# Brannam Medical Centre

## Inspection report

Brannam Medical Centre
Brannam Square
Kiln Lane
Barnstaple
Devon
EX32 8GP
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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 location** | Good |
|---|---|
| Are services safe? | **Good** |
| Are services effective? | **Good** |
| Are services caring? | **Good** |
| Are services responsive? | **Outstanding** |
| Are services well-led? | **Good** |

# Overall summary

**This practice is rated as Good overall.** (Previous inspection November 2014 – Good)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Outstanding

Are services well-led? - Good

We carried out an announced comprehensive inspection at Brannam Medical Centre on 4 May 2018. The inspection was a routine inspection as part of our inspection schedule.

At this inspection we found:

- The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved processes.
- Audit was embedded, with the practice routinely reviewing the effectiveness and appropriateness of the care it provided. Care and treatment was always delivered according to evidence-based guidelines.
- All 30 patients gave strongly positive feedback at the inspection about staff treating them with compassion, kindness, dignity and respect.
- Staff were caring and raised funds for local charities every year.
- People's individual needs and preferences were central to the planning and delivery of flexible tailored services. All patient feedback highlighted ease of access to the appointment system, on the day assessment and minor illness services. Extended hours were available every day enabling working patients and school children to access a range of services from the multi-disciplinary team.
- As a training practice, there was a strong focus on continuous learning and improvement at all levels of the organisation. Proactive succession planning based on staff development and training of future GPs, doctors and practice nurses was evident.
- Brannam Medical Centre had successfully registered a further 1650 additional patients in 2017/18 due to the closure of a nearby practice. The practice list size had increased by 3,000 in the last three years. Patient feedback shared with us by patient representatives indicated existing patients had reported no adverse impact for them.

We saw areas of outstanding practice including:

A housebound patient pathway was developed and adopted locally, enabling vulnerable patients with long term conditions to have comprehensive regular reviews at home carried out by the practice nurse and pharmacist. In total 160 patients, had regular reviews of their health by these staff and received proactive support to reduce any associated risks.

In response to patient need, the practice had set up in-house free counselling service for patients, in conjunction with the local college. Sixty patients with long term conditions, including obesity were able to access support between April 2017 and March 2018. This was in addition to hosting the secondary care depression and anxiety services at the practice for patients.

**Professor Steve Field** CBE FRCP FFPH FRCGPChief Inspector of General Practice

## Population group ratings

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

## Our inspection team

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

## Background to Brannam Medical Centre

The partnership of GPs registered as Brannam Medical Centre runs one registered location at the Brannam Medical Centre, which was inspected on 4 May 2018. This was a comprehensive inspection.

The practice is located at:

Brannam Medical Centre

Brannam Square

Kiln Lane

Barnstaple

Devon

EX32 8GP

The practice provides a primary medical service to 16,150 patients of a diverse age group. The practice population is in the fifth deprivation decile for deprivation. In a score of one to ten the lower the decile the more deprived an area is. Particular areas of Barnstaple and the surrounding villages have higher levels of deprivation. There is a practice age distribution of male and female patient's equivalent to national average figures. Average life expectancy for the area is similar to national figures with males living to an average age of 80 years and females to 83 years.

There is a team of 12 GPs partners, supported by a salaried GP and two GP retainers (seven male and eight female). Three of the GP partners job share. The team are supported by a practice manager, six practice nurses, three healthcare assistants and a part time clinical pharmacist. There are administrative and reception staff.

Brannam Medical Centre is an approved training practice providing vocational placements for GPs registrars. Four GP partners are approved to provide vocational training for GPs, second year post qualification doctors and medical students. A GP registrar was on placement when we inspected with this increasing to three from August 2018. Teaching placements are provided for medical students, post qualification doctors, student nurses, paramedics and physician assistants.

Patients using the practice also have access to community nurses, mental health teams and health visitors. Other health care professionals visit the practice on a regular basis.

The practice is open between 8am and 6:30pm Monday to Friday. Appointments are available from 8am every morning and 6pm daily. Extended hours opening is available on a Tuesday to Friday from 7am to 8am and 6.30pm to 8pm on Mondays. The practice offers a range of

appointment types including book on the day, telephone consultations and advance appointments. Outside of these times patients are directed to contact the out of hour's service by using the NHS 111 number.

Good

# Are services safe?

**We rated the practice as good for providing safe services.**

### Safety systems and processes

The practice had clear systems to keep people safe and safeguarded from abuse.

- The practice had appropriate systems to safeguard children and vulnerable adults from abuse. All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Reports and learning from safeguarding incidents were available to staff. Staff who acted as chaperones were trained for their role and had received a DBS check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.)
- Staff took steps, including working with other agencies, to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- We reviewed one file for a newly recruited member of staff and found the practice carried out appropriate staff checks at the time of recruitment and on an ongoing basis.
- There was an effective system to manage infection prevention and control.
- The practice had arrangements to ensure that facilities and equipment were safe and in good working order.
- Arrangements for managing waste and clinical specimens kept people safe.

### Risks to patients

There were adequate systems to assess, monitor and manage risks to patient safety.

- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness, busy periods and epidemics.
- There was an effective induction system for temporary staff tailored to their role. This included an induction pack should any locum staff work at the practice.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections including sepsis. Assessment tools were seen displayed in all clinical areas for staff to follow if a patient presented with infection.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

### Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- The practice had a software risk management system, which was originally piloted for the Clinical Commissioning Group and is now use as part of an enhanced service. This enabled patient records to be analysed to produce risk profiles and target audit activity and health screening. The care records we saw showed that information needed to deliver safe care and treatment was available to staff. There was a documented approach to managing test results.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made timely referrals in line with protocols.

### Appropriate and safe use of medicines

The practice had reliable systems for appropriate and safe handling of medicines.

- The systems for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment, minimised risks.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with current national guidance. The practice had reviewed its antibiotic prescribing and taken action to support good antimicrobial stewardship in line with local and national guidance.
- Patients' health was monitored in relation to the use of medicines and followed up on appropriately. Patients were involved in regular reviews of their medicines.

### Track record on safety

The practice had a good track record on safety.

Good

# Are services safe?

- There were comprehensive risk assessments in relation to safety issues.
- The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture of safety that led to safety improvements.

**Lessons learned and improvements made**

The practice learned and made improvements when things went wrong.

- Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice. Awareness was raised about safe practice when using sharp instruments following a member of staff having a needle stick injury.
- The practice acted on and learned from external safety events as well as patient and medicine safety alerts. We saw several examples including: audit was undertaken on receipt of the safety alert about the risks of sodium valproate. This demonstrated the practice had identified all childbearing female patients who were prescribed sodium valproate, reviewed and altered the prescription where appropriate and advised them of the associated risks during pregnancy. Since the national review of asthma deaths, the practice continued to carry out audits for assurance of patient safety when using inhalers for their condition. An audit in 2018, found 24 patients (out of 16100 patients at time) potentially needing follow up. Further enquiry established 12 required review including two housebound patients, which had been done.

**Please refer to the Evidence Tables for further information.**

Good

# Are services effective?

**We rated the practice and all of the population groups as good for providing effective services overall .**

(Please note: Any Quality Outcomes (QOF) data relates to 2016/17. QOF is a system intended to improve the quality of general practice and reward good practice.

**Effective needs assessment, care and treatment**

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff used easy read and picture prompt cards to support patients' independence, for example when preparing patients with learning disabilities for well woman/man health checks.
- Staff used appropriate tools to assess the level of pain in patients. Templates seen on the computer system prompted staff to record baseline information.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. The practice used an appropriate tool to identify patients aged 65 and over who were living with moderate or severe frailty. Those identified as being frail were referred to the community matron for proactive care management.
- Patients aged over 75 were invited for a health check. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Patients who were housebound were visited at home by a practice based nurse and pharmacist and had regular clinical reviews of their medication and long term condition/s.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice had arrangements for adults with newly diagnosed cardiovascular disease including the offer of high-intensity statins for secondary prevention, people with suspected hypertension were offered ambulatory blood pressure monitoring and patients with atrial fibrillation were assessed for stroke risk and treated as appropriate.
- The practice was able to demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension). Patient records were analysed using a software system to produce risk profiles and health screening.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were above the target percentage of 90%.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation.

Working age people (including those recently retired and students):

Good

# Are services effective?

- The practice's uptake for cervical screening was 79.2%, which was almost in line with the 80% coverage target for the national screening programme. (Uptake rates locally were 76% and 72 % nationally). Staff verified every contact with eligible women was used to encourage and support them to have cervical screening.
- The practices' uptake for breast and bowel cancer screening was above the national average.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- A register was held of all patients falling within the pre-diabetic range, who could be at risk of developing diabetes. At the time of the inspection there were 110 patients on the register. These patients were monitored and given education and support for healthy living to reduce the risk.

People experiencing poor mental health (including people with dementia):

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services. There was a system for following up patients who failed to attend for administration of long term medication.
- The practice recognised the link between depression and living with a long term condition/s, including obesity. Patients were able to access in house talking therapy to support them.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- 82% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This is comparable to the national average.
- 96% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This is above the national average.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example 96% of patients experiencing poor mental health had received discussion and advice about alcohol consumption. This is above the national average.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis at the local memory clinic in Barnstaple.
- The practice offered annual health checks to patients with a learning disability.

**Monitoring care and treatment**

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. Scheduled audits of clinical and non-clinical areas were agreed and completed over the course of every year.

- The practice used information about care and treatment to make improvements. An audit reviewed exception reporting at the practice for 2016/17. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate. During 2016/17 there was a significant increase in patients registering due to the closure of a nearby practice, some of whom had been exempted by the previous practice. Of 268 patients who were exempted in 2016/17 only 15 of those were exempted in 2017/18 for appropriate clinical reasons.
- The practice was actively involved in quality improvement activity. Where appropriate, clinicians took part in local and national improvement initiatives

such as the diabetes integration pilot running across three areas in Devon. Brannam Medical Centre's involvement was to improve care planning and information for new patients diagnosed with diabetes.

**Effective staffing**

Staff had the skills, knowledge and experience to carry out their roles.

- Staff had appropriate knowledge for their role, for example, to carry out reviews for people with long term conditions, older people and people requiring contraceptive reviews. A practice based pharmacist was jointly funded with NHS England and was carrying out regular medicine reviews with patients in clinics and their own homes.
- Staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.
- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. There was a low turnover at the practice, no new healthcare assistants had been employed since our last inspection. The ongoing training for healthcare assistants was comprehensive. The practice was aware of the requirements of the Care Certificate. The practice ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing.
- There was a clear approach for supporting and managing staff when their performance was poor or variable through the staff development system of appraisal.

**Coordinating care and treatment**

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for people with long term conditions and when coordinating healthcare for care home residents. The shared information with, and liaised, with community services, social services and carers for housebound patients and with health visitors and community services for children who have relocated into the local area.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

**Helping patients to live healthier lives**

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their own health, for example through social prescribing schemes.
- Staff discussed changes to care or treatment with patients and their carers as necessary. The visiting service by the practice nurse and pharmacist to review 160 housebound patient's, also ensured additional support was put in place where needed. Staff shared examples such as arranging for the patient to have equipment to promote their independence within their physical limitations.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.

**Consent to care and treatment**

Good

# Are services effective?

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making. Since the last inspection, all staff had completed mental capacity act training to raise their awareness about capacity to consent issues.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately by undertaking an annual audit.

**Please refer to the Evidence Tables for further information.**

Good

# Are services caring?

**We rated the practice as good for caring.**

**Kindness, respect and compassion**

Staff treated patients with kindness, respect and compassion.

- Feedback from 30 patients, verbally and in comment cards was strongly positive about the way staff treat people.
- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- Staff were compassionate and chose a charity each year to raise funds for. In 2017/18 the practice had raised £800 for the local hospice through various events including cake and book sales and taking part in a fun run.

**Involvement in decisions about care and treatment**

Staff helped patients to be involved in decisions about care and treatment. They were aware of the Accessible Information Standard (a requirement to make sure patients and their carers can access and understand the information that they are given.)

- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.
- The practice proactively identified carers and supported them.

**Privacy and dignity**

The practice respected patients' privacy and dignity.

- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Staff recognised the importance of people's dignity and respect. They challenged behaviour that fell short of this.

**Please refer to the Evidence Tables for further information.**

Outstanding ☆

# Are services responsive to people's needs?

**We rated the practice, and all of the population groups, as outstanding for providing responsive services**

The practice had further developed services since the last inspection and is rated outstanding for responsive because:

- People's individual needs and preferences were central to the planning and delivery of flexible tailored services.
- The involvement of other organisations and the local community had been integral to how services were planned to meet patient needs. There were innovative approaches to providing integrated person-centred pathways of care that involve other service providers, particularly for people with multiple and complex needs.
- There was a proactive approach to understanding the needs of different groups of people and to deliver care in a way that meets these needs and promotes equality. This was particularly so for people who were in vulnerable circumstances or who had complex needs.
- People were able to access appointments and services in a way and at a time that suited them.
- There was active review of complaints and how they were managed and responded to, and improvements are made as a result. People who used services were involved in the review.

**Responding to and meeting people's needs**

Services were tailored to meet the needs of individual people and are delivered in a way to ensure flexibility, choice and continuity of care. It took account of patient needs and preferences.

- Patients were actively involved in the development of services through the patient representative group and virtual group. The practice facilitated patient representation with stakeholder groups such as the clinical commissioning group to influence wider development and integration of health and social care services in the area.
- The practice understood the needs of its population and tailored services in response to those needs. Several examples were seen and included: The rapid access clinic had been extended increasing patient access to nurse, health care assistants and GP assessment for urgent health matters. Extended opening hours and appointments were available every week day, either early morning or late evening. A practice based pharmacist had been appointed and was carrying out medicine reviews with patients in surgery and at home. Minor illness clinics were run by a duty GP and nursing staff every morning. GPs specialised in particular areas such as dermatology providing near patient screening for early diagnosis and treatment.
- Telephone consultations and lunchtime appointments were available which supported patients who were unable to attend the practice during normal working hours.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services.
- The practice provided effective care coordination for patients who are more vulnerable or who have complex needs. They supported them to access services both within and outside the practice.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.
- The national GP survey results for 2017 were significantly positive in regard to accessing appointments, opening hours and overall experience.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice was proactive in tailoring responses to the needs of older patients. Risk profiling was used to identify what support a patient might need and was put in place to reduce risk of hospital admissions. Home visits and urgent appointments for those with enhanced needs were carried out by GPs, the practice nurse and pharmacist.
- Reviews of patients who were housebound and had long term conditions were carried out with them at their own home.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.

# Are services responsive to people's needs?

- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.
- In house talking therapy set up by the practice in conjunction with the local college was available for patients with long term conditions, including obesity. Sixty patients had been referred to the counsellor between April 2017 and March 2018.
- The practice was involved with the national diabetes audit and integrated diabetes project to improve primary/secondary care experiences for patients. The pathway for reviewing housebound patients with diabetes had been recognised as an exemplar to be implemented at other practices in the area. 160 housebound patients at Brannam Medical Centre were able to have the full range of checks, normally done at the practice, in their own home.
- Near patient testing for conditions requiring regular blood monitoring were available. Patients were able to receive immediate blood results and have their medicines dosages changed accordingly before leaving the practice.

Families, children and young people:

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment via the rapid access service when necessary.
- After and before school routine appointments were available, avoiding any disruption to the school day.
- Parents were able to access longer appointments for their baby to be checked and have their first immunisations. At these appointments staff explained the immunisation schedule and arranged future appointments with the parent/s. This had an impact on update rates, which were significantly above the national target of 90%.

Working age people (including those recently retired and students):

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, extended opening hours every weekday. Rapid access clinics ran over the lunch period. Patients were able to have physiotherapy appointments onsite rather than at the local hospital. Telephone consultations were offered as required.
- Patients were able to sign up for online access to their records, request medication and appointments.
- NHS health checks were offered including cholesterol testing.
- Travel clinic services, including yellow fever were available by appointment, including during extended hours, with nursing staff.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode. Systems were in place to facilitate communication between secondary care and people with no fixed abode, whereby the practice acted as a point of contact.
- The practice had an established relationship with travellers visiting the area during the summer fairs providing access long appointments for a comprehensive review of their health.
- There was proactive management of patients at risk to developing long term conditions. The practice held a register of patients in the pre-diabetic range. At the time of the inspection, 110 patients on the register were able to access education about living healthily, regular health reviews and in house talking therapies.

People experiencing poor mental health (including people with dementia):

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- GP regularly reviewed all patients with mental health and dementia. Patients who failed to attend were proactively followed up by a phone call from a GP.
- Patients who were on long standing medicines given by injection (depot) were allocated a named nurse for continuity of care. Longer appointments were given.
- The practice hosted talking therapy appointments via the local depression and anxiety service.

Outstanding ☆

# Are services responsive to people's needs?

- In collaboration with the nearby college, qualified counselling services were provided in-house and free of charge for patients needing it with 60 patients benefitting from this in the previous 12 months.

**Timely access to care and treatment**

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- 30 patients verbally and in comment cards reported that the appointment system was easy to use.

**Listening and learning from concerns and complaints**

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. The practice learned lessons from individual concerns and complaints and also from analysis of trends. Minutes of the annual audit meeting showed 21 complaints had been reviewed at the end of March 2018 for the previous 12 months. It acted as a result to improve the quality of care.

**Please refer to the Evidence Tables for further information.**

Good

# Are services well-led?

**We rated the practice and all of the population groups as good for providing a well-led service.**

### Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them. For example, the overall practice list had increased by 3,000 patients since 2014. Of these, 1650 patient registering following the closure of another practice and was well managed. The practice had planned for future population growth in the area to avoid impact on services.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

### Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality, sustainable care.

- There was a clear vision and set of values. The practice had a realistic strategy and supporting business plans to achieve priorities. The practice developed its vision, values and strategy jointly with patients, staff and external partners.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The practice planned its services to meet the needs of the practice population.
- The practice monitored progress against delivery of the strategy.

### Culture

The practice had a culture of high-quality sustainable care.

- Staff stated they felt respected, supported and valued. They were proud to work in the practice. The practice gave staff financial rewards and organised regular social events for team building.
- The practice focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff was supported to meet the requirements of professional revalidation where necessary.
- Clinical staff was considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

### Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. We saw several examples, including: standing items at the weekly senior management meeting monitored patient health review performance (Quality outcome framework - QOF). Equity and safety management of GP patient list size. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control

Good

# Are services well-led?

- Practice leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

**Managing risks, issues and performance**

There were clear and effective processes for managing risks, issues and performance.

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Practice leaders had oversight of national and local safety alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.
- The practice had plans in place and had trained staff for major incidents.
- The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

**Appropriate and accurate information**

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Audit was embedded with an audit schedule covering clinical and organisational areas. We saw several examples: annual audits to determine whether patients at the end of their life had treatment escalation plans in place. Annual audit to determine whether exception reporting of any patient reviews was based on clinical assessment. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The practice used performance information which was reported and monitored and management and staff were held to account. For 2016/17 the practice had achieved an overall quality outcome framework (QOF) score of 100% for reviewing patients.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

**Engagement with patients, the public, staff and external partners**

The practice involved patients, the public, staff and external partners to support high-quality sustainable services.

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. There was an active patient representation group as well as a virtual group.
- The service was transparent, collaborative and open with stakeholders about performance.

**Continuous improvement and innovation**

There were evidence of systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement as a training practice. For example, staff was supported to develop in house. Some staff had moved from administrative, to clinical positions which had facilitated them being accepted onto pre-registration nursing and midwifery courses.
- Staff knew about improvement methods and had the skills to use them.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.

**Please refer to the Evidence Tables for further information.**