Plympton Health Centre

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Plympton Medical Centre, which is part of the Beacon Medical Group on Thursday 26 March 2015. There are four practices within the Beacon Medical Group. We only inspected Plympton Health Centre during this inspection.

Overall the practice is rated as good. Specifically, the five domains of safe, effective, caring, responsive and well-led are rated as providing services that are good. It was also rated good for providing services for the six population groups.

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

There was a track record and a culture of promptly responding to incidents, near misses and complaints and using these events to learn and change systems so that patient care could be improved.

Staff were aware of their responsibilities in regard to consent, safeguarding and the Mental Capacity Act 2005 (MCA).

The practice was clean and tidy and there were infection control procedures in place.

Medicines were managed well and there were effective systems in place to deal with emergencies.

The GPs and other clinical staff were knowledgeable about how the decisions they made improved clinical outcomes for patients and care plans were not always kept under review.

Most data outcomes for patients were either equal to or above the average locally.

Patients were generally complimentary about the staff and how their medical conditions were managed, although patients told us that changes at the practice were taking time to get used to.

Practice staff were professional and respectful when providing care and treatment.

The practice planned its services to meet the diversity of its patients. Adjustments were made to meet the needs of the patients. Changes were in progress to improve the appointment system to ensure good access to the service.

Summary of findings

There were clear recruitment processes in place and robust induction processes in place.

The practice had a vision, clear ethos and mission statement which were understood by staff. There was an emerging leadership structure in place and staff felt supported.

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

The Provider should:

- Develop an annual clinical audit policy.
- Ensure staff meeting minutes show when items for action have been completed.
- Ensure there are records showing when learning actions following significant events analysis have been completed.
- Develop an effective system to monitor staff training.
- Coordinate IT system records to inform and prioritise indicators for child safeguarding concerns.
- Ensure that an evaluation of new clinical services takes place at the end of pilot programmes.
- Evaluate the effectiveness of changes intended to improve telephone access for patients.
- Publicise patient survey results.
- Ensure all staff are aware where emergency equipment is stored in the practice.

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.

The practice was clean, tidy and hygienic. Arrangements were in place that ensured the cleanliness of the practice was consistently maintained with structured programmes in place to ensure clinical equipment was cleaned.

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 to relevant staff following such investigations.

Staff had an awareness of the Mental Capacity Act 2005 (MCA) and of their responsibilities regarding safeguarding adults and children. All staff had received training in safeguarding awareness.

There were arrangements for the efficient management, storage and administration of medicines within the practice with systems in place to identify when equipment needed to be replaced.

Recruitment procedures and checks were completed on permanent staff as required to help ensure that staff were suitable and competent. There were robust induction processes in place.

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.

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 Excellence (NICE) guidelines and other locally agreed guidelines. The nursing team used clear evidence based guidelines and patient directives when treating patients.

The practice used the national Quality Outcome Framework (QOF- a national performance measurement tool) scheme and knew where additional actions were needed to improve these targets. Data showed that the practice was performing equally when compared to neighbouring practices in the clinical commissioning group (CCG). Care was planned and well managed.

Summary of findings

Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessment of patients' capacity to make informed choices about their treatment and the promotion of good health.

Patients with complex care needs and vulnerable patients had their care planned in line with NICE guidelines. Some patients had been involved in forming personalised care plans to assess and show how care would be delivered. Care plans we looked at had been updated within the last three months to ensure their relevance to health needs.

Audits were performed and completed regarding patient outcomes, which showed a safe, consistent level of care and effective outcomes for patients. However, there was no policy governing the audit cycle or clinical lead for coordinating the audit cycle.

Patients told us staff asked for their consent before any treatment was provided. There was a chaperone service available.

There was a systematic induction and staff training programme in place based on individual staff personal professional development, with a culture of further education to benefit patient care and increase the scope of practice for staff. However, there was a lack of overall staff training plan that considered the training and development needs of the staff team as a group.

Are services caring?

Good

The practice is rated as good for providing caring services.

Feedback from patients about their care and treatment was positive. The patients we spoke with on the day and friends and family surveys reflected this feedback. Patients described the practice as caring.

We observed a person centred culture. Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieve this.

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

Patients said they were treated with respect, care, privacy and dignity and said 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 learnt from and responded in a timely way to patient feedback, incidents and informal comments. However, evidence was not always clear that actions and learning as a result of patient comments was signed off as completed.

Summary of findings

There was an accessible complaints system. The practice responded quickly to issues raised even if they were informal verbal complaints.

The practice planned and provided appropriate services for patients and worked well with commissioners and other health care providers to ensure patients received effective care.

The appointment system had been reviewed and revised to improve access to patients, following complaints. Patients said they could get an appointment easily in advance or with a GP on the same day.

Are services well-led?

Good

The practice is rated as good for being well led.

The practice had a formal vision, ethos and mission statement which included being on the patients side. Staff were clear about this vision. The leadership structure in place was still evolving and embedding. The provider recognised where weaknesses remained and had a plan to address where leadership could be further improved.

The provider had a number of policies and procedures to govern activity. There were systems in place to monitor and improve quality and identify risk.

There was a culture of wanting to improve and learn following any significant event or complaint. Action and learning was shared with the staff team. Actions or learning from staff meetings or significant events was not always signed off when completed or reported as so. Staff grievance protocols were followed but records of staff grievances were not completed fully.

The practice welcomed feedback from patients through surveys, although survey results were not as yet publicised on the revised practice website. The practice was in the process of developing a patient participation group (PPG).

Staff had received induction, training and performance reviews. Not all annual staff appraisals had been completed in the last 12 months, but were scheduled to be completed within seven days of our inspection visit. There were regular staff meetings.

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 had an open list. Patients aged 75 and over had their own allocated GP but had the choice of seeing whichever GP they prefer across the four location sites. Treatment was organised around the individual patient and any specific condition they have.

A programme of pneumococcal, shingles and influenza vaccinations were provided at the practice for older people. Vaccines for older people who have problems getting to the practice or those in local care homes were administered in the community by the community nurses in the Plympton area. Nurses and GPs undertook home visits for older people and patients who require a visit following discharge from hospital.

In October 2014, through the Prime Minister's Challenge Fund (PMCF), the practice recruited a practice pharmacist, who had developed a tool for medications review in nursing homes focussing on medicines safety and efficacy particular for polypharmacy (multiple medicines) issues. Initial work was carried out remotely with follow up on site accompanied by a practice GP.

The practice had a system to identify older patients and coordinated the multi-disciplinary team (MDT) for the planning and delivery of palliative care for people approaching the end of life. This included the community matron, district nurses and a palliative care specialist nurse. Patients on the palliative care register were discussed at regular MDT meetings.

The practice worked to avoid unnecessary admissions to hospital and collaborated with other health care professionals to provide joint working. This included providing personal care plans for those at high risk. Vulnerable patients were discussed at the monthly MDT meetings where care plans, discharge records and medications were reviewed.

Practice staff worked with the rapid response care coordination team and falls service. This included launching a mobile GP service in October 2014, which provided rapid support to patients requiring an urgent home visit. This was funded by PMCF and enabled the practice to release additional time for a GP to triage, visit and assess individual patients.

The premises were all one level for easy access. Chairs in the waiting room included some with arm rests to assist patients to stand.

Summary of findings

People with long term conditions

Good

The practice identified patients who might be vulnerable, have multiple or specific complex or long term needs and ensured they were offered consultations or reviews where needed.

The staff at the practice maintained links with external healthcare professionals for advice and guidance. Particular clinics operated for patients with diabetes, cardiovascular disease, asthma and chronic respiratory conditions. The nurses attended educational updates to keep sure their lead role knowledge and skills up to date.

The asthma and chronic lung disorders clinics used spirometry to assess the evolving needs of this patient group. The practice promoted independence and encouraged self-care for these patients. For example, for hypertension patients the practice advised and supported home monitoring with patient's own blood pressure machines.

Patient information leaflets were available in the waiting areas and corridors of the practice.

The practice employed a specialist healthcare practitioner, to deliver an outreach telephone clinic for this group of patients with long term conditions. The healthcare practitioner contacted patients to ask key questions and check whether their rescue packs were still in date. This contact checked with patients whether they felt their condition was controlled and additional face to face support was offered if needed, including medicines reviews.

The practice pharmacist had shadowed the nursing team through their long term conditions clinics to provide qualitative feedback and to make recommendations on improvement bring together specialist knowledge and skills sharing between the nurses and pharmacist.

There were regular diabetic clinics to treat and support patients with diabetes, which included education for patients to learn how to manage their condition through insulin and lifestyle behaviours. All newly diagnosed patients with diabetes were referred for health education. Where appropriate, the practice referred to locally provided weight management services.

Families, children and young people

Good

GPs performed 24 hour post natal baby checks following discharge from hospital or home delivery and carried out six week checks on all babies registered.

There were well organised baby and child immunisation programmes available to ensure babies and children could access a full range of vaccinations and health screening. Regular immunisation clinics were held at the practice.

Summary of findings

Ante-natal care was provided at the practice by a midwife who had access to the practice computer system and could speak with a GP should the need arise. The practice worked with health visitors and school nursing team, although contact at Plympton was more phone based than face to face contact between healthcare professionals. Systems were in place to alert health visitors when children had not attended routine appointments and screening.

Patients had access to a full range of contraception services (including coils and implants) and sexual health screening including chlamydia testing and cervical screening. Dedicated well woman clinics were run. There were quiet private areas in the practice for women to use when breastfeeding.

One of the partners was the named GP for a local special needs school supporting children and young people with severe learning needs. The GP provided a weekly visit to the school to review health needs of children who attended the school.

There was a designated lead for safeguarding and a lead at each site. Child protection was mandatory training for all staff. Staff were trained to recognise child safeguarding concerns and to make appropriate alerts.

Working age people (including those recently retired and students)

Good

The practice had a higher than CCG average number of working age adults. Advance appointments (up to six weeks in advance) and evening appointments were available twice a week to assist patients not able to access appointments due to work commitments. Patients could access evening appointments at any site four times a week. There was an online appointment booking system. Patients were able to opt in to a text message reminder service for appointments.

Travel advice was available from the GPs, nursing staff and in-house pharmacist.

The staff offered opportunistic health checks on patients as they attend the practice. This included offering referrals for smoking cessation, providing health information, routine health checks and reminders to have medication reviews. The practice also offered age appropriate screening tests such as cholesterol testing. Smoking cessation clinics were held in-house on a weekly basis.

Patients could order repeat medication online, by post or in person. The practice was working with a community pharmacy to develop a model whereby patients with less complex needs could access support through their high street pharmacy.

Summary of findings

In the Ivybridge branch location a minor injuries service was open to the general public, including patients registered at Plympton Health Centre. Anybody could turn up without pre-booking an appointment, within 48 hours of their injury. This provided convenient access to people living and working in Ivybridge and the surrounding areas.

The practice offered out of area registrations to patients to enable people who work in the local area to access healthcare support. The clinical system operated across all the four sites so that patients are able to be seen in any location. This helped those who worked or have other commitments in a different area than they live.

Additional triage was offered to patients, so that the in-house pharmacist could screen minor ailments or medication queries. This could be done by telephone to support patients from any location.

For those patients who required urgent access and where appointments were not available on the day the practice offered the option of a telephone consultation with a GP. This was particularly useful to patients with other commitments who were not able to make it to the practice.

There were new services, including specialist musculoskeletal and dermatology clinics. This support, provided by specialist GPs, provided additional screening and treatment plans for an increased number of patients rather than onward referral to secondary care.

People whose circumstances may make them vulnerable

Good

The practice had a learning disabilities register. These patients were offered a health check each year, during which their long term care plans were discussed with the patient and their carer if appropriate. Practice staff liaised with the community disabilities nurse who saw those patients who had difficulty attending clinic.

Practice staff were able to refer patients with alcohol addictions to an alcohol service for support and treatment.

The practice worked with and referred patients to a community matron who visited vulnerable patients to assess and facilitate any equipment, mobility or medication needs they may have. These patients were discussed at regular multidisciplinary meetings.

There were a small number of patients whose first language is not English. A translation service was available.

The practice promoted its chaperone service and reminded patients that if they do require assistance, they could ask. All clinical staff and senior reception staff had received chaperone training.

Summary of findings

People experiencing poor mental health (including people with dementia)

Good

The practice had a register which identified patients who had mental health problems. There was also a GP lead for dementia and mental health.

There was a practice attached community dementia care practitioner who attended regular MDT meetings. There were nationally recognised examination tools used for people who were displaying signs of dementia.

Patients had access to an in house counsellor for depression, alcohol issues or more general issues. Patients who had depression were seen regularly and were followed up if they did not attend appointments.

In house mental health medicine reviews were conducted to ensure patients received appropriate doses of their medicines. Blood tests were regularly performed on patients receiving certain mental health medications.

Clinical staff had received training in and were aware of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards.

The practice had identified patients with dementia. The reception teams had received additional training around identification and support available to carers. This was provided via the local representative charity and was promoted through the practice newsletter.

Summary of findings

What people who use the service say

We spoke with six patients during our inspection and with two members of the patient participation group (PPG).

We sent a comments box by post with comments cards for patients to complete prior to the inspection. Unfortunately the practice informed us that the box and cards had not been received. Therefore we were unable to collect comment cards that patients had completed prior to the inspection.

In conversations with patients during the inspection, patients told us about their experiences of care. They told us appointments were easy to get and that the planning of their care was always discussed with them. Patients said the repeat prescription service worked well. Patients said GPs and nurses were kind and positive. One person thought reception staff could be a little intrusive about asking personal questions about their health. People said it was not always possible to see their named GP, but understood advance bookings could be made if they wanted to see their own GP.

In 2014 526 patients registered across the four site locations took part in the GP Patient survey. Results indicated satisfaction rates in line with other practices in the locality and local CCG area. Areas of concern were in regard to ease of telephone access, helpfulness of reception staff and privacy at the reception desk, seeing a preferred GP, waiting times, opening hours and changes to the services following the merger of the four practices into the Beacon Medical Group. The practice had acted upon patient feedback and had taken steps to resolve issues of concern. For example, a new telephone system had been installed. This was still in the first month of use and the practice had not yet evaluated if the issues relating to telephony had been resolved effectively yet.

Patients knew how to contact services out of hours and 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. Patients said they felt listened to and felt confident the practice would listen and act on complaints.

Patients were satisfied with the facilities at the practice. Patients commented on the building always being clean and tidy.

The Beacon Medical Group had an established PPG at one of its branch locations and this model was being introduced at Plympton Health Centre. The PPG at Plympton had appointed a Chair and was in the process of recruiting members for a virtual PPG.

Areas for improvement

Action the service SHOULD take to improve

- Develop an annual clinical audit policy.
- Ensure staff meeting minutes show when items for action have been completed.
- Ensure there are records showing when learning actions following significant events analysis have been completed.
- Develop an effective system to monitor staff training.
- Coordinate IT system records to inform and prioritise indicators for child safeguarding concerns.
- Ensure that an evaluation of new clinical services takes place at the end of pilot programmes.
- Evaluate the effectiveness of changes intended to improve telephone access for patients.
- Publicise patient survey results.
- Ensure all staff are aware where emergency equipment is stored in the practice.

Plympton Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC lead inspector. The team also included two GP specialist advisors and a practice nurse specialist advisor.

Background to Plympton Health Centre

Plympton Health Centre was inspected on Thursday 26 March 2015. This was a comprehensive inspection.

Plympton Health Centre is situated in the town of Plympton and has a patient list of approximately 13,000. Plympton Health Centre is part of the Beacon Medical Group which on 1st April 2014 merged the then Plym River Surgery (now called Plympton Health Centre), Ivybridge Health Centre, The Ridgeway Surgery, Chaddlewood Surgery and Wotter Surgery. The Group is now one large practice collectively known as the Beacon Medical Group. The Group operates over four sites, serving a total patient list of 33,000. The practice is a training practice for doctors who are training to become GPs. On the day of our inspection at Plympton Health Centre there were no GP trainees on duty. We did not visit the other practice sites at Ivybrige, Chaddlewood and Wotter on this occasion.

Across the Beacon Medical Group there are 19 GP partners. Partners hold managerial and financial responsibility for running the business. Eight GP partners, three salaried GPs and one GP registrar (trainee GP) work at Plympton Health Centre. There is a mixture of both female and male GPs. The GP team are supported by a chief operating manager and a tier of upper non-clinical managers. There is a team of practice nurses, phlebotomists (staff who take blood) and healthcare practitioners; all who are contracted to work across any of the four practice locations. The Group also employ a pharmacist and a team of administrative and reception staff.

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

Plympton Health Centre is open from Monday to Friday, between the hours of 8am and 6pm. Evening routine appointments until 8pm on Monday and 8:30pm on Thursdays are available for people who were unable to access appointments during normal opening times.

The practice had opted out of providing out-of-hours services to their own patients and referred them to another out of hours service.

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 Plympton Health Centre, 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 NEW Devon Clinical Commissioning Group (CCG).

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 Thursday 26 March 2015. We spoke with six patients, eight GPs, four of the nursing team and members of the management, reception and administration team. 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, the practice used reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. Staff told us that when they were involved in a complaint or incident it was discussed with them but they were also supported through the process.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last year. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last year and we were able to review these. Significant events was a standing item on the practice meeting agenda to review actions from past significant events and complaints. There was evidence that the practice had learned from these. For example a significant event where a patient collapsed in the practice and staff commenced emergency cardiac treatment. After the significant event the practice reviewed their emergency protocol to identify if changes could be made. This included a review of emergency equipment by a paramedic. Records showed that the findings were shared with relevant staff and the wider staff group. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager who coordinated the process and monitored incidents. We tracked two incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result which included staff development and support. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated by email to practice staff. Alerts were coordinated by action by the Group pharmacist who disseminated any actions to GPs and nurses. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at the monthly educational meeting to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

We looked at training records which showed that all staff had received relevant role specific training on safeguarding. During the inspection not all staff training records for safeguarding were accurate as some individual staff training records had not been updated to reflect the training in safeguarding they had completed. However, following the inspection the practice sent us evidence to show that staff had undertaken relevant training. For example, GPs and nurse leads for safeguarding had received level 3 training and practice nursing staff had received level 2 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 for safeguarding agencies were easily accessible.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern. The practice had systems to manage and review risks to vulnerable children, young people and adults and the practice kept a record of vulnerable and at risk patients' names on a white board. However, there was no electronic list of vulnerable children maintained. There were also infrequent meetings between the safeguarding GP and the health visitor to discuss and review vulnerable children and families at the Plympton practice. Following our inspection the practice wrote to us and told us they were making

arrangements to improve their electronic systems to safeguard vulnerable children. They also told us they were taking steps to schedule regular meetings with health visitors to discuss any vulnerable babies, children or families.

There was a chaperone policy, which was visible in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

Medicines management

We checked medicines stored at Plympton Health Centre. They were stored securely and were only accessible to authorised staff. Vaccine fridges were locked. The temperatures in the medicines refrigerators were monitored to show that these medicines were stored within the recommended ranges. Systems were in place to check that medicines were within their expiry date and suitable for use. Expired and unwanted medicines were disposed of in line with waste regulations. Systems were in place to deal with any medicines alerts or recalls, and records kept of any actions taken.

Blank prescription pads and printer forms were held securely on arrival in the practice, before use. Records were held of forms received, and systems were set up to record when these forms were taken for use, during our inspection. This enabled an audit trail to be maintained, of the whereabouts of these forms. GPs did not take prescription pads out with them on home visits. This reduced the risk of prescription pads being stolen. GPs used a system of printing off a traceable prescription electronically for the visit and then recording if this was used when they returned.

Suitable emergency medicines were held at the practice. Regular checks were recorded to make sure that they were within expiry date, available and suitable for use if needed. The practice told us the content list of emergency medicines had been recently reviewed in terms of continued relevance for use in emergency situations.

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 and GP for infection control who carried out infection control audits. The last audit was completed in March 2015. Actions to be addressed were identified in this audit. We saw all identified actions had been completed and signed off in the audit and communicated to the staff team as completed in a staff meeting, for example regarding changing of disposable privacy curtains. All staff received induction training about infection control specific to their role and received annual updates. There were also cleaning schedules for contracted out domestic cleaners.

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

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

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). The practice was in the process of negotiating regular testing with a specialist contractor.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this had taken place in March 2014 and again in March 2015. All portable electrical equipment was routinely tested and last checked in January 2015. A schedule of testing was in place.

Staffing and recruitment

Good

Are services safe?

Recruitment records were structured and well organised. They contained evidence that appropriate recruitment checks had been undertaken on permanent staff prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks for all staff through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

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. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring safety and responding to risk

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

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

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). Records confirmed that it was checked regularly. We found the emergency bag heavy. This may impact upon taking the emergency equipment, which included oxygen in a cylinder and a defibrillator, quickly to a patient in need as this would be a two person job to carry the equipment. We brought this to the attention of the practice and they said they would consider options, such as using a trolley on wheels to store emergency equipment, so that no delays would occur when responding to an emergency situation. Three non-clinical staff we spoke with were unaware of where the emergency equipment was held.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis (severe allergic shock) and hypoglycaemia (low blood sugar). Emergency and urgent medicines were also kept in doctors bags so GPs could perform home visits and have access to medicines in the rural places they visited. Processes were in place to check whether emergency medicines and doctors bag medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

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

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

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. Staff explained any updates were shared at the monthly educational meetings and by email. 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. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. The practice also benefitted from specialist GPs in forensic medicine and muscular skeletal disorders. Staff were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines. Our review of the clinical meeting minutes confirmed that this happened.

We spoke with three GP partners about data from the local CCG. There were very good processes and systems for discussing clinical monitoring via QOF. For example, there was a register of patients with learning disabilities and mental health needs and all these patients had received an annual review. Not all patients with diabetes had received a review in the last 12 months, but records showed there was a plan to ensure all patients with diabetes were invited to attend the practice for a review of their condition. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We found that these had been formed with patient involvement and had been kept under regular three monthly review.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of suspected cancers. We saw audit results from the last year which checked and showed that this was happening.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients, but there was a lack of overall clinical lead to implement and monitor the practice wide strategy for clinical outcomes. For example, there were GP leads for specialist clinics, for safeguarding vulnerable patients and for coordinating weekly nursing home visits. However, the Beacon Medical Group board and list of GP partners did not identify a lead clinical GP. When speaking with clinical staff if was not clear how the Group's strategic five year clinical plan would be assessed as effective, and by whom.

The practice showed us examples of clinical audits that had been undertaken in the last two years. Audits tended to be those required by the CCG. We saw examples of full audit cycles, for example, the audit of minor surgery each year looking for complication rates, diagnosis and to check consent procedures had been followed.

The GPs told us clinical audits were also often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, we saw an audit regarding the prescribing of antibiotics to make sure the prescribing levels were in line with the CCG. Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines, increased awareness amongst the GPs and altered their prescribing practice, in line with the guidelines.

Good

Are services effective?

(for example, treatment is effective)

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national) clinical targets.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. For example, the practice had identified they were running slightly below target for some diabetic screening and had introduced plans to address this.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. Patients said they were sent reminders for when their condition and medicines were due to be reviewed. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. There was a lead GP for palliative care who coordinated collaborative working through a 'virtual ward' engaging with social care, mental health, palliative care, district nursing and other community providers to review cases of the most vulnerable patients.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed individual staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support, fire training and infection control training. Not all electronic staff training records were up to date reflecting actual training that had been undertaken, such as safeguarding training. There was no overarching staff training plan for the whole staff team, which would help to identify areas for individual staff training to make the staff team stronger in terms of specialist skills for the health needs of the patient list.

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 were expected to undertake an annual appraisal that identified learning needs from which action plans were documented. Not all annual appraisals had been undertaken, For example, the nursing team had been restructured in the last year and appraisals had not taken place. However, the outstanding nursing appraisals had been planned and scheduled for the week following our inspection visit. This was confirmed by the nursing staff we spoke with. Our interviews with staff confirmed that the practice was supportive in providing training and funding for relevant courses. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology, ear syringing, travel health and extended roles such as asthma, COPD, diabetes and coronary heart disease.

The Beacon Medical Group had a team of staff responsible for human resource policies and procedures. We reviewed a number of policies, including the recruitment policy and induction policy which were in place to support staff. Staff we spoke with knew where to find these policies if required.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a protocol outlining the responsibilities of relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we

Good

Are services effective?

(for example, treatment is effective)

spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

The practice held multidisciplinary team meetings to discuss the needs of complex patients. These were divided into separate meetings. For example a monthly MDT meeting included community nurses, dementia specialist nurses, palliative care team and GPs to discuss palliative and vulnerable patients. This was an opportunity to review patients who were on the practice palliative care register. Decisions about care planning were documented in the patients shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner for the benefit of patients.

Electronic systems were also in place for making referrals through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that this system was easy to use.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it and had completed training. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure. We were shown audits for minor surgery which confirmed the consent process for minor surgery had been followed in over 94% of cases each year.

Health promotion and prevention

The GP and practice nurses were informed of all health concerns detected on new patients and these were followed up in a timely way. The practice had numerous ways of identifying patients who needed additional support, and was motivated in offering additional help. For example, the practice was offering specialist musculoskeletal and dermatology clinics. This support, provided by specialist GPs, was providing additional screening and treatment plans for an increased number of patients rather than onward referral to secondary care. This meant patients were typically seen within four to six weeks rather than 18 weeks, in a clinic close to their home. The practice told us they had found that for 80% of patients their care could be administered in this way rather than referral into secondary care.

Practice staff worked with a local rapid response care coordination team and falls service. This included launching a 'mobile' GP service in October 2014, which provided rapid support to patients requiring an urgent home visit. This was funded by Prime Minister's Challenge Fund (PMCF) and enabled the practice to release additional time for a GP to visit, triage and assess individual patients. These patients were often at point of crisis and on the verge of emergency hospital admission. Since October 2014 the practice had made 74 visits and calculated that some 34 admissions had been avoided. The practice told us this initiative was a good opportunity to disrupt current working patterns and through earlier visits in the day be able to support individuals. For example, later visits often mean that the multi-disciplinary support isn't able to mobilise before the end of day and individuals are kept un-necessarily in hospital. This pilot project's initial funding was coming to an end. We asked if there were plans to continue with this service. However, the practice was not able to confirm if this would be possible. The practice told us they were reviewing this service to see if there was an alternative provider to take on the service across a broader geography

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 National GP 2014 survey. 526 patients across the four sites took part in a survey which asked 29 questions where people rated their experiences of the services. The evidence from all these sources showed patients were satisfied in line with responses to the same questions asked at other practices across the CCG. Patients indicated they were treated with compassion, dignity and respect. Areas identified for improvement were in making appointments and in some cases, the overall experience of the practices. However, the survey took place during the time of the merger of the practices where changes to staffing structures and practice identities were taking place. The Beacon Healthcare Group had analysed the survey results and had implemented actions to improve services for patients.

We did not have patient comment cards to review at the inspection as the practice told us they had not been received. We spoke with six patients on the day of the inspection. They were satisfied with the services and told us ease of obtaining appointments had improved and that they were getting used to the changes that had inevitably taken place as a result of the four practices merging. The practice had a newsletter for patients in the waiting areas which informed patients of any changes at the practice and rationales for the changes.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Not all consulting rooms had internal privacy curtains but patients told us consulting room doors were always closed during consultations. Where curtains were available these were disposable for infection control purposes and audits showed these were changed six monthly in line with national guidelines. We saw that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager.

Care planning and involvement in decisions about care and treatment

Patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, patients felt the GP was good at explaining treatment and results and patients felt confident in the care and treatment they received. We saw that patients with complex needs had a personalised care plan in place which showed they had been involved in decision making.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents 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. For example, we were given examples where practice staff had given advice and help to patients to help them manage their treatment and care when it had been needed. The patients we spoke with on the day of our inspection echoed this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required. One person told us of how nursing staff had given them additional time to explain treatment for their child following a GP consultation and for them to be sure they understood the treatment regime.

Notices in the patient waiting room, on the TV screen and the practice newsletter also informed 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 and they were invited to attend a health check if they performed a caring role for a family member or partner.

Staff told us that if families had suffered a bereavement, their usual GP contacted them. Patients we spoke with who had had a bereavement confirmed they had received this type of support and said they had found it helpful.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. For example, the practice cared for patients living in four local nursing homes. GPs made weekly visits to each of the nursing homes to discuss patients of concern. The Beacon Medical Group had recruited a pharmacist in October 2014 who developed a tool for medications review in nursing homes. This focussed on medicines safety and efficacy, particular for multiple medicines issues. Initial work was carried out remotely with follow up on site accompanied by a practice GP with the goal of improving medicines safety and quality of life improvements, such as reduced frequency and dosage of medication as appropriate and reviewing medication, for example, where the nursing home manager identified lethargy and lack of alertness among patients.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patients. In patient surveys negative comments had been made regarding accessing appointment by telephone lines. As a result the practice had recently installed a new phone system with the aim of providing improved access to speaking with reception staff.

The practice was developing its' patient participation group (PPG). We met the recently appointed chair of the PPG who told us the practice management were keen to meet with the PPG regularly to discuss patient feedback.

Tackling inequity and promoting equality

The practice had access to online and telephone translation services and had a hearing loop for patients with hearing loss.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months and said that this training had been interesting.

The premises and services were suitable to meet the needs of patient with disabilities with consulting rooms being on one level, ample parking and wide corridors. Most consulting room couches were not height adjustable. However, there were foot stools provided to allow people to step up to the couches.

We saw that the waiting areas were large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Access to the service

Plympton Health Centre was open from Monday to Friday, between the hours of 8.00am and 6.00pm. Evening routine appointments were available until 8.00pm on Monday and 8:30pm on Thursdays for people who were unable to access appointments during normal opening times. Patients could also book advance appointments up to six weeks in advance. Patients could order repeat prescriptions either in person or on-line via the practice website. The practice boundary covered a large geographical area including a number of rural communities. The practice had a small branch to support patients in the rural area of Wotter, with a service two days per week, including dispensing services. This service was intended to meet the needs of individuals who are restricted in accessing more urban services.

Comprehensive information was available to patients about appointments on the practice website and within the practice leaflet. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent 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.

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to local nursing homes by a named GP and to those patients who needed one.

Patients were generally satisfied with the appointments system but said it was sometimes difficult to get through on the telephone. They confirmed that they could see a

Good

Are services responsive to people's needs?

(for example, to feedback?)

doctor on the same day if they needed to or speak to the pharmacist via the telephone triage if they had a medicines query. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice manager was the designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system. Information on making a complaint was located in the waiting room, within the practice information leaflet and on the practice website.

Patients we spoke with were aware of the process to follow if they wished to make a complaint but none of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at complaints received in the last 12 months and found these had been handled in an open and timely way. We saw examples where patients had received an apology and explanation and saw correspondence to show patients were informed at stages of the process and were informed of where to pursue their complaint if they were not satisfied.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review themes had been identified, such as telephone access to appointments and prescribing errors. Lessons learned from individual complaints and themes had been acted on, for example in employing a pharmacist and installing additional telephone lines.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear mission statement which read: 'Be the largest primary care provider in Plymouth and South Hams. Work with our patients, carers, communities and partners as one team. Be a sustainable practice that thrives on innovation.'

We spoke with staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. Staff explained that there had been training days when the vision and values were focused upon.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. These were kept under review and monitored by the practice management.

There was a leadership structure across the Beacon Medical Group, which was still in the process of developing. For example there had been a restructuring of the nursing team and this now had clearly defined roles and areas of speciality, such as for nurses training. There was a current vacancy for a nurse clinical lead but the practice told us they had advertised and were in the process of appointing into this role following successful interview. The reception staff and administrative staff were being restructured and these staff told us they felt involved in this process and their concerns or suggestions were listened to. There was a structure for GP partners and salaried GPs, However there were no GP clinical leads identified within this structure. Staff told us they felt valued, supported and knew who to go to in the practice with any concerns.

The practice was carrying out clinical audits which it used to monitor quality and systems to identify where action should be taken. We saw examples where clinical audits demonstrated a clear full cycle to show outcomes were kept under review, for example for identifying patients with mental health needs who needed additional review of medicine and care plans. However, there was no practice policy for clinical audits which outlined a strategy for what audits would be completed during an annual cycle. This reflected the absence of clinical lead roles at the practice.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at weekly partners meetings and monthly educational meetings where action plans were produced and maintain or improve outcomes. For example as a result of analysing QOF performance the practice had developed a detailed protocol for when monitoring the effectiveness of medication management for people taking Warfarin medication, which acts as a blood thinner in patients at risk of blood clots and stroke/heart attack.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings or the monthly educational meetings. We also noted that team away days were held year. Minutes were maintained for staff team meetings but varied in the way they were laid out. For example, whole team meetings, nurses meeting and administrative staff meetings had different templates. It was not always clear to see in minutes that agreed actions resulting from minutes had been actioned and signed off as completed. We discussed this with the practice management who told us agreeing on a standardised template would improve this.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys and complaints received. We looked at the results of the annual patient survey, which had highlighted issues with customer service issues. As a result the practice had included customer service training as part of the education programme for individual staff members. There was not in place a staff training plan for the staff team as a whole, although annual staff training such as safeguarding, infection control and fire safety was identified in each staff member's training plan. The Beacon Medical Group had a website where there were tabs for each practice. Patient survey results were not yet available on the website and were not displayed in the practice waiting areas.

The practice had a patient participation group (PPG), which was in the process of development. The PPG was

Are services well-led?

Good

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

advertising for new members in the practice information leaflet. We spoke with a representative from the group who felt assured that the group would be set up via its terms of reference to influence change for the benefit of patients.

The practice had gathered feedback from staff through staff meetings, appraisals, informal discussions and the monthly educational meetings. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

As part of the staff restructuring following the merger of the practices the Group had set up staff communications meetings. The meetings were made up with staff representatives, nominated by the staff employees, who met with managers and Group directors to express any staff concerns or ideas whilst teams were being restructured. We spoke with three staff who were in these roles and they told us this had impacted positively upon staff morale during a time of change. For example there were meetings every two weeks for administrative and reception staff whilst new job descriptions were being developed.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice. We looked at the one example of a whistleblowing concern raised in the last 12 months. We were satisfied that the concerns raised had been addressed, however the policy had not been followed because of incomplete record keeping of all meetings held by the provider with the whistleblower. This risked concerns not being addressed fully. We spoke with the Operations Manager and a GP partner who had been involved in addressing the whistleblower's concerns and they told us there was learning to be taken away from ensuring record keeping was full and accurate.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and peer support. The practice was a GP training practice for doctors who wished to become GPs. We did not speak with any trainees on this occasion as there were no trainees on duty on the day we visited.

There was evidence that learning took place following significant events, but learning actions following significant events analysis were recorded as completed. However, when we spoke with clinical staff they could tell us what action and learning they had taken as a result of significant events.

The practice was involved in some innovate pilots to improve patient access to services and extended services, for example the use of a pharmacist during telephone triage, new services such as same day morning responses to home visit requests, muscular skeletal and sexual health clinics. Some funding for these pilots was coming to an end and not all evaluation of new services had taken place. It was not, therefore, clear if all new services would continue as planning for new sources of funding or changes to staffing structures, such as morning GP routines, had not been agreed.