Wellington Medical Centre

Inspection 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 location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Overall summary

This practice is rated as Good overall. (Previous inspection 4 November 2014 – Good)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? - Good

We carried out an unannounced comprehensive inspection at Wellington Medical Centre on 24 May 2018 as part of our inspection programme.

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 their processes.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. They ensured that care and treatment was delivered according to evidence- based guidelines.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- There was a strong focus on continuous learning, mentorship and improvement at all levels of the organisation.
- The practice was in the process of implementing an initiative called 'House of Care'. A holistic approach to managing patients with long term conditions to be more informed and involved in their care and a shared approach to providing the care and treatment they needed.
- The practice worked with other local health, social care and voluntary services. For example, the Taunton and Area Wellbeing Service to provide additional support in the community, signposting and enabling patients to take better control of their health and wellbeing.
- The practice initiated a project with Weston Power, Western Water and Taunton Borough Council and was aimed at patients with long term conditions to improve some of their living environments (cold homes) by signposting them to other organisations for support to initiate change in their homes

The areas where the provider **should** make improvements are:

- Review arrangements for maintaining a list of those staff who had attended fire drills to ensure that all staff had participated.
- Review arrangements to continue maintaining the records of the training achieved by the clinicians.
- Continue to review the arrangements for their mental health register, those patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses so that they had a comprehensive, agreed care plan documented in the previous 12 months.
- Review arrangements for maintaining a consistent use of consent forms by clinicians for the provision of treatment.

Professor Steve Field CBE FRCP FFPH FRCGPChief Inspector of General Practice

Population group ratings

Older people	Good
People with long-term conditions	Good
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.

Background to Wellington Medical Centre

The name of the registered provider of Wellington Medical Centre. The service is provided from one address; Mantle Street, Wellington, Somerset, TA21 8BD, and delivers a primary medical service to approximately 15,169 patients, including 327 patients living in care and nursing homes in the area. The practice is situated in a purpose-built building near the centre of the town of Wellington. Information about Wellington Medical Centre can be found on the practice website www.wellingtonmedicalcentre.co.uk.

According to information from Public Health England the practice area population is in the fourth least deprived decile in England. The practice population of children and those of working age is similar to local and national averages. The practice population of older people 65 years and above are slightly above local and national averages. Of patients registered with the practice, 98% are White or White British, 1.1% are Asian or Asian British, 0.2% are Black or Black British, 0.7% are mixed British and 0.1% are Other.

The practice team is made up of ten partners and one salaried GP. Overall the practice has the equivalent of just over 8 WTE (whole time equivalent) GPs at the practice (five male and six female). There are six practice nurses and four health care assistants. The practice has additional clinical specialist staff including two primary care practitioners, two practice pharmacists and a Musculoskeletal practitioner. In addition, the practice staff included a dedicated patient wellbeing advisor. The practice manager is supported by administrators, secretaries, and reception staff.

When the practice is not open patients can access treatment via the NHS 111 service.

The practice provides family planning, surgical procedures, maternity and midwifery services, treatment of disease, disorder or injury and diagnostic and screening procedures as their regulated activities.

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. Specific members of the administration team were assigned to manage all safeguarding information received in. All staff 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.
- Missed appointments for children were monitored and flagged up to GPs.
- 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.
- 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.
- There were fire safety systems and fire drills were carried out regularly. However, a record of whom had participated in fire safety drills was not kept and therefore the practice could not be certain staff had sufficient experience to participate effectively should the need arise.
- 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 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.

- There were comprehensive risk assessments in relation to safety issues.

Good

Are services safe?

- 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.
- The practice acted on and learned from external safety events as well as patient and medicine safety alerts.

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.

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.) The practice had opted out of fully using the national Quality and Outcomes Framework (QOF) and were using some indicators to provide a baseline or register of patients identified as being at higher risk and need for support. The practice used an alternative scheme implemented by Somerset Clinical Commissioning Group, the Somerset Practice Quality Scheme (SPQS). The aims of the scheme were to actively monitor performance and improve the quality of general practice. The practice told us the SPQS priority this year was monitoring falls, hypertension (high blood pressure) and bone health. We looked at information from both QOF and SPQS to establish the outcomes for patients.

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.
- The practice had developed detailed signposting care pathways for clinicians to use to support good decision making to meet patient's needs. These were regularly monitored and audited.
- We saw no evidence of discrimination when making care and treatment decisions.
- The practice used the Consult Connect service which gave instant access to advice for a range of specialities at the local main hospital.
- Staff used appropriate tools to assess the level of pain in patients.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.
- The practice provided anti–coagulant (medicines taken to reduce blood clotting for patients with heart or vascular conditions) monitoring clinics so that patients did not have to travel further afield.

Older people:

- Older patients who were 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 had a clinical review including a review of their medicines.
- 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 with their named GP 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.
- The practice was in the process of implementing an initiative called 'House of Care' a holistic approach to managing patients with long term conditions to be more informed and involved in their care and a shared approach to providing the care and treatment they needed.
- 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 was able to demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension)
- The practice told us they were aware of the significant negative variation in QOF data to the national average regarding managing patients with long term conditions such as asthma and chronic obstructive pulmonary disease (COPD). They were able to provide information of why this had occurred, through staffing issues, and what actions they had in place to rectify the gap in patients receiving the checks they required. This had

included the employment of new staff with the necessary skills and other health care professionals to take other roles to ensure these staff had the capacity to do so.

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 98% which was above the target percentage of 95%.
- 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.
- The practice hosted the Health Visitor team which meant they were accessible and were able to participate in regular multi-disciplinary and safeguarding meetings.
- The practice was able to offer a full range of contraceptive services.

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

- The practice's uptake for cervical screening was 75%, which is below the 80% national coverage target for the national screening programme but similar to the clinical commissioning group and current national averages. The practice told us that they liaised with the screening services and proactively followed up women who have not had screening when due.
- The practices' uptake for breast and bowel cancer screening was in line 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. 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. They shared information with other Somerset services such as the Out of Hours, Ambulance and other GP services so that patients received continuity of care.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. The practice flagged up, in medical records, siblings or others living in the same household.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice had implemented personal care and escalation plans for patients seen as vulnerable and those diagnosed with frailty.
- The practice hosted the federation Well Being Service Advisor who was able to source or direct patients to other services if required.

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. The practice were aware of the significant negative variation highlighted in the latest published QOF data in regard to smoking cessation and recording of alcohol consumption and had actions in place such as increased staffing and monitoring in place. There was a system for following up patients who failed to attend for administration of long term medication.
- 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.
- QOF data showed that 8% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months which was below the national average of 84%. The practice provided additional information to show that 1.6% of the practice population has been diagnosed with dementia. Of this group, 81% were recorded as having a care plan in place.
- QOF data showed that 23% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan

documented in the previous 12 months. This was below the national average of 90%. We were informed by the practice that this information was incorrect. Following the inspection visit the practice carried out a review of the information they had and found that some aspects of coding on the patient records had been incorrectly done. Following a review, the practice had identified that 53% (similar to other Somerset GP services) of patients had had a review of their care in the last 12 months and had a documented care plan in place. The practice told us that actions were now in place to continue to review their mental health register and ensure that patients care needs were being met.

- 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.
- 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. For example, reviews of unplanned admissions and readmissions. Where appropriate, clinicians took part in local and national improvement initiatives. This has included, supporting a local area pilot of initial patient assessment by a musculoskeletal practitioner which led to the practice employing a practitioner after the pilot had finished. This meant patients were able to have a more direct pathway to the treatment they needed.

- The practice used information about care and treatment to make improvements.
- The practice was actively involved in quality improvement activity. Where appropriate, clinicians took part in local and national improvement initiatives.

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.
- 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 mentorship, protected time and training to meet them. There were some central records of skills, qualifications and training that staff had obtained. The practice manager was in the process of sourcing from the clinicians and new staff, copies of training certificates for their personnel records. 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. The induction process for healthcare assistants included 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.

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. They 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.

Good

Are services effective?

- 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 practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.

Consent to care and treatment

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.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision. However, we did identify through conversations with GPs that there was an inconsistent use of consent forms for certain procedures although patients verbal consent was recorded in the patient record.
- The practice monitored the process for seeking consent appropriately.

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 patients was positive about the way staff treat people.
- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.

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 that 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.

Good

Are services responsive to people's needs?

We rated the practice, and all of the population groups, as good for providing responsive services.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs.
- Telephone consultations 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 were more vulnerable or who had 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 practice offered a 24 hour ECG monitoring service on behalf of other practices in the Taunton & Area Federation.
- The practice worked with other local health, social care and voluntary services. For example, the Taunton & Area Wellbeing Service which provided additional support in the community, signposting and enabling patients to take better control of their health and wellbeing. A Wellbeing Advisor was based at Wellington Medical Centre, and worked with the practice to enable patients access other sources of support as well as monitor those more at risk.
- The practice hosted 'drop in' sessions so patients could have access to the voluntary sector. This included Marie Curie, Air Ambulance and the Alzheimer's Society.
- The practice supported patients in the local community with contract agreements to provide GP services. They provided a dedicated GP service to in-patients Wellington Community Hospital, delivering three ward rounds each week. They also provided a similar service to detained mental health patients in the Wellesley Hospital.

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 responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GPs, primary care practitioners and practice nurse also accommodated home visits for those who had difficulties getting to the practice due to limited local public transport availability.
- The practice enabled patients to participate in weekly exercise classes by hosting chair based exercises facilitated by Age Concern.
- The practice had facilitated Abdominal Aortic Aneurysm screening to be held at the surgery reducing the need to attend hospital.
- The practice had worked with different projects and stakeholders to assist patients achieve receiving the right care and support. This included being an outlet for the Lions Club "Message in a bottle" campaign which encourages vulnerable patients to have personal and medical information accessible in a container which was then stored in the patients fridge. This enabled visiting emergency services having timely information about the patient's health and medicines.

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. Staff were aiming to ensure multiple conditions were reviewed at one appointment. Patients were usually seen by their own GP to provide continuity of care for patients with long term conditions. Patients were followed up if they did not attend.
- The practice had focused campaigns involving various staff including the pharmacists to ensure that certain patients with long term conditions were managed and supported better, for example hypertension.
- The practice offered longer appointments and home visits if required. Flexible appointments including attending in the evening were available if they were not able to attend during the day.
- The practice was participating in the NHS Digital Diabetes Prevention Programme by directing patients to go online and use the programme to assess and make changes to their lifestyle.

Good

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.

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.
- The practice has a system of follow up for children who did not attend appointments and immunisations.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.
- The practice hosted the Health Visitors weekly baby, breast feeding and weening clinics which facilitates easy communication with GPs and other staff at the practice should it be required.

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 and Saturday appointments.
- The practice worked in conjunction with other Taunton and Area Federation practices to access appointments at other practices if they are unable to have appointments at their own practice.

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.
- The practice liaises with the local authority to ensure that all known patients with a learning disability have been identified to the practice so that they could be invited for an annual health check.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.
- The practice hosted a domestic abuse support group.

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.
- Staff, members of the patient participation group and carer support group have had dementia awareness training provided by a local dementia awareness group.
- The practice informed patients experiencing poor mental health how to access support groups and voluntary organisations.

Timely access to care and treatment

Patients were 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.
- Patients 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. It acted as a result to improve the quality of care. For example, concerns were expressed by a patient about the outcome of their blood sugar test results carried out at the practice by nursing staff. Although there were other aspects to the patient's care that they were concerned about – the issue of the abnormal blood results led to the practice replacing the equipment used as it was deemed faulty. This meant the risks to other patients not receiving their necessary care in a timely way was reduced.

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.
- 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 had a strategic plan in place for 2017 – 2020. The plan clearly outlined how 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 and had implemented 10 High impact actions. This was an NHS England strategy to improve time available to practices to provide care that were in line with improving how they delivered the service.
- 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 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 were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff were 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. The governance and management of partnership, 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
- 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.

Good

Are services well-led?

- 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. 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.
- 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 participation group and they worked with the practice to improve the outcomes for patients and the community. This included raising money to replace equipment and a local community scheme of providing a practice patient car for assisting patients with attending their appointments. The practice shared information with the PPG on a regular basis and they felt they were listened to and their comments acted upon.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

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

- There was a focus on continuous learning and improvement.
- 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.
- The practice was able to gain funding for a new telephone system with enhanced systems. This linked to practice IT systems which enabled patients to cancel appointments without the requirement to speak with a member of staff.
- The practice initiated a project with Weston Power, Western Water and Taunton Borough Council called Wellington Health Homes. The seven-month project (2016/2017) called Wellington Healthy Homes was aimed at improving some of the living environments (cold homes) for patients with long term conditions. The project provided patients with advice and signposted them to other organisations for support to initiate change in their homes.

Good

Are services well-led?

Please refer to the Evidence Tables for further information.