medications for patients with more than one long term condition, who might have repeat prescriptions for multiple medications. Patients who had more than one long term condition were offered appointments at one clinic following another, to avoid additional travelling. Clinics had been combined for multiple conditions.

If patients failed to arrive for their warfarin blood level checks this was flagged up on the computer system and patients were contacted as this may affect their health. There was a list of weekly non-attenders for routine appointments and staff contacted patients if their non-attendance may put them at risk.

Families, children and young people

Good

The practice offered after school appointments at the rapid access clinic (RAC) including regular asthma appointments. They planned to adjust the timing of these RAC appointments so that children could come straight from school. Children's flu vaccination clinics

were held during half term and after school. Childhood immunisation appointments were also offered after school. A child immunisation clinic ran weekly, with information clearly presented on the practice's website. Between 96% and 98% of children had received their vaccinations.

The practice worked collaboratively with school nurses and midwives with a midwife not employed by the practice but working from the premises. GPs referred any patients with maternity complications to co-located midwife or if significant by ambulance to the district general hospital.

A monthly meeting was held at the practice where the health visitors, midwife, school nurse came to meet with GPs and staff where concerns are discussed, including concerns for unborn children and action plans noted. Staff said they found these meetings helpful in their understanding of families of troubled children. The records of children who have enhanced health visitor services or where there are child protection concerns are coded as required to enable monitoring.

Quarterly searches were run to identify children who had missed more than three appointments either at hospital or in the practice in the last six months. This was a risk indicator suggesting there might be underlying problems in the family. The information was circulated to their usual GP for consideration and any further action. The health visitors and child's GP are informed of children who repeatedly fail to attend for immunisation.

The practice had direct phone contact with health visitors, multiagency safeguarding hub (MASH) and emergency agencies. Staff had received training for child protection and understood their responsibility to report any concerns to the safeguarding lead.

The GPs attended training on identifying sepsis in a child last month and adopted the leaflet "Information if Your Child has a Temperature" for use in the practice.

The practice ran a weekly "drop in" family planning clinic over a lunch hour with a female GP and practice nurse available for registered and non-registered patients. This included contraception for teenagers. The GP assessed the patient as to their ability under the Gillick competences to make this decision in their own best interest, with encouragement towards the patient having some dialogue with their parent as they felt appropriate.

The practice manager was keen to set up a young person's section on the practice website and was considering going through the local college to promote the PPG, hoping to attract potential members.

Summary of findings

Working age people (including those recently retired and students)

Good

Data from Public Health England showed that there were fewer than average people aged 30 – 45 in the local population.

Some of the health care assistants' general clinics run through the lunch hour for patients to attend during a lunch break. Nurse clinics run on two evening per month for chronic diseases to meet patient demand for evening clinics. This was described as flexible, for example, smear tests could also be added to these clinics.

12% of patient contact was by phone – not a system of triage, but by patient choice for consultations. They were querying whether there might be a place for email consultations or Skype. The practice offered on line appointment booking and on line repeat prescription ordering, text reminders, and telephone calls to remind patients of appointments.

Family planning lunch time appointments were offered and there were plans to offer Rapid Access Clinic appointments over lunch time. Evening appointments were available for health checks, chronic disease management and flu vaccination. Appointments could be made from 7:30am on four mornings per week. There was information on the website about a new GP service available at the local hospital on Saturday mornings.

NHS health checks and new patient checks, smoking cessation clinics, weight management and travel clinic advice were offered. Health promotion material was made available on the practice's website and on patient information screens, display boards, and messages sent with prescriptions.

GPs had supported patients and their own staff to make a phased return to work. We heard about examples within the practice.

People whose circumstances may make them vulnerable

Good

There were no barriers to registering with the practice. Travellers who arrived with the fair were able to book for children's immunisations and antenatal care as required as temporary residents. Patients were registered either using the medical centre address or the address of the local refuge. They were often seen in the rapid access clinic if they found it difficult to pre-book appointments. A practice nurse said the rapid access clinic was well used and was a way of effectively connecting with homeless patients, who could turn up and be seen without having to make an appointment. The rapid access clinic was open each afternoon Monday to Friday. Homeless patients referred on to other services could collect details of other medical appointments or messages from the practice

Summary of findings

There was also a drop-in clinic for patients under the age of 21, for contraception and general advice. No appointment was necessary and it was open to non-registered patients.

Individual patients, who were known to GPs as vulnerable for any reason, were to be 'flagged up' on computer screens so that staff were aware as necessary with a message personalised to the patient's needs.

A register was kept of all patients who had a learning disability. They were offered half hour annual health checks and provided with a health plan. A team member met annually with the local learning disability nurses to check the register remained accurate. The local team provided information about activities suitable for people with learning disabilities along with health information, in an easily understandable format.

Four GPs had gone on training about working with patients with drug and alcohol issues.

Staff compiled a weekly list of vulnerable patients who needed follow-up, having missed for example, international normalisation ratio (INR) which checks whether the anti-coagulant medicine is being given at the correct therapeutic dose. The GP would then decide what action was needed to ensure the patient's safety.

People experiencing poor mental health (including people with dementia)

Good

Patients with mental health problems were scheduled where possible to see the same practitioners at the practice, to maintain consistency and to develop trust. Annual physical health checks had been offered, and nurses said they tried to do other general health checks at the same time as seeing a patient for a mental health issue, if this were convenient for the patient, to avoid multiple trips to the practice for them. Of the patients on the register with a diagnosed mental health condition, 78% have had a blood pressure check, while 50% had an agreed care plan.

A dedicated community psychiatric nurse (CPN) came for a weekly meeting with GPs and staff over coffee. There was no representative from Child and Adolescent Mental Health Service (CAMHS) at this or any of the meetings.

The practice assessed patients who had long term conditions and multi-morbidities for anxiety and depression. The templates used at regular clinics for patients with diabetes, coronary heart disease (CHD) and COPD prompted the clinician to ask patients if they have low mood or any concerns.

Summary of findings

If a patient failed to attend for a mental health related appointment and they were known to be under the community mental health services, staff contacted the local mental health team to alert the non-attendance to them. Staff said that all mental health patients had a care plan and community based key worker. Patients had a named nurse for their depot injections. If patients did not turn up for their depot maintenance injection, a protocol was in place for staff to ring the CPN to report this and also inform their GP.

Longer appointments and quitter times of day were not routinely offered to patients with mental health problems, but were available on request. Each GP had a personal receptionist for the patients on their list, which meant that staff making the appointment were likely to know the patient's individual needs and could tailor the appointment, for example, to see the same nurse for injections if possible. The GP's personal receptionist was likely to know which patients may become agitated in a full waiting room and those who had difficulty getting to early appointments. If a patient became distressed in the waiting room, staff called a GP and nurse for immediate support and phoned the CPN. Staff said they could always find a spare consulting room, somewhere quiet.

There were leaflets about the depression and anxiety service (DAS) available for patients to self-refer, with details on the patient information screen in the waiting room.

Summary of findings

What people who use the service say

We spoke with 15 patients during our visit and received five completed comment cards.

None of those interviewed had any complaints regarding this practice. All felt that the practice was of a high standard, staff friendly and approachable, and the building modern, clean and welcoming.

Patients said they had been contacted with a text message to remind them of their appointment. They said the reception staff were very good when they arrived. Some said they appreciated the improvements in arrangements for wheelchair users.

No-one complained about having to wait; one said they expected delays but generally there was no problem, while another patient said their appointment had been a minute early on the day of this visit. One person said they did not mind waiting, because they could browse the book stall.

Patients were pleased with the continuity provided, one saying they had been with the practice for many years and normally saw the same GP. They appreciated they would have to wait a few days for a non-urgent appointment with a part time GP.

Patients said their care in an urgent situation had been good – such as home visits over the course of the day.

Patients commented that they were treated with respect, and their surname was always used. GPs listened to them and were not patronising. Patients told us the receptionists engaged with them and treated them with respect.

Areas for improvement

Action the service SHOULD take to improve

The provider should train staff in the Mental Capacity Act 2005 and its relevance for their work in respect of patients who may lack capacity to give informed consent to care and treatment.

Outstanding practice

A nurse and GP were on duty every afternoon, running a 'never full' system. Anyone who asked for a rapid access appointment was seen on the day and this included patients with minor injuries.

Brannam Medical Centre

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 second CQC inspector and an Expert by Experience (this is a person who has personal experience of using or caring for someone who uses this type of service).

Background to Brannam Medical Centre

Brannam Medical Centre is a town centre practice, based at Brannam Square, Kiln Lane, Barnstaple, Devon, EX32 8GP

Around 13,500 patients are registered with the practice. Two thirds of the area is urban, one third, rural. Data from Public Health England shows that there are fewer than average people aged 30 – 45 in the local population. There are more men and women than average aged 60 – 75.

The practice is expecting to see the patient population grow and have incorporated this in their service planning. The current arrangements with eight lists would be able to provide a service for an additional 1,000 patients.

There are ten partners, a salaried GP and a retainer GP of whom five are women. Full time GPs provide nine sessions and provide a service to up to 2,000 patients. There are eight lists at this practice, each with its dedicated receptionist. Two of the GP partners job-share, including sharing the receptionist. Six practice nurses are employed, totalling 3.66 whole time equivalent (WTE) as five were not full time. Three health care assistants are employed, totalling 1.65 WTE.

This is a training practice, with a registrar and a trainee doctor in the third year of their foundation programme.

The CQC intelligent monitoring placed the practice in band 6. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

Out of practice hours, patients are directed to call NHS111 where they may be directed to an out of hours GP if appropriate. Brannam Medical Centre does not provide this service.

Why we carried out this inspection

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

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. 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.

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 18 November 2013.

During our visit we spoke with a range of health care professionals and administrative staff and spoke with patients who used the service including members of the patient participation group (PPG). We also talked with carers and family members. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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

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

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

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

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts (NPSA) as well as comments and complaints received from patients. The practice manager received the NPSA alerts, actioned them and sent them to the executive partner. She logged what action was taken, for example, if a relevant incident report about a device was received, it would be passed to the treatment room lead.

Medicines and Healthcare Products Regulatory Agency (MHRA) alerts were emailed to the practice manager who forwarded them to GPs with lead roles in prescribing. In turn these GPs reviewed the alerts and decided which to take to the GPs' weekly meeting where it was agreed what actions would be appropriate for example, stopping or changing the medication. An example was given where two drugs had been discussed at this meeting. It was decided that a patient list would be provided for each GP and a common approach was agreed in cases where clear risk was evident. In more borderline 'low risk' cases, considerations were made on an individual patient basis.

The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, the most recent had been a letter found in the wrong patient's record. This was discovered during the pilot to enable patient access to their records. Following this discovery three identifiers were used on letters to avoid a recurrence. The pilot was amended to exclude letters from patient access. Staff training was provided with respect to scanning documents, to promote accuracy. This was discussed at a reception team meeting, and subsequently at the quarterly significant event analysis (SEA) meeting.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. One example from recent practice followed a patient's referral by a GP suspecting a diverticular abscess to the surgical emergency clinic at the local district general hospital. The proforma for that referral required that a urine sample was sent. For various reasons this did not happen and the patient did not obtain the urgent surgical review required. There were three lessons learned from this SEA - GPs should consider overriding a requirement for an additional test if it would delay referral and was not critical to the pathway and the relevant staff member should alert a GP to any urgent task which was still outstanding at the end of the working day. The practice produced information to give to patients, telling them the reason for a request to return a urine specimen for examination.

Another example of dealing with a problem in a way that improved the service for patients was that a GP had not been able to get to speak to a health care professional about a patient and messages left on their answerphone were not being responded to. A meeting was arranged where the GPs highlighted to the provider how important the communication was. Following this, the provider improved reception resources and access for GPs to the health care professionals.

The accident reports of the previous year included two where a patient had their fingers trapped in a door, or had been in danger of this. The door closers were adjusted and at a business meeting, a GP introduced a proposal to provide devices to prevent finger crushing on doors throughout the practice.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. There were suitable policies to provide guidance for staff including protocols to follow should they need to raise an alert. The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern. They were also aware of their responsibilities under the whistle blowing policy.

We looked at training records which 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 and knew how to share information, properly record

documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact phone numbers were available for staff to use.

GPs told us of an alert that had been made by a school who had contacted the multi-agency safeguarding hub and the practice simultaneously. The case was later highlighted at the regular child protection meeting following the initial alert. A receptionist reported concerns about a family member's behaviour with their child. This was discussed at the weekly meeting with the school nurse.

Practice nurses had not attended Mental Capacity Act (MCA) training specific to their role. Some had read the MCA policy at the practice and there may have been a video to watch. Health care assistants did not demonstrate understanding of issues of capacity to make informed consent.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. Most receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

Two GPs, including the lead for child protection, had achieved level 3 in child protection training, and the other GPs were all in progress toward this, having achieved level 2. All GPs had completed training in safeguarding vulnerable adults. GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. GPs were aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as the police and social services.

Medicines management

There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy. There were four vaccine storage fridges. While none were hardwired, three had plugs that were acceptably labelled to prevent them being turned off or disconnected. The fourth fridge plug was unlabelled and plugged into an extension lead which did not provide a sufficiently secure connection. We brought this to the attention of the practice manager who said action would be taken to ensure the plug was removed from the extension lead and plugged into a socket and labelled to not switch off so that vaccines would continue to be stored at the correct temperature. All vaccine fridges were alarmed in case the internal temperature rose to an unsafe level. There were max/min thermometers in each fridge and temperature readings were taken each day the practice was open. Records indicated acceptable temperatures were being maintained.

A prescribing co-ordinator was employed and two administrative staff specifically managed prescriptions. The prescribing team met weekly. The neighbouring pharmacist carried out regular medication checks. A running record was kept for each drug. No controlled drugs were stored in the practice. Prescription pads were stored securely. The practice was well organised with respect to high risk medicines. The prescriptions were generated with a reminder that a blood test was necessary before the prescription was authorised. Staff told us the system worked effectively.

The IT system also flagged up other risks for example, when a patient had an infection such as C.difficile. Broad spectrum antibiotics (which can lead to increased rates of some infections) were discouraged by local formularies. The IT system raised an alert when GPs actioned a prescription. GPs said they had not often observed these drugs being prescribed.

Patients were happy with the system for repeat prescriptions. Prescriptions were easily accessible either on line, by email or by completing forms at the practice and they could collect medicines from a designated pharmacy. One patient said their repeat prescriptions were delivered from the chemist and this worked very well. Another said they found electronic ordering to be wonderful.

Patients said their GP had explained the need for their medicines and any side effects, but they were not aware of receiving leaflets with the medication. GPs told us that

patients receiving multiple prescriptions had reviews of their medicines at least annually, and that one of the indicators for a quality monitoring pilot in 2013-14 was to audit polypharmacy in the elderly.

GPs monitored their own medication bags and the prescribing co-ordinator also checked the medicines they carried when going on home visits. The registrar had their own bag, which was stocked by the practice. However, locums were not part of this system.

GPs carried a laminated dose chart so could be immediately aware as to what dose to give in the event of an emergency. Controlled drugs were not carried and not stocked. Town pharmacies would enable a GP to obtain a controlled drug to meet patient need and were open until the early evening.

There were systems that ensured medicines and equipment was in date and maintained to be in working order. Anaphylaxis kits were available in the emergency equipment bags in addition to adrenaline kept as stock at the practice. Emergency equipment was suitable for use with babies, children and adults. Staff knew where to find the equipment in the event of an emergency and could describe a time recently when the equipment had been needed. When children's clinics were running in a different part of the building, the nurses took the child resuscitation equipment with them, to be easily available for use in an emergency.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept.

Patients we spoke with told us there were good hand hygiene facilities in the toilets. Hand gel was provided at the entrance. Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. In 2013 a practice nurse arranged to borrow a UV light detector and examined each staff member's hands after the morning session to highlight the importance of good technique with hand washing.

Two members of the patient reference group (PRG) helped with an infection prevention and control (IPC) audit. They checked public areas and a sample of GP consultation rooms, bringing items left in a sink to the notice of the responsible person. The practice met with the cleaning company, and brought to their attention the need to check corners of rooms.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

The practice had a lead 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. Infection control was part of the induction training for new staff and thereafter on-line training was available for staff.

Some instruments used in minor surgery were for single use, but others were sent to the hospital to be sterilised for re-use. The practice kept a record of when packs came into the practice and the asset numbers of the packs but not when packs were used for individual patients. The nurses said they would amend their audits of packs to reflect which packs had been used for individual patients for traceability purposes. Nurses could demonstrate records to show that when packs were used, contents were checked and all items were accounted for.

A housekeeping audit had been recorded on 29 January 2014. The practice manager had carried out this check with a GP. A variety of shortfalls were identified and action taken in response. For example, the cover of a treatment chair was found to be damaged and was replaced. A cover being used for a small bed in a consultation room was found to be inappropriate and was removed. Equipment for recording the electrical activity of the heart was removed from the top of a fridge. Additions were made to the task list for the cleaners, to include wiping couches and cleaning toys. We found that not all sinks had liquid soap dispensers, now they have, if practicable. Sharps boxes now were all placed safely. A crack noticed in plasterwork in a consultation room was promptly repaired, so the wall could be kept clean and hygienic.

Good

Are services safe?

The treatment rooms where the health care assistants provided clinics, including phlebotomy, were clean and tidy. The floors were carpeted. The practice had an action plan for replacing the carpets with washable non-permeable flooring, recognising that carpets in treatment rooms are not best practice. Quotes had been received and the practice manager said the new flooring would be in place by March 2015.

Curtains round couches were replaced at six monthly intervals. Clinical waste was stored safely and disposed of legally.

A legionella risk assessment was professionally carried out on 29 July 2012 and subsequently reviewed by the practice manager. The caretaker was trained to carry out the monthly checks on water temperatures and boiler maintenance was arranged to ensure suitably hot water throughout the system to avoid risk of legionella developing.

Equipment

Equipment had been calibrated and electrical safety tested in the last 12 months. Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly 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. The practice manager ensured that safety checks were updated.

Staffing and recruitment

Records we looked at 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 through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. A new partner was currently undergoing a DBS check for their registration with CQC. DBS checks were carried out for all staff, at level one for administrative staff, and level two for health care assistants.

Brannam Medical Practice had not used an agency to source their locums, having always been able to use locums who had trained here. One of the GPs was educational supervisor of a previous registrar and had booked her to cover as locum. The practice manager checked the locum GP was is on the performers' list but no other checks had been made. References had been provided for a salaried GP and their qualifications and employment history were on file. A vaccination record was kept.

Staff told us there were enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. Nurses could summon an additional nurse if their clinic was beginning to run late. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring safety and 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.

The executive partner and practice manager had walked round the building with a tick list and give instructions to the caretaker at six monthly intervals. The caretaker also reported issues when noticing any problem. They were currently concentrating on the new rooms and on disabled access. The facilities suitable and in a good state of repair. All doors to staff areas were secure.

Fire extinguishers and fire and security alarms were serviced and checked professionally. There was an automatic connection from the alarms to the fire station outside practice opening hours.

Annual fire training had been arranged for staff through the North Devon practice managers group. The practice manager and two staff had been trained as fire wardens.

The practice had a fire risk assessment, set up by a professional fire trainer and reviewed in February 2014 by the practice manager. Two actions had been taken as a result of the review of the policy. Staff identified that the alarm could not be heard in one part of the building, and

the arrangements were altered to remedy this. Smoke detectors were installed in cleaning cupboards. Two additional fire extinguishers were provided in response to advice from the supplier.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. 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). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

Staff told us of a response recently made to a medical emergency. A patient became unwell whilst sitting in waiting area. A nurse was alerted and helped the patient move to a treatment room where observations were taken to check their health status. A GP was asked to review the patient in the treatment room. The GP identified that this patient required hospital assessment. The patient was observed in the treatment room with door ajar and in an area of frequent footfall to deliver frequent observation until the ambulance arrived.

There was a pilot for emergency care practitioners to see urgent cases, managed by the SW Ambulance services. We asked patients how well they had been treated in an emergency. Two patients said a GP had to be called for a home visit and the response was deemed to be very good. One had three different GP's in one day and could not fault the service provided.

The business continuity plan had been discussed with the reception team recently. The plan was available in print in the office, containing many useful contact numbers

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Patients told us the GP was aware of their previous medical history when they visited for an appointment, that they had enough time with the GP and that they considered the GP made appropriate decisions about their treatment. All those elderly patients interviewed had been offered regular health checks.

The practice was proactive in checking outcomes and considering the best possible way of providing the service. The GPs took lead roles in specialist clinical areas such as diabetes, heart disease, women's health and substance misuse. GPs also took lead roles in areas of development such as research and clinical audit and membership of the GP provider group.

NICE guidance was discussed at Monday lunch time meetings where the responsible GP for an individual disease area would present a summary before discussion. For example there had recently been a lively debate regarding use of statins (cholesterol lowering drugs) which produced the agreed action of awaiting definitive guidance from the local prescribing team.

GPs had reviewed patients who had been diagnosed with cancer but not referred under the two week rule, to identify any learning. In the case of rectal cancer it was identified that some of the diagnoses had been made at an open access sigmoidoscopy clinic, indicating that diagnosis was not delayed. National data showed the practice was below average for new cancer diagnosis being made at emergency hospital admission, demonstrating good practice.

A high percentage of patients had their annual review – 95% of patients with diabetes, 85% for chronic obstructive pulmonary disease (COPD), and 78% for asthma. National data showed the practice was above average in keeping a register of patients with a learning disability and those in need of palliative care. They were high achievers in providing and measuring quality of service, being involved in a pilot to test new indicators for the quality and outcomes framework (QOF). The QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice in their surgeries.

Care plans for patients with complex needs were drawn up at the weekly gold standards framework (GSF) meeting. Each GP discussed patients of all ages. District Nurses attended, but not practice nurses as these were mostly housebound people. Other patients were invited to an appointment at the practice to complete their care plan, and were asked for consent to share this with the out of hours (OOH) service. Special patient messages for OOH services were attached to the computerised record. GPs were taking action to identify patients who were likely to fall into this group, for example visiting patients who recently moved into a care home to review their medication.

A practice nurse gave an example of good service planning with the fitting of intra-uterine coils. In case the fit was not right and the patient experienced problems needing adjusting, coils were not fitted routinely on Fridays. They were done earlier in the week in case the patient needed to come back and be seen at one of the rapid access clinics, therefore not having a problem over the weekend. Patients were provided with an information sheet prior to and after the fitting and routinely followed up six weeks after the fitting.

Management, monitoring and improving outcomes for people

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

The practice had a system in place for completing clinical audit cycles. Audits had been done for the benefit of patients as well as meeting QOF requirements. There was a culture of willingness to challenge. There were a range of audits that had been reviewed and repeated annually. Audits were routinely done on the whole practice list, not just those on individual lists of the GP doing the audit. Compliance audits with regard to high risk medicines requiring monitoring had been discussed annually over the past ten years.

Examples of clinical audits included an audit of management of patients in respect of prostate specific antigen (PSA) test results. This was with regard to NICE

guidance to identify whether all the patients above the current recommended threshold had been referred on for further assessment. A cancer care audit was carried out in March 2014, to improve outcomes for cancer patients through timely diagnosis, to be repeated annually. Any diagnoses that had not been referred through the two week rule were considered under significant event analysis as to whether anything could have been done differently and whether there was any learning for the team.

An audit was carried out in 2012 to ensure splenectomy patients were fully vaccinated against pneumococcal, haemophilus influenza type B and meningococcal C as well as being advised on antibiotic cover. A follow-up audit in 2013 continued to ensure patients were offered immunisation and also a vaccine for meningitis that worked by provoking the body's immune response to the bacteria.

An audit of intra-uterine coil insertion between April 2013 -2014 was carried out, recording expulsions, bleeding, pain and infections. An action plan resulting from audit included encouraging patients to make an appointment for their check up before leaving the premises as a significant number had not returned for their check-up.

Practice nurses had monitored a cohort of diabetic patients with reduced kidney function to assess the impact of the prescribed medicines.

A practice nurse had done nursing clinical audits, for example on respiratory and COPD conditions so that they could check the treatment followed NICE guidelines for patient pathways. She had recently done a blood monitoring audit and cytology audit, which were presented at a staff meeting in-house for discussion.

GPs in the practice undertook minor surgical procedures in line with their registration and NICE guidance. A skin cancer surgery clinic had been offered since November 2013 at Brannam Medical Centre for low risk excisions, by a GP registered with a special interest in dermatology. The service was monitored, to ensure patients were receiving treatment sooner than if referred to secondary care. After the first year an audit was carried out to assess the usage, types of cases presenting, suitability, infections recorded, and number of referrals to hospital potentially saved. The findings were discussed at a practice educational meeting, concluding that the clinic was beneficial to patients and reduced referrals. Other GPs in the practice had selected patients appropriately for this clinic and infection rates had been low.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. 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. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. We received positive feedback from the trainees we spoke with. One identified a positive aspect was that there were two trainers in the practice, with other GPs providing comprehensive support. They enabled the trainee's level of skill to be defined so they could practice effectively to the extent of their competence.

The nurses were well organised with specific roles and responsibilities. One nurse had achieved a diploma in diabetes care, another had done a Macmillan course on cancer care review. A practice nurse ran baby immunisation clinics and asthma reviews as these were areas of her professional interests. She had recently attended training on childhood asthma at the practice.

Succession planning, a standing item on the agenda for development at practice meetings, looked ten years ahead, to be prepared for likely changes.

Staff were supported in role development. For example, one person currently a health care assistant was in training to become an assistant practitioner. A health care assistant who had been trained to be a phlebotomist ran two routine clinics per week, where she provided ear syringing, dressings, vitamin B12 injections, Doppler testing for foot care for diabetic patients and flu injections. A receptionist had trained and become a health care assistant, and an apprentice was currently working with District Nurses to

gain experience. The practice equated staff roles with their preferences, where possible. For example one senior administrator told us they preferred to work closely with patients, while another preferred computer work.

Working with colleagues and other services

Patients told us about a range of referrals that had been made on their behalf, which had all worked well. They said they got copied into letters to and from consultants, which they appreciated.

GPs told us they had analysed their patient referrals to check for best practice. For example, they had reviewed referrals made by locums. Trainees dictated their referrals and had them reviewed by their trainer before sending. These were also monitored in terms of comparison of areas of referral data within the practice. Internally the practice had undertaken a speciality specific review to look at whether the referrer's option was correct.

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X-ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post.

Weekly virtual ward meetings were held, where GPs met with the hospice nurse, community matron and district nurses. Patients were discussed individually and their care plan updated as necessary. With patient consent, the care plans were shared with the providers of the OOH cover. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

The community psychiatric nurse came to the practice weekly for regular discussions about patients with mental health problems. If there were an emergency, staff would check with the patient's GP and would contact the mental health team for advice during daytime and if necessary would contact the duty mental health team social worker or duty on call psychiatrist depending on the time of day. If violence was shown staff would contact police.

Test results were checked and dealt with the same day. If a GP was absent, the lead receptionist would reallocate test results. Locums knew the need to check bloods and training would be given if new to the practice. An electronic system enables checking of test results. The patient may phone after 11;30am to hear their results. If the result indicated a problem, the GP sent a task via the computer asking staff to ask the patient to book an appointment with the GP or nurse.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. The practice had been involved in a COPD pilot, whereby they shared information with the community respiratory team, but this project was no longer running.

The practice had systems to provide staff with the information they needed. Staff used an on-line electronic patient record to coordinate, document and manage patients' care. Staff were trained on the system and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure. Written consent had not been recorded in patient records, but the decision about treatment and verbal consent were both recorded for injections, intra-uterine contraceptive devices (IUCD) and excisions, using a template on the computer to remind and support clinicians.

One GP had completed some training on the Mental Capacity Act 2005(MCA) and was able to discuss its purpose. An example of its relevance was described in a situation where a stroke patient refusing carers did not comprehend the effect on his wife. Discussions were held that involved the patient and wife as well as community nurses and wider working with the podiatrist and complex care team was undertaken to manage future potential issues. A plan was in place to re-engage social services if further help was needed. The GP identified sources of support such as the practice's policy and procedure, the learning disability team, or psychiatrist as well as their adult safeguarding lead colleague. The care planning process was used to arrive at decisions about treatment,

Good

Are services effective?

(for example, treatment is effective)

care and support for patients and their informal carers. We were not given an example of a multi-disciplinary meeting to determine that a decision was in a patient's best interest, which might be necessary if there were conflicting views and the patient was assessed as lacking capacity to make their own decision.

A GP who had specific training in the Mental Capacity Act 2005 was available to discuss and advise on individual cases. One GP took responsibility for reviewing patients living in care homes including those receiving specialised dementia care. For making decisions about treatment escalation plans (TEP) they consulted the person's next of kin or person who had power of attorney.

A practice nurse who spoke with us was aware of consent issues around childhood immunisations and safeguarding awareness, but not sure about the issues of capacity to give informed consent. She had not had training whilst at Brannam Medical Centre. Health care assistants who spoke with us were aware of the safeguarding leads at the practice and how to escalate concerns. She also was aware of the principles behind whistle blowing and expressed confidence in raising concerns within the practice. They were not familiar with issues of capacity to give informed consent.

Health promotion and prevention

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and all were offered an annual physical health check. A health trainer and physiotherapist were provided within the practice at no charge to the patient (not funded by the practice).

There was an abundance of health information on display boards in the two waiting areas. There was a separate notice board for Devon Care. Other information was provided but had not been sorted into categories that could make it easier for patients to find information useful for their situation.

A patient information screen had been provided in the waiting room. The PRG were asked to report on whether it was moving too quickly. They suggested putting a summary on paper so patients would not have to write down contact details for services that they needed.

Advisory links were provided for the practice's website, about health conditions. The PRG were asked for their views on how helpful these were which resulted in the practice manager asking software manufacturers to make them more user friendly.

Guidance regarding anticoagulation was circulated regularly in respect of patients who may be at risk of coagulation. GPs felt that the practice was doing well with regard to getting those patients who would benefit from medication on to treatment and showed us examples patients taking on the GPs advice to maintain their health and well-being.

When patients were discharged from hospital, their GP reviewed the discharge information and decided on necessary follow up. This could be a home visit or telephone call by GP or they could request a visit by a District Nurse. The practice nurse lead for COPD or diabetic patients would be informed. All patients who were case managed via the Unplanned Admissions direct enhanced service were contacted by a member of the team within three days of discharge.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients who spoke with us all felt GPs, nurses and other staff were friendly, approachable and professional. They felt supported and well cared for, and had been treated with compassion, dignity and respect. They said they had enough time with the GP to talk about their health concerns. Five comment cards had been completed and all were complimentary of the service provision. They said their GP and staff were caring and showed concern for the patients. One family with a profoundly disabled child appreciated the dignified way in which the GPs and staff always spoke directly to the child and responded to their individual care needs.

Patients said they were not kept waiting long when they came for their appointment, no more than five or ten minutes. PRG members told us they helped patients by directing them to the waiting room they need to be in. GPs and nurses all came to the waiting rooms to collect their patient, which resulted in immediate communication and contact with the patient. We observed GPs and staff interacting with patients in a considerate and kindly manner.

We did not see a sign offering the use of a private room for confidential discussion but reception staff told us they could provide one of several rooms on request. These were also offered to patients who were distressed or had special needs, to provide them with privacy and maintain calmness for other patients.

We saw that doors to consultation rooms were closed during appointments to ensure privacy. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. Confidential conversations could not be heard in the waiting rooms. Those patients sitting next to the treatment room could overhear some personal conversations.

Care planning and involvement in decisions about care and treatment

An above average proportion of respondents to the GP patient survey stated that the last time they saw or spoke to a GP, the GP was good or very good at involving them in decisions about their care. Patients who spoke with us said they were happy that their GP listened to them. They said the GP was welcoming if they wanted to involve their partner in discussions about their care and treatment. Patients could choose to change their GP without giving a reason or request a GP by gender.

Patients said they had been given sufficient information about their health condition. Leaflets were available generally on the request of the patient, unless a new diagnosis had been made in which case information was provided by the GP.

Patient/carer support to cope emotionally with care and treatment

A patient who had been with the practice for a long time told us their husband passed away two years ago and they felt well supported and cared for. Staff told us that GPs phoned bereaved relatives and might visit. Staff also gave practical advice about death certificates and funeral directors.

This practice was involved in an early pilot for carer support, with training provided by the local authority. The PRG chair was involved. Support for carers had been provided. Once identified by the practice, they were invited for an assessment. A carers' register was kept, health checks with HCAs were offered as well as flu reminders and signposting to other services that might be helpful.

There was a separate notice board for Devon Care in the waiting room and information and links on the practice's website.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. Patients' individual needs and preferences were central to the planning and delivery of tailored services. The services were flexible, provided choice and ensured continuity of care. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

On the day of the inspection, a practice nurse was providing a clinic for child flu vaccinations. Information was provided for parents who may be vegetarian, or will not use pork products, that the nasal flu vaccination contained pork gelatine so that parents could make an informed decision regarding the immunisation.

Patients could access appointments and services in a way and at a time that suited them. Patients said it had been easy to get an appointment and staff would provide treatment and care other than the clinic that was running if a patient needed to be seen. One patient described how they were accompanying a relative for a routine appointment when they developed a symptom. They mentioned this to a nurse who arranged for them to see a GP right away so they did not have to wait for an appointment either later that day or on another day. They had found this very reassuring.

Members of the Patient Reference Group (PRG) told us they had been impressed by the two way communication they had with the practice and their experience was that GPs and managers listened to them and took notice of their views. For example, when a new leaflet was published, the management checked with the PRG first, for example to ensure the colours worked in the intended way.

Tackling inequity and promoting equality

There was a proactive approach to understanding the needs of different groups of people and to deliver care in a way that met these needs and promoted equality. This included patients who were in vulnerable circumstances or had complex needs. Staff said the rapid access clinic was well used and was a way of effectively connecting with homeless patients, who could turn up and be seen without having to make an appointment. The rapid access clinic was open each afternoon when the practice was open.

There was level access to the consultation and treatment rooms. PRG members told us that wheelchair access continued to be discussed. Work was in progress to deal with the slight lip to the wheelchair ramp. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. There were a variety of standard chairs, some fabric padded, some wood, some with arms to help patients with restricted mobility. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities. The reception window had been lowered so that wheelchair users could speak easily to staff.

A hearing loop, which patients with hearing aids may tune into so they can hear reception staff, had been installed but was awaiting batteries.

The practice population was overwhelmingly English speaking though it could cater for other languages through translation services.

Access to the service

Information from Public health England showed that above average proportion of patients were satisfied with telephone access to the practice and had a good overall experience of making appointments. Practice records showed that most phone calls were answered within 30 seconds.

There was no telephone triage system for allocating GP appointments. Instead an innovative system had been introduced called the Rapid Access Clinic. A nurse and GP were on duty every afternoon, running a 'never full' system. This clinic included homeless people amongst its patients. Anyone who asked for a rapid access appointment was seen on the day and this included minor injuries.

Patients told us they had got an appointment on the day when they had needed one and they had been able to see their own GP in 'a couple' of days.

Patients were offered the option of a telephone consultation with their GP, which was well used, as 12% of patient contact was by phone. The practice was considering the potential for email consultations or SKYPE.

Good

Are services responsive to people's needs?

(for example, to feedback?)

A third of the practice population lived in rural areas, covering a wide area. GPs made home visits when necessary although journey times meant that each visit could take an hour.

Patients told us that they had an allocated GP but were happy to visit others in emergencies or when aware there own GP was away. They said the practice was flexible and they had been given appointments in the afternoons even if it was not the appropriate clinic for them, for example, the rapid access clinic.

Managers and partners were discussing the possibilities of extending opening hours. They opened at 7:30am every morning from Tuesday to Friday. No appointments were currently offered between 1 and 2pm and this was being considered because the practice and the car park were quiet at this time. Some of clinics ran through the lunch hour for patients to attend during a lunch break. They had previously opened on Saturday mornings and were planning to open on a limited number of Saturday mornings over the winter, providing a duty GP.

Advice to patients about opening hours and what to do to speak to a GP out of hours was clearly displayed and also available on the practice's website.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns with an active review of complaints and how they were handled. The complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system. The procedure was displayed as well as information about advocacy services. Complaints forms were readily available on the reception desk. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

Members of the PRG said they had been advised the practice recorded all complaints and criticisms as well as compliments and must respond to all. Anonymous comments were discussed in meetings and recorded in the minutes. Their experience was that staff at the practice liked and respected each other and wanted to give a good service.

We looked at four complaints received in the last year and found these were satisfactorily handled and dealt with in a timely way. One had been a patient expressing anxiety, but had been logged as a complaint so the practice manager could evidence what had been done. This was excellent practice, showing openness and transparency in dealing with problems that arose and reliability in dealing with them.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to provide a family GP service with each GP having personal lists to provide continuity of care including health promotion. The partners were keen to be involved with innovations and volunteered to take part in pilot schemes. For example, Brannam Medical Centre was one of four pilots introducing an on-line system for recording and sharing information and helping to establish it. Electronic prescribing had been introduced and electronic discharge was being piloted. One of the GPs worked one day per week with the CCG and involved the practice when new procedures were being trialled.

Staff told us they had been invited to be included in vision setting exercises for the development of the practice business development plan. Benefits to patients were the priority as well as performance issues. The management team had discussed federating with other practices.

Governance arrangements

There was a clear leadership structure with named members of staff in lead roles. A GP had taken responsibility as executive partner for a five year period. He also took the lead on clinical governance and attended the GP forum and the GP provider group. Another GP took the lead for GP commissioning and also was the Caldicott Guardian and information governance (IG) lead for the practice. One GP was lead for safeguarding vulnerable adults and also lead for mental health, neurological diseases and substance misuse. There was a lead nurse for infection control. We spoke with ten members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

Senior management meetings were held monthly, with health and safety a standing item. A weekly business meeting was held, involving the partners and practice manager. Amongst the issues discussed recently were rotas, prescribing practice, and QOF performance. The lead nurse and administrative staff joined as appropriate.

Trained nurses met quarterly and health care assistants were invited to attend, which made them feel valued.

Treatment room staff met together at approximately six weekly intervals. Minutes of all the meetings were available on the practice's intranet as well as agendas for forthcoming meetings. Staff told us they found that communication within the practice was good.

Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. Staff and GPs attended team away days where the practice two, five and ten year plan had been discussed. Staff told us this was a really good practice for team work, role development and training. The clinical meeting structure was good. Multi-disciplinary meetings to co-ordinate care of patients with complex care needs took place weekly.

Practice seeks and acts on feedback from its patients, the public and staff

In 2013 a team health audit had been carried out by the treatment room staff. The results were described as positive but it identified that health care assistants (HCAs) at times felt isolated as their rooms were away from the main treatment room. The practice took action in response by providing each with a nurse mentor for support and guidance, as well as providing a weekly meeting with the treatment room lead nurse to discuss any concerns. The HCAs also now ran some of their clinics from the main treatment room.

The patient reference group (PRG) met quarterly. The practice manager always attended along with one or two GPs. One GP joined the meeting specifically when access to patient records was discussed. The practice also had a virtual patient forum (VPF) to enable them to engage more frequently with a larger number of patients for questionnaires and surveys.

Amongst the actions taken in response were the lowering of the reception desk for the convenience of wheelchair users, and the involvement of PRG members in an assessment of infection control to look at cleanliness from the patient's point of view.

PRG members told us their purpose was to improve communication between the practice and patients. They helped with the annual survey. They had distributed survey forms, and helped patients complete them in the waiting

Are services well-led?

Good

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

room. They had also helped at the flu vaccination clinics and used their time to promote the PRG. This year they wanted to help by reducing the number of questions on the survey, to simplify it.

A staff member produced a monthly newsletter and PRG members suggested district nurses could increase the circulation by taking it to patients when they made home visits.

The main information board was in an area where patients often did not see it, and it was not well organised. PRG members considered they might be able to help with better presentation of this information.

PRG members told us they had been asked by the practice for feedback about the level of service they wanted, for example, the speed of response. They were pleased overall with the standard of communication and said that GPs and managers had a democratic and respectful way of relating to patients.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Staff told us that regular appraisals took place which included a personal development plan. Monday lunchtime they had an educational meeting, where they discussed NICE guidelines. GPs came into the Monday educational meetings even when they were not on duty, showing their interest and the significance of these meetings for the practice.

We saw a sample of staff files including the study log. These showed staff attended training sessions to maintain their clinical skills, to further their professional education and to maintain safe practice at work, such as fire training and CPR, which all staff undertook.

The practice was a GP training practice, with medical students coming from the Peninsula Medical School. One of the doctors in training said they found it helpful that this practice had two trainers as well as other GP support. The trainers considered how as a GP in training appointment lengths could be safely reduced, as the trainee gained experience and became ready for this. The trainee discussed individual patients either with one of the trainers or with the patient's own GP, depending on the problem and whether there had been a previous presentation. They knew which GP to go to for additional expertise in, for example, dermatology or women's health.

A registrar told us they had been given the correct support, and not exposed to risk. Clear lines of responsibility were made available for discussing any complex issues as they arose.

A locum, recently qualified, asked for double appointments, so they could fully assess the patient. They took their place on the rota for duty GP work, and said that though it could be busy, it was not too bad, as this was the most supportive practice they had worked in. As locum they attended all meetings along with the GP partners which provided them with learning about local resources, change in prescribing guidance and system reviews. They attended meetings about prescribing practice, the weekly GSF meetings and the monthly meeting attended by the school nurse.

A recently appointed practice nurse felt the manager at the practice was approachable and supportive. A nurse described the practice's strengths as team working and staff development with good training opportunities. For example, she was being supported and encouraged to do a Diploma in Diabetes care, an area of health she was interested in.

HCAs told us they attended staff meetings and lunchtime educational meetings at the practice and found managers responsive and decisive. One was aiming to become and assistant practitioner, through the course run at Plymouth University. There had been good progression for staff. For example, health care assistants (HCAs) had trained as nurses; receptionists have progressed to management. The administration team currently had three apprentices, one of whom won the 'apprentice of the year' award.

A nurse had been dedicated to work for the Primary Care Research network, showing the outward looking nature of this practice.