Brannel Surgery

Quality Report

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Date of inspection visit: 4 February 2015
Date of publication: 30/04/2015

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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

Brannel Surgery was inspected on Wednesday 4 February 2015. This was a comprehensive inspection.

We found the practice to be good for providing well-led, safe, effective, caring and responsive services. It was also good for providing services for the six population groups.

Our key findings were as follows:

There were systems in place to address incidents, deal with complaints and protect adults, children and other vulnerable people who use the service. Significant events were recorded and shared with multi professional agencies. There was a proven track record and a culture of promptly responding to incidents and near misses and using these events to learn and change systems changed so that patient care could be improved.

There were systems in place to support the GPs and other clinical staff to improve clinical outcomes for patients. According to data from the Quality and Outcomes Framework (the annual reward and incentive programme detailing GP practice achievement results) outcomes for patients registered with this practice were equal to or above average for the locality. Patient care and treatment was considered in line with best practice national guidelines and staff are proactive in promoting good health. There were sufficiently skilled and trained staff working at the practice.

The practice was pro-active in obtaining as much information as possible about their patients which does or could affect their health and wellbeing. Staff knew the practice patients well, are able to identify people in crisis and are professional and respectful when providing care and treatment.

The practice planned its services to meet the diversity of its patients. There were good facilities available, adjustments were made to meet the needs of the patients and there was an effective appointment system in place which enabled a good access to the service.

Summary of findings

The practice had a vision and informal set of values which were understood by staff. There were clear clinical governance systems and a clear leadership structure in place.

We found an outstanding area of practice:

- The practice had developed a relationship with the Police Community Support Officer who referred patients that he has had concerns about in the community. This had been very useful in averting crisis situations before they had escalated.

There were areas of practice where the provider should make improvements.

The provider should:

- All clinical staff should receive training in the Mental Capacity Act (2005). The MCA is a legal framework which supports patients who needs assistance to make important decisions.

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.

Patients we spoke with told us they felt safe, confident in the care they received and well cared for.

There were sufficient numbers of staff working at the practice. Staffing and skill mix were planned and reviewed so that patients received safe care and treatment at all times.

Staff turnover was low. Recruitment procedures and checks were completed on permanent staff as required to help ensure that staff were suitable and competent. Induction procedures for staff, including locum GPs were detailed.

Significant events and incidents were responded to in a timely manner and investigated systematically and formally. There was a culture to ensure that learning and actions were communicated following such investigations.

Staff were aware of their basic responsibilities in regard to safeguarding and the Mental Capacity Act 2005 (MCA). However, not all staff had received MCA training. All staff had received appropriate training in safeguarding adults and children. There were safeguarding policies and procedures in place that helped identify and protect children and adults who used the practice from the risk of abuse.

There were arrangements for the efficient management, storage and administration of medicines within the practice and within the dispensary. Prescription stationary was stored and used effectively and in an appropriate way.

There were clear processes to follow when dealing with emergencies. Staff had received basic life support training and emergency medicines were available in the practice or within GP bags. Checks on these medicines were performed by dispensing staff.

The practice was clean, tidy and hygienic. Arrangements were in place that ensured the cleanliness of the practice was consistently maintained. There were systems in place for the retention and disposal of clinical waste.

Are services effective?

Good

The practice is rated as good for providing effective services.

Systems were in place to help ensure that all GPs and nursing staff were up-to-date with both National Institute for Health and Care

Summary of findings

Excellence (NICE) guidelines and other locally agreed guidelines. GPs, nursing staff and dispensary staff used clear evidence based guidelines and directives when treating patients. Evidence confirmed that these guidelines were influencing and improving practice and outcomes for patients.

The practice used the national Quality Outcome Framework (QOF- a national performance measurement tool) scheme. Data provided data to show that the practice was performing equally or slightly higher when compared to neighbouring practices in the Clinical Commissioning Group (CCG).

People's needs were assessed and care was planned and delivered in line with current legislation. This included assessment of capacity and the promotion of good health. Staff had received training appropriate and in addition to their roles. Effective multidisciplinary working was evidenced.

Regular completed audits were performed of patient outcomes which showed a consistent level of care and effective outcomes for patients. We saw evidence that audit and performance was driving improvement for patient outcomes.

There was a systematic induction and training programme in place with a culture of further education to benefit patient care and increase the scope of practice for staff.

The practice worked together efficiently with other services to deliver effective care and treatment.

Are services caring?

Good

The practice is rated as good for providing caring services.

The practice was small compared to the national average. Both staff and patients said this helped with communication and provide a personal service. Feedback from patients about their care and treatment was consistently positive. The comment cards we received, a friends and family survey from December and January and survey data from 2014 reflected this feedback. Patients described the practice as caring and said they trusted the GPs and knew them well.

We observed a person centred culture and found strong evidence that staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. We found many positive examples to demonstrate how people's choices and preferences were valued and acted on.

Accessible information was provided to help patients understand the care available to them.

Summary of findings

Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

We found the practice had a proven track record of learning from and responding in a timely way well to patient feedback, complaints, incidents and informal comments.

Patients said they could get an appointment easily in advance or with a GP on the same day but sometimes had to wait a little longer to see the GP of their choice. There were no female GPs at the practice, but the GPs had ensured that practice nurses were skilled and knowledgeable in women's health issues.

The practice reviewed secure service improvements where these were identified. For example, a scheme to prevent unnecessary hospital admissions.

There was an accessible complaints system with evidence that the practice responded quickly to issues raised even if they were verbal informal complaints. There was evidence of shared learning, by staff and other stakeholders, from complaints.

Are services well-led?

Good

The practice is rated as good for well led.

The practice had a vision and strategy which included providing a supportive accessible service within the confines of a rural community.

Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management.

The practice had a number of policies and procedures to govern activity. There were systems in place to monitor and improve quality and identify risk. The process of clinical governance was robust and there was a culture of wanting to improve and learn following any significant event or complaint. Action and learning was shared with the whole team.

The practice learnt from events and complaints and welcomed feedback from patients through the suggestion box and surveys. The practice had an active patient participation group (PPG) who considered themselves to be a critical friend of the practice. Staff had received induction training, regular performance reviews and attended staff meetings and events.

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

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

All patients aged 75 and over had a named GP but were able to choose an alternative if they wished or if this was more convenient for the patient.

Pneumococcal vaccinations and shingles vaccinations were provided for older people. Housebound older patients receive immunisations at home where necessary.

The practice did not provide specific older person clinics. Treatment was organised around the individual patient and any specific condition or need they had. A computer pop up alert system prompted clinicians to offer any tests or routine monitoring.

The practice worked with the community multidisciplinary team to identify patients at greater risk of admission. Practice nurses and GPs worked with the community nursing team to provide a streamlined service.

The practice identified older patients with life-limiting conditions and co-ordinated a multi-disciplinary team (MDT) for the planning and delivery of palliative care for people approaching the end of life.

Family and Carers were included in consultations where patients requested. The practice communicated with family members (with consent) to clarify information or inviting them to come along with the patient.

The GPs worked to avoid unnecessary admissions to hospital and used care plans which were reviewed every three months to avoid patients being admitted to hospital unnecessarily.

People with long term conditions

Good

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

The practice had a system to identify patients with long term conditions and arrange treatment, reviews and follow up care at a time suitable to the patient. Patients with long term conditions described the practice as efficient and organised when arranging care and treatment and said the practice reminded them of upcoming health care and medicine reviews.

Summary of findings

Patients with diabetes were reviewed by the practice staff and community nurse specialist where required. These reviews included a medicines check, health and lifestyle advice, blood tests and foot care. There were clear guidelines and care templates for GPs and practice nurses to follow.

Patients with long term conditions had personal care plans in place. Respiratory and diabetic clinics were run by practice nurses with specialist qualifications. The nurses attended educational updates to make sure their lead role knowledge and skills were kept up to date.

The practice have effective links with the specialist nursing teams and regularly liaise with the heart failure specialist nurse, community psychiatric nurse, respiratory nurse and diabetic specialist nurse. The diabetic specialist nurse holds joint clinics within the practice on a monthly basis. The practice offer in house diabetic retinal screening on several dates throughout the year.

The practice provided clinics for asthma and chronic lung disorders (COPD) including using spirometry, a lung capacity test, as part of its service to assess the evolving needs of this group of patients.

The practice promoted independence and self-care for patients with long term conditions. For example, some patients monitored their own health remotely and contacted the practice should their symptoms change. The practice had ambulatory BP machines and a range of digital machines that could be loaned to patients should it be clinically necessary.

The computer system contained health promotion prompts so opportunistic screening could take place regardless of for the reason for the patient's attendance.

All patients with complex needs who were in receipt of a care plan were contacted by the practice following any admission or attendance at A&E and home visits were undertaken if required to ensure medicine reviews were performed.

The practice sent 'special messages' to the out of hour's providers about patients with complex needs and those at the end of their life so the out of hour's service was aware of their care and treatment.

The practice used the Quality and Outcomes Framework (QOF) which is a national performance measurement tool. The practice used the QOF to identify and support patients with long term conditions to ensure their needs were monitored and gave assurances that they were providing care to set practice standards and working within NICE Guidelines.

Summary of findings

Families, children and young people

Good

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

The practice held weekly baby and child immunisation appointments and sent letters of invitation to all parents and carers.

Patients who did not attend for their immunisations were reviewed by the practice nurse and GP and contacted by the practice if required. If there were any concerns regarding the reasons for non-attendance these are raised with the health visitor who visited the practice once a week and was able to speak with practice staff on a daily basis should it be necessary.

Ante-natal care was provided at the practice. Midwives communicated with the GPs and practice team on a daily basis should this be necessary. The practice staff also worked with health visitors, dieticians, school nurses and podiatrists.

Patients had access to contraception advice and had access to a full range of contraception services including the insertion of implants. Patients could also access chlamydia testing and cervical screening. There were private areas for women to use when breastfeeding.

All nurses and GPs were competent to take blood from children to avoid long journeys to hospitals.

The practice provided a room and worked with a local charity, who offer counselling to bereaved children.

Appropriate systems were in place to help safeguard children or young people who may be vulnerable or at risk of abuse. All staff had received training on safeguarding children and young people.

The practice made sure they are 'young people friendly', for example, in respect of confidentiality and consent, an easy to access service, a welcoming environment and staff trained on issues that young people face. The practice supports the C-Card scheme. The C-card is given so that a younger person can get free condoms at different places across Cornwall & the Isles of Scilly.

Working age people (including those recently retired and students)

Good

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

The practice offered telephone consultations and four week advanced booking for appointments. Evening appointments were also available.

NHS Health checks, weight checks, healthy living advice, blood pressure checks, new patient checks and smoking cessation appointments were offered at a time convenient to the patient.

Summary of findings

There was an online appointment booking system and online prescription request via the practice website which patients said was easy and convenient to use. Patients who received repeat medicines were able to collect their prescriptions at a pharmacy of their choice or at the practice dispensary if appropriate.

The practice offered travel advice and vaccinations. Nurses who provided this service had received specialist training.

Physiotherapy services were available to patients at various locations around Cornwall so patients could book with a Physiotherapist near to where they work.

People whose circumstances may make them vulnerable

Good

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

The practice had a register to identify patients with a learning disability. A health care assistant provided learning disability health reviews to ensure health needs were met in a more relaxed and appropriate environment. A carer usually attended these reviews for support and to ensure the patient's views and concerns are taken into consideration. If necessary, these patients were visited at home if they chose.

The practice had a protocol for safeguarding of vulnerable people and had an appointed adult safeguarding lead. All members of staff had received training in safeguarding and were aware of how to identify abuse and knew what action to take if abuse was suspected. There was easy access to guidance when information was required. Adults being identified as vulnerable had an appropriate easily identifiable note on their electronic records to make this easily recognisable to any health care professional meeting with that person.

The GPs referred any vulnerable patients to the community matron and dementia liaison member of staff for support.

People experiencing poor mental health (including people with dementia)

Good

Patients on the practice mental health register are offered annual health checks which focus on general physical health. This includes ensuring they are up to date with routine screening and vaccinations.

The practice used QOF to ensure mental health checks and medicine reviews were conducted to ensure patients received appropriate doses and care plans were in place. Blood tests were regularly performed on patients receiving certain mental health medicines.

Summary of findings

The practice have in-house counsellors with very short waiting lists and access to counselling outside of the practice in various locations for patients who prefer not to come to the practice or wish to be seen outside of working hours.

Staff at the practice promote a local stress buster course which is held locally and on a regular basis. GPs keep counselling self-referral packs and actively signpost patients to local groups, such as the Memory Cafes and a local mental health charity which offers structured activity to promote positive wellbeing.

The practice offer rooms for local mental health workers to see patients at the practice to try and make it as easy as possible for patients to access services.

All the clinicians were aware of the link between physical and mental health and encourage subsidised exercise referral programmes and local walking groups.

The practice had a dementia register and were aware that the practice numbers for dementia were quite low despite completing a recent audit.

Summary of findings

What people who use the service say

We spoke with 15 patients during our inspection.

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 experience with us. Comment cards stated that patients appreciated the service provided, the caring attitude of the staff and the staff who took time to listen effectively. There were comments praising GPs, nurses and the reception team. Comments also highlighted a confidence in the advice and medical knowledge, ease of getting an appointment and a feeling of not being rushed.

These findings were reflected during our conversations with the 15 patients we spoke with, on the day of inspection, and from looking at the survey from 2014. The feedback from patients was overwhelmingly positive. Patients told us about their experiences of care and praised the level of care and support they consistently received at the practice. Patients said they were happy, very satisfied and said they had no complaints and received good treatment. Patients told us that the GPs and nursing staff were excellent.

Patients were happy with the appointment system although said they sometimes had to wait for their appointment or it took longer to see the GP of their choice. We were told patients could either book routine appointments four weeks in advance or make an appointment on the day. We spoke with one patient who had made their emergency appointment that morning.

Patients knew how to contact out of hours services and said information at the practice was good. Patients knew how to make a complaint. None of the patients we spoke with had done so but all agreed that they felt any problems would be managed well. Other patients told us they had no concerns or complaints and could not imagine needing to complain.

Patients were satisfied with the facilities at the practice and commented on the building always being clean and tidy. Patients told us staff respected their privacy, dignity and used gloves and aprons where needed and washed their hands before treatment was provided.

Patients found it easy to get repeat prescriptions and appreciated having the dispensary on site.

Areas for improvement

Action the service SHOULD take to improve

- All clinical staff receive training in the Mental Capacity Act (2005) The MCA is a legal framework which supports patients who needs assistance to make important decisions.

Outstanding practice

- The practice had developed a relationship with the Police Community Support Officer who referred patients that he has had concerns about in the community. This had been very useful in averting crisis situations before they had escalated.

Brannel Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The team also included a GP specialist advisor and a practice manager specialist advisor.

Background to Brannel Surgery

Brannel Surgery provide primary medical services to approximately 4,800 patients. The practice is located in a rural area of Cornwall and is a dispensing practice to approximately 3,850 of the practice population. A dispensing practice is where GPs are able to prescribe and dispense medicines directly to patients who live in a rural setting which is a set distance from a pharmacy. The practice provides a service to a diverse age group.

There was a team of three male GP partners. Partners hold managerial and financial responsibility for running the business. The GP team were supported by three registered nurses, a health care assistant and phlebotomist. There were six dispensing staff, a practice manager and additional administrative and reception staff. The practice was aware that they do not have female GPs and have attempted to recruit female GPs. As a result the practice has ensured that the practice nurses have skills and knowledge in managing women's health issues.

Patients using the practice have access to community staff including district nurses, community psychiatric nurses, health visitors, physiotherapists, speech therapists, counsellors, podiatrists and midwives.

The practice is open from Monday to Friday, between the hours of 8am and 6pm. Evening appointments were available with a GP one day a week to help those patients who worked during routine office hours.

The practice had opted out of providing out-of-hours services to their own patients and refers them to another out of hour's service.

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.

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.

Detailed findings

How we carried out this inspection

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

- 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
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Before conducting our announced inspection of Brannel Surgery, we reviewed a range of information we held about the service and asked other organisations to share what they knew about the service. Organisations included the local Healthwatch, NHS England, and the local Cornwall Clinical Commissioning Group.

We requested information and documentation from the provider which was made available to us either before, during or 48 hours after the inspection.

We carried out our announced visit on Wednesday 4 February 2015. We spoke with 15 patients, three GPs, three of the nursing team and four of the management and administration team. We collected 21 patient responses from our comments box which had been displayed in the waiting room. We observed how the practice was run and looked at the facilities and the information available to patients.

We looked at documentation that related to the management of the practice and anonymised patient records in order to see the processes followed by the staff.

We observed staff interactions with other staff and with patients and made observations throughout the internal and external areas of the building.

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 as well as comments and complaints received from patients. These alerts were circulated and discussed at partner and management meetings and if necessary resulted in new policies being devised.

Staff were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. Staff said the process was handled well and was a supportive process.

We reviewed safety records, incident reports and minutes of meetings where incidents and significant events were discussed. Records showed the practice had managed these consistently over time and so could show evidence of a safe track record.

Learning and improvement from safety incidents

There was a culture of using any incident, accident or event as an opportunity to learn from and improve the service. The practice had a clear systematic process in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred over the last year. Significant events were discussed within 24 hours of occurrence. The practice did not hold specific significant event meetings but discussed events formally at the practice and clinical meetings to make sure action had been taken and the event reviewed. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. For example, it was highlighted that incorrect allergies were recorded. The staff member responsible was supported and education and new systems were introduced.

Staff explained the system they used to manage and monitor incidents. We tracked examples of incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example, a patient had reported that they had been given the wrong medicines at the dispensary. Staff were reminded about the process and checks in place to minimise this occurring. The patient was issued the correct medicines and an apology given.

National patient safety alerts were disseminated verbally and electronically to practice staff. Staff were able to give examples of recent alerts.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received safeguarding 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 details were easily accessible using the staff intranet system.

The practice had an appointed GP safeguarding lead. They could demonstrate they had the necessary advanced level 3 training to enable them to fulfil this role. Nursing staff had attended level 2 training.

Quarterly child safeguarding meetings took place at the practice. These were attended by the GP safeguarding lead, one other GP, office manager, health visitor, midwife and a school nurse. Communication also took place outside of these meetings. Practice staff said communication between health visitors and the practice was good and any concerns were followed up. For example, if a child failed to attend routine appointments the GP could raise a concern for the health visitor to follow up.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans and patients with mental health issues.

There was a formal chaperone policy and patients were aware of this service. A chaperone is a member of staff or person who acts as a witness for a patient and a medical practitioner during a medical examination or treatment.

Good

Are services safe?

Selected staff had been trained to be a chaperone and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

Medicines management

The practice was a dispensing practice to approximately 3,850 of the 4,800 patients. A dispensing practice is where GPs are able to prescribe and dispense medicines to patients who live in a rural setting which is a set distance from a pharmacy.

We checked medicines stored in the dispensary and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that these medicines were kept at the required temperatures. The temperature in the room and refrigerator at the time of our inspection were within the recommended ranges for storing these medicines. Fridge temperatures were recorded and included the minimum and maximum range.

There were clear operating procedures in place for dispensary processes. Systems were in place to ensure all prescriptions were signed before being dispensed. The practice had a system in place to assess the quality of the dispensing process and had signed up to the Dispensing Services Quality Scheme, which rewards practices for providing high quality services to patients of their dispensary.

Any errors or near misses were recorded, monitored and actions put in place to reduce the risks of any recurrence. The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. There were arrangements in place for the destruction of controlled drugs. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

Blank prescription pads and printer forms were held securely in the practice.

We saw records showing that dispensary staff had received appropriate training and had regular checks and appraisals of their competence.

The practice had established a home delivery service for patients who were unable to collect their prescriptions from the surgery. They also had arrangements in place to ensure people were given all the relevant information they required with their medicines.

We checked medicines stored elsewhere in the practice. Medicines stored in the treatment rooms and medicine refrigerators were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which included records of fridge temperatures and clear processes when vaccines arrive at the practice. We found that not all vaccine fridges had inaccessible plug sockets or systems to reduce the risk of unplugging the fridge.

Detailed systems were in place to check medicines stored within the practice and within doctors bags were within their expiry date and suitable for use.

We saw evidence that medicines and prescribing patterns were kept under review as a way of improving patient safety but also as part of the local clinical commissioning group incentive scheme.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of directions and evidence that nurses had received appropriate training to administer vaccines. The nurses had also received appropriate training to administer travel vaccinations and give travel advice.

Patients were pleased with the process of obtaining repeat prescriptions and appreciated having the dispensary.

Cleanliness and infection control

We observed the premises to be clean and tidy. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead nurse for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy. An infection control audit had been completed in September 2014 and had highlighted the need to introduce more effective cleaning schedules and introduction of disposable items.

An infection control policy and supporting procedures were available for staff to refer to. There were also flowcharts and a policy for dealing safely with a needle stick injury.

Good

Are services safe?

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 toilets and treatment rooms.

The practice employed their own cleaning staff who were considered part of the team. There were cleaning schedules in place for all areas of the practice. Cleaning staff signed to say when each area had been cleaned. The nursing staff and practice manager monitored this process.

Equipment

Staff 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 was last inspected for safety in April 2014.

Staffing and recruitment

Many members of staff had been in post for a number of years and said Brannel Surgery was a good place to work. The practice had a recruitment policy that set out the standards it followed when recruiting staff. Recruitment records contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, health assessment and registration with the appropriate professional body.

Criminal records checks through the Disclosure and Barring Service (DBS) had been performed for the GPs and nursing staff working alone with young people. The practice had a risk assessment in place to explain why administration staff who did not have one to one contact with patients had not had a DBS check performed.

Staff told us about the arrangement in place to cover each other's annual leave. For example, blood tests were checked by other GPs in the absence of an individual GP.

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 keep patients safe.

Monitoring safety and responding to risk

The practice had their own risk assessment and policy which focused on all areas of the building and the practice used an external company to maintain servicing contracts. These included water safety, electrical equipment and fire systems. Fire drills were performed twice a year and equipment checked four times a year by external contractor. Legionella risk assessments had been done in house in July 2014.

A clear system and maintenance records were kept to demonstrate that there was in place to report and treat any defects or physical issues with the premises. Staff said the system worked well.

There was a detailed business continuity plan in place which explained what action was necessary in the event of incidents including major incidents, a loss of power or epidemic or pandemic.

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 the emergency equipment was checked regularly by a nominated member of staff.

Emergency medicines were available at the practice and were stored centrally for easy access. The medicines included those for the treatment of cardiac arrest, anaphylaxis (allergic reaction to medicines) and severe low blood sugar.

Processes were in place to check whether emergency medicines and equipment were within their expiry date and suitable for use. All the medicines and equipment we checked were in date and fit for use.

Good

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 approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. The staff had templates, guidelines and policies to use for guidance when treating patients with long term conditions. These were based on NICE guidelines and were kept under review. Any changes to these were communicated using the staff computer system.

Patients were pleased with the care, treatment and advice they received. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. The GPs and nurses completed assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate. We saw examples where care for vulnerable patients or those with long term conditions had been reviewed together with the multidisciplinary team where appropriate.

The practice nurses and GPs led in specialist clinical areas such as diabetes, heart disease and asthma. Nursing staff and GPs were open about asking for advice and support from each other when needed. The nursing team had experience in managing long term conditions and supported the GPs well. The practice provided evidence to show patients with long term conditions were offered reviews annually or more frequently as required.

The practice completed audits to ensure patients were receiving appropriate care and treatment. For example, we saw several examples of medicine audits to check that patients were receiving the medicine most suitable to them and audits to monitor that patients on certain medicines had received a medicines review and further health check. We also saw some examples of audit to ensure customer satisfaction was monitored. For example, an audit of the time patients were waiting to collect their prescriptions resulted in a numbering system to speed up accurate location and dispensing of medicines.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients who had been discharged from hospital.

National data and practice computer systems showed that the practice was in line with referral rates to hospital and other community care services for all conditions. The GPs used national standards for the referral of suspected cancers within two weeks. We saw systems used by administration staff to show how routine and urgent referrals were made.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

The GPs showed us examples clinical audits that had been undertaken in the last year. All of these were completed audits where the practice was able to demonstrate that care and treatment was effective or show the changes which were made to improve care since the initial audit.

Learning from significant events, clinical supervision and staff meetings were used to review patient outcomes achieved and areas where patient outcomes could be improved. Staff spoke positively about the culture in the practice and said there was not a name and shame environment but events were used positively to improve services. An example included how staff were educated and supported following a dispensing error.

There was a protocol for repeat prescribing which was in line with national guidance. In accordance with the protocol, 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 that the latest prescribing guidance was being used. Patients said they were sent reminders on the prescription or by letter regarding these checks and thought the system worked well. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines.

Good

Are services effective?

(for example, treatment is effective)

The practice have been involved in clinical research for several years under the management of the primary care research network.

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 annual basic life support and safeguarding training. There was a culture of educational development at the practice and all staff said they had access to the training they needed to fulfil their roles.

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).

All staff received annual appraisals that identified learning needs from which action plans were developed. Staff confirmed that the practice was proactive in providing training and funding for relevant courses.

The practice nurses and health care assistants were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, they showed evidence of their training in administration of vaccines, cervical cytology and travel advice. Those with extended roles such as diabetes and asthma management were also able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. It received blood test results, X ray results, and letters from the local hospitals including discharge summaries, out-of-hours GP services and the out of hours service both electronically and by post. The practice manager provided a clear policy on managing these results. All staff we spoke with understood their roles and felt the system in place to communicate blood test results and hospital discharges worked well. There were no instances within the last year of any results or discharge summaries that were not followed up.

The multidisciplinary team could speak with the GPs when required. The district nurses and health visitors are based at another GP Practice in the same locality. The midwife was based at Penrice Hospital, St Austell and were all given access to clinical rooms for seeing patients and office space/ IT access for administration if they required it. We spoke with one health care professional who said communication between healthcare professionals and the practice was good.

Information sharing

The practice used a variety of ways to communicate with other providers. The practice provided detailed clinical information electronically to the out of hour's service about patients with complex healthcare needs. The practice receive information back from the out of hour's provider directly into the computer system to inform the GPs.

Electronic systems were in place for managing cervical smear appointments (Open Exeter). The practice used a local system and national choose and book system to access hospital appointments for patients. (The choose and book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use and showed us the back-up system to ensure the appointments had been arranged.

There was a practice website with information for patients including signposting, services available and latest news. Information leaflets and posters about local services were available in the waiting area.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, and said once they had got used to it the system was easy to 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

Staff had a basic understanding of the Mental Capacity Act 2005 and were aware of their duties in fulfilling it. Nursing

Good

Are services effective?

(for example, treatment is effective)

staff said they would refer any concerns to the GPs. Not all staff had received training in MCA. The MCA is a legal framework which supports patients who needs assistance to make important decisions.

There was a practice policy for documenting consent for specific interventions. For example, for all immunisations, contraceptive procedures, minor surgery and cervical smears. We saw anonymised examples of where nursing staff had recorded consent for these procedures.

Health promotion and prevention

The practice offered patients a health check when they were registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture between the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged between 18-25 years and offering lifestyle and smoking cessation advice to smokers.

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 had systems in place to make sure they were all invited for an annual health check. For example, of the 28 patients on the register all had been invited for a health check. Ten patients had received a check, five had refused, two had moved away and eight had not responded. Systems were in place to chase up patients who had not responded to the invitation.

The practice's performance for cervical smear uptake was comparable to other practices in the CCG area. There was a policy to offer written reminders for patients who did not attend for cervical smears and the practice monitored the number of patients who did not attend annually. These patients were then contacted again after five years to determine whether they wished to reconsider their disclaimer.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. For example, practice data showed that 87 of the 92 children between the ages of 20 weeks had received the first course of their childhood immunisations.

There was a range of leaflets and information documents available for patients within the practice These included information on family health, travel advice, long term conditions and minor illnesses.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the most recent improving practice questionnaire performed by the practice in 2014. This showed that over 85% of 25 respondents were satisfied with the care they received. This was higher than the national average. The practice shared the initial findings from the recent friends and family test. These results showed that all 25 of the initial respondents would be extremely likely or likely to recommend the practice to their friends and family.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 21 completed cards, all were positive about the service experienced. The comment cards included comments from patients stating that they thought the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect.

We spoke with 15 patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

There was a visible, person-centred culture at the practice. Staff were motivated and inspired to offer care that was kind and promoted people's dignity. Relationships between patients, those close to them, and staff were strong, caring and supportive. These relationships were highly valued by all staff and promoted by the practice management team. Staff were seen to be respectful, pleasant and helpful with patients and each other during our inspection visit.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice staff worked hard to prevent potentially private conversations between patients and reception staff being overheard.

Care planning and involvement in decisions about care and treatment

Patients we spoke to on the day of our inspection told us that GPs discussed health issues with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards and friends and family questionnaire were also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language but said the numbers of patients were very small. We saw notices in the office areas informing patients this service was available.

Patient/carer support to cope emotionally with care and treatment

Patients were positive about the emotional support provided by the practice staff. They said they had received help to access support services to help them manage their treatment and care when it had been needed. The patient comment cards we received were also consistent with this feedback.

Notices in the patient waiting room told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer so opportunistic checks could take place.

Staff told us that if families had suffered bereavement, their usual GP provided support. The GP could refer children to a children's bereavement charity for counselling and support. There were posters and leaflets offering advice on how to find a support service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had a proven track record of responding to patient feedback. The practice used complaints, significant events, surveys, comment cards and face to face meetings with patients and the patient participation group to improve the service.

The practice had an active patient participation group (PPG) who told us they felt the practice responded well to questions, feedback and suggestions.

Patients said they had been asked for feedback from surveys and knew they could give feedback to the reception staff. The most recent survey in March 2014 had showed overall practice scores were consistently higher than the national average. For example, 87% of the practice patients said they had been satisfied withn the visit compared with the national average of 80%. Also, 88% of Brannel patients said they were shown respect by staff compared to 84% of the national average responses. The survey showed the practice had scored higher than the national average in all 28 questions set.

Tackling inequity and promoting equality

The premises and services were purpose built and had been adapted to meet the needs of people with disabilities. There was level access and a designated accessible toilet. The door to the practice had a door bell for people to ring if they had difficulty opening it independently.

The practice had open spaces in the waiting room which provided turning circles for patients with mobility scooters or wheelchairs. Corridors and doors were wide making the practice easily accessible and helping to maintain patients' independence.

We saw that the waiting area was large enough to accommodate patients with prams and allowed for easy access to the treatment and consultation rooms. There were quiet areas for breast feeding mothers, play areas for children and baby changing facilities available.

Access to the service

Patients were generally pleased with the appointment service at the practice and said they could get a same day appointment if necessary. Patients told us that when they got to see the GP or nurse they never felt rushed. Patients also said it took longer to make an appointment with a GP of their choice but knew they could get an appointment with any GP on the same day. The responses from the patient survey in 2014 reflected these findings.

Opening hours were planned around the needs of the population. The practice was open between the hours of 8am and 6pm. Appointments could be booked four weeks in advance. Evening appointments were available one day a week to promote access to services to patients who worked during normal office hours.

Comprehensive information was available to patients about appointments on the website and within the practice. This included how to arrange urgent appointments and home visits and how to seek medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns and used this process as a part of its quality monitoring system. The practice's complaints policy and procedures were displayed in the practice and were in line with recognised guidance and contractual obligations for GPs in England. The practice manager was a designated responsible person who handled all complaints in the practice. There had been six formal complaints received in the last year. We looked at the summary of these complaints. We saw that all complaints had been satisfactorily handled and dealt with in a timely way. We saw evidence of learning and changes in systems, policies and processes as a result of complaints. The practice used the complaint summary to look at trends. Practice staff were keen to use comments and verbal feedback as a way of improving services.

We saw that information was available to help patients understand the complaints system. Patients were aware of the process to follow if they wished to make a complaint, but patients said they had not needed to complain.

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

Staff were able to describe the vision, values, strategic and operational aims of the practice which included providing a supportive accessible service within the confines of a rural community. Staff said one of the main strengths of the practice was the morale and team atmosphere. There were clear lines of accountability and areas of responsibility. Staff knew what their responsibilities were in relation to these.

Governance arrangements

There were structured meetings to discuss incidents, events, complaints, and clinical matters, but because the practice was small daily discussions also took place which meant any issues were dealt with and communicated promptly. We saw examples where the practice responded immediately to events, incidents and complaints, often finding solutions and actions before they were formally addressed at the clinical and practice meetings. The GPs and practice manager played a central role in coordinating this process and communicating any actions. There were practice meetings four times a year to discuss business issues, current complaints and significant events.

The practice had a number of written and electronic policies and procedures in place to govern activity and these were available to staff. We looked at the safeguarding adult and child policies and whistleblowing policies and saw these had been reviewed within the last year. Staff said having these on the practice intranet system meant they were easy to access and highlighted when any changes or updates had been made.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. QOF data for this practice showed it was performing in line with national standards.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. We looked at three examples of clinical audit. For example, one audit included a review of patients aged over 65 years on more than 20mg of a medicine used for depression and anxiety was conducted because of the side effects. These patients were contacted and had their medicines changed or stopped. This was re-audited after six months to confirm that no one was receiving more than 20mg of this medicine daily.

Another audit looked at the number of patients prescribed antibiotics in January, February and March 2014 to make sure prescription rates were appropriate. The GP was in the process of re auditing this again. This shows the GPs are aware for the correct audit cycle and focus on patient outcomes as well as financial incentives.

The practice manager showed us the contracts for, systems, records and processes to identify and reduce risk in the environment where they had control. Staff were aware of their roles in these processes. For example, nurses knew about how to safely dispose of clinical waste and the fire marshals knew how to respond in the event of a fire.

Staff at the practice discussed complaints, significant events and incidents informally as they occurred and more formally at the practice meetings. The records for these events showed the action and learning that took place. Staff said communication of these issues was effective and was done either at meetings, on a one to one basis or using the practice intranet system.

Leadership, openness and transparency

Staff described a clear leadership structure where the practice manager had a central role in the coordination of these roles. We spoke with staff and they were clear about their own roles and responsibilities. They all told us they thought the practice was well led and felt well supported and knew who to go to in the practice with any concerns. Staff appreciated the social activities that took place to improve morale and team building.

Staff said there was an open culture within the practice and they had the opportunity and were happy to raise issues at any time.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example, recruitment procedures and induction process which were in place to support staff. Staff knew where they could find these. This support was provided for locums who visited the practice as well as permanent staff.

Seeking and acting on feedback from patients, public and staff

Are services well-led?

Good

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

The practice had gathered feedback from patients through a patient survey in March 2014. The survey showed that the practice scored higher than the national average in all areas. The survey found that patients felt that it was easy to get an appointment. For example 78% of the respondents said they could get an appointment compared to 68% nationally. 83% of patients also said both GPs and nurses gave them enough time and 86% explained tests and treatments compared to 81% nationally. Patients also said the GPs involved them in their care, treated them with care and concern and took their problems seriously.

The practice had an active patient participation group (PPG). There were approximately 15 members on the PPG and they met every two months. The PPG said the practice manager chaired the meeting and they wanted to keep the group informal. They felt they could influence changes by speaking to the practice manager. The PPG said they had been very involved in keeping the dispensary open by objecting to planning from a commercial pharmacy being introduced in the community. Other influences including helping at the flu clinics and having an input into the patient survey.

The practice had gathered feedback from staff through face to face discussions, appraisals and through staff meetings. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

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 said there were no restrictions on the amount of study days they may attend. We looked at staff files and training records and saw that regular appraisals took place which included a personal development plan.

The practice had completed reviews of significant events and other incidents and formally shared action and learning from these events with the staff group to ensure the practice improved outcomes for patients.