

Wincanton 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

Wincanton health centre was inspected on Tuesday 9 December 2014. This was a comprehensive inspection.

Wincanton health centre provides primary medical services to approximately 8,500 patients of a diverse age group. The practice was situated in a purpose built building on the outskirts of Wincanton.

The team at Wincanton health centre was composed of four GP partners and a practice manager who was also a partner. The partners at the practice hold managerial and financial responsibility for running the business. The practice employs three acute care practitioners (ACPs). The ACPs are able to assess, diagnose, treat and prescribe medicines for acute common conditions such as minor accidents, chest and urine infections. In addition the team were supported by three practice nurses, two health care assistants, and additional administrative and reception staff.

Patients using the practice also had access to community staff including district nurses, an independent living team, community psychiatric nurses, health visitors, physiotherapists, speech therapists, counsellors, podiatrists and midwives.

We rated this practice as good.

Our key findings were as follows:

There were systems in place to address incidents, deal with complaints and protect adults, children and other vulnerable people who use the service. Significant events were recorded and shared with multi professional agencies and there was evidence that lessons were learned and systems changed so that patient care was improved.

There were systems in place to support the GPs and other staff to improve clinical outcomes for patients. Patient care and treatment is considered in line with best practice national guidelines and staff are proactive in promoting good health.

The practice were pro-active in obtaining as much information as possible about their patients which do or

Summary of findings

can affect their health and wellbeing. Staff knew the practice patients well, were able to identify patients in crisis and were professional and respectful when providing care and treatment.

The practice planned its services to meet the diversity of its patients. There were appropriate facilities available, adjustments were made to meet the needs of the patients and the appointment system enabled good access to the service.

There was a clear leadership structure in place. The team structure had changed in recent months with the introduction of a new advanced nursing team. Any issues we identified had already been recognised and were being addressed to make sure quality and performance was monitored and risks were identified and managed.

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

The provider should ensure that:

- All nursing and medical staff should receive training in the Mental Capacity Act (2005).
- The practice should ensure quality standards are monitored whilst the new systems are introduced, to ensure all patients with severe mental illness were being seen each year for a review.

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?

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.

, Staffing levels and skill mix were planned and reviewed so there were sufficient staff to provide care and treatment at all times.

Recruitment procedures and employment checks were completed as required. Risk assessments were performed when a decision had been made not to perform a criminal records check on administration staff.

Significant events and incidents were investigated systematically and formally. There was a culture to ensure that learning and actions had been taken and communicated to all members of the team following such investigations, and staff confirmed their awareness of investigation findings.

There were safeguarding policies and procedures in place that helped identify and protect children and adults from f abuse.

There were arrangements for the efficient management of medicines within the practice.

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

Good



Are services effective?

The practice is rated as good for providing effective services.

Systems were in place to help ensure that GPs and nursing staff were up-to-date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines. Evidence confirmed that these guidelines were influencing and improving practice and outcomes for patients. For example, guidelines for national immunisation programmes were being followed.

The practice had opted out of the national Quality and Outcomes Framework (QOF). The QOF is a voluntary national performance measurement tool which provides financial incentives to practices for meeting health related targets. An alternative Somerset Practice Quality Scheme (SPQS) was being used to link more closely to

Good



Summary of findings

locally based needs. QOF figures and data for previous years requested at the inspection showed that the practice was performing comparably to other practices in the clinical commissioning group (CCG).

People's needs were assessed and care was planned and delivered in line with current legislation. Patients with long term conditions had received annual health reviews which were comprehensive and holistic. This included assessment and the promotion of good health. Staff had received training appropriate and in addition to their roles. Effective multidisciplinary working was evidenced.

Staff were aware of the Mental Capacity Act 2005 (MCA) but were not all aware of their responsibilities under the legislation. The Mental Capacity Act 2005 is legislation that protects and supports people who do not have the ability to make decisions for themselves. Not all staff had received this training in this legislation.

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

There was a systematic induction and training programme in place with a culture of further education.

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

Are services caring?

The practice is rated as good for providing caring services.

Feedback from patients about their care and treatment was consistently positive. Survey data reflected this feedback.

We observed a person centred culture and found strong evidence that staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. We found many positive examples to demonstrate how people's choices and preferences were valued and acted on. Accessible information was provided to help patients understand the care available to them.

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

Good



Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

Good



Summary of findings

We found the practice had a proven track record of responding to patient feedback. The practice used complaints, significant events, surveys, comment cards and face to face meetings to improve the service. We saw many examples of where patient feedback had influenced change.

The practice was supported by an active and diverse patient participation group (PPG). The practice had asked representatives from the PPG to be involved in planning when the new premises was being built.

Patients said they were happy with the appointment system and could get an appointment with a GP on the same day they requested one if necessary.

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

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

Are services well-led?

The practice is rated as good for well led.

The practice had a clear vision and strategy and strong leadership team. There had been changes to the nursing team in recent months. The new team had identified where improvements were needed and were beginning to address these at the time of our visit.

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

The practice had a number of policies and procedures to govern activity. These were in paper and electronic formats so staff had easy access to them. There were systems in place to monitor and improve quality and identify risk. The practice's approach to clinical governance was systematic and included the whole team.

The practice learned from past events and routinely sought feedback from patients e..

Staff told us they felt supported and well managed. Staff had received inductions, regular performance reviews and were able to attend staff meetings and events.

Good



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

Patients aged 75 and over had their own allocated GP but had the choice of seeing whichever GP they preferred. Flu, Pneumococcal and Shingles vaccinations were provided at the practice for those in the appropriate age groups. Vaccines for older people who had problems getting to the practice or those in local care homes were administered in the community by the practice nurses. Nurses and GPs did home visits for older people and for patients who required a visit following discharge from hospital.

Treatment was organised around the individual patient and any specific condition they had.

The practice had a system to identify older patients and held a multi-disciplinary team (MDT) meeting for the planning and delivery of palliative care for people approaching the end of life. The MDT was attended by practice clinical staff, district nurses, the hospice nurses, the Independent Living Team and community psychiatric nurses (CPNs).

The practice website included a number of links containing extensive information about the promotion of health for conditions which affect older people.

The practice worked to avoid unnecessary admissions to hospital and worked with other health care professionals to provide joint working.

The clinical areas in the practice were all on one level and were easily accessible. There were some chairs in the waiting room with arm rests to assist patients to stand.

Good



People with long term conditions

The practice identified patients who might be vulnerable, have multiple or specific complex or long term needs. The practice ensured patients with long term conditions were offered consultations or reviews where needed. The staff at the practice worked together with and maintained links with external health care professionals for advice and guidance.

Patients with long term conditions had detailed tailor-made care plans in place. All patients with a long term condition were invited in for an annual review around the time of their birthday. The “birthday review” was a review of all chronic conditions the patient may have and was offered at a time that suited the patient.

Good



Summary of findings

Each nurse has a recognised clinical area in which they specialised and were supported by a named GP. All practice nurses offered reviews for all conditions and provided clinical support to one another in their areas of clinical specialty and interest.

The GPs and nurses attended educational updates to make sure their lead role knowledge and skills were up to date. Practice staff also involved healthcare specialists for advice where appropriate.

The practice promoted independence and encouraged self-care for this population group by using patient held personalised care plans.

There was a blood pressure machine in the waiting area so patients could monitor their own blood pressure. The practice nurses provided weight management support for patients and a dietician held a clinic once a month.

The practice was in the process of introducing group education sessions for patients who were newly diagnosed with a chronic condition. The patient participation group had also facilitated talks of common conditions for patients which were free of charge. Health education was provided on healthy diet and life style as part of the birthday review and in general consultation.

Patients receiving certain medicines were able to access screening services at the practice to make sure the medication they received was effective.

Families, children and young people

There were baby and child immunisation programmes available.

Ante-natal care was provided by a team of visiting midwives who held clinics at the practice. The midwives had access to the practice computer system and could speak with a GP if the need arose. The practice also had strong relationships with health visitors who were based at the local children's centre. Systems were in place to alert GPs when children did not attend for immunisation.

The practice held monthly multi-disciplinary meetings to discuss vulnerable children and all at risk families. This meeting was attended by the health visitors, the GPs, and nurse practitioners.

Women, men and young people had access to a full range of contraception services and sexual health screening including chlamydia testing and cervical screening. There was a quiet private area in the practice for women to use when breastfeeding.

Appropriate systems were in place to help safeguard children or young people who may be vulnerable or at risk of abuse.

Good



Summary of findings

Working age people (including those recently retired and students)

Good



Advance appointments, (usually up to around six weeks in advance) evening and Saturday morning appointments were available to assist patients not able to access appointments due to their work or study times.

There was a virtual patient participation group (PPG) at the practice which had a high number of working age members. These PPG members used electronic communication to provide feedback to the practice.

Foreign travel advice was available from the nursing staff within the practice and supporting information leaflets were available within the waiting areas.

Patients who received repeat medicines were able to collect their prescription at a pharmacy of their choice.

People whose circumstances may make them vulnerable

Good



The practice had an at risk register for patients about whom any of team had expressed a concern. These patients were reviewed monthly at the multidisciplinary team meetings.

The practice had a small minority of patients whose first language was not English and offered a telephone translation service where appropriate. Family members were used to translate at times at the patient's request. Information posters were on display in different languages.

Patients with learning disabilities were offered a health check every year during which their long term care plans were discussed with the patient and their carer if appropriate.

Practice staff were able to refer patients with drug and alcohol addictions to a drug and alcohol service for support and treatment. The support service visited the practice if the patient chose this.

People experiencing poor mental health (including people with dementia)

Good



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Summary of findings

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Summary of findings

What people who use the service say

We spoke with nine patients during our inspection and three representatives from the patient participation group (PPG).

The practice had provided patients with information about the Care Quality Commission prior to the inspection. Our comment box was displayed and comment cards had been made available for patients to share their experience with us. We collected three comment cards, all of which contained positive comments. Staff explained that patients had been reluctant to complete CQC comment cards as they had just completed another survey. We looked at this survey conducted last month and saw that 398 of the 407 respondents said they would be extremely likely or likely to recommend the practice to friends and family.

Comments from the friends and family survey contained detailed comments which indicated that patients appreciated the service provided, caring attitude of the staff and for the staff who took time to listen effectively. There were many comments praising GPs and the new nurses. Comments also highlighted a confidence in the advice and medical knowledge and not being rushed.

These findings were reflected during our conversations with patients and discussion with the PPG members. The feedback from patients was overwhelmingly positive. Patients told us about their experiences of care and praised the level of care and support they consistently received at the practice. Patients quoted they were happy, very satisfied and said they had no complaints and got good treatment. Patients told us that the GPs and nursing staff were excellent.

All nine patients told us they were happy with the appointment system and said they found it easy to get repeat prescriptions and said they thought the information provided and the practice website was good.

Patients knew how to contact services out of hours and said information at the practice was good. Patients knew how to make a complaint but told us they had no concerns or complaints and could not imagine needing to complain.

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

Areas for improvement

Action the service SHOULD take to improve

- All nursing and medical staff should receive training in the Mental Capacity Act (2005).
- The practice should ensure quality standards are monitored whilst the new systems are introduced, to ensure all patients with severe mental illness were being seen each year for a review.

Wincanton Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The team also included a GP specialist advisor, a practice manager specialist advisor and an expert by experience. CQC define an expert by experience as a person with personal experience of these services as service users or family carers.

Background to Wincanton Health Centre

Wincanton health centre provides a service to approximately 8,500 patients in the Somerset town of Wincanton.

Wincanton health centre provides primary medical services to a diverse population age group and is situated in a purpose built practice in the outskirts of the town centre.

The team at Wincanton health centre composed of four GP partners and a practice manager who was also a partner. There are three female GPs and one male. The partners at the practice hold managerial and financial responsibility for running the business. The practice also employs three acute care practitioners (ACPs). The ACPs are able to assess, diagnose, treat and prescribe medicines for acute common conditions such as minor accidents, chest and urine infections. In addition the team were supported by three practice nurses, two health care assistants, and additional administrative and reception staff.

The practice is open between the hours of 8.30 and 6pm. Pre bookable evening appointments were available until

7.30pm with a GP every Monday to help those patients who worked during routine office hours. Pre booked appointments were also available on Saturday mornings from 08.30am until 11.30am.

Patients using the practice also had access to community staff including district nurses, community psychiatric nurses, health visitors, physiotherapists, midwives and counsellors.

The practice had opted out of providing out-of-hours services to their own patients and refer 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.

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?

Detailed findings

- 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 Wincanton 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 Somerset Clinical Commissioning Group.

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

We carried out our announced visit on Tuesday 9 December 2014. We spoke with nine patients and eight members of staff at the practice during our inspection and collected three patient responses from our comments box which had been displayed in the waiting room. We obtained information from and spoke with the practice manager, GPs, receptionists/clerical staff, and nursing staff. We observed how the practice was run and looked at the facilities and the information available to patients. We also spoke with three representatives from the patient participation group (PPG).

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

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. These alerts were circulated and discussed at partner and management meetings and if necessary resulted in a policy being devised.

Staff were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, administration staff had identified a patient had not been referred to the hospital as per GP instructions. An investigation was carried out which identified the cause and staff told us this was immediately rectified. Staff were supported and informed of actions taken.

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

Learning and improvement from safety incidents

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 were discussed at the weekly partners meeting and allocated formally to a partner for investigation. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. For example, incorrect labelling of blood samples had been identified and rectified. Further action prompted staff to be more vigilant when labelling samples and this action was reviewed to make sure the risk of the incident had been removed or reduced. 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 explained the system they used to manage and monitor incidents. We tracked three incidents and saw records were completed in a comprehensive and timely

manner. We saw evidence of action taken as a result. For example after an expired medicine had been administered to a patient, a new process of weekly medicine checks was introduced.

National patient safety alerts were disseminated verbally and by email to practice staff. Staff we spoke with were able to give examples of recent alerts. For example, Ebola guidance had been received which had resulted in a new policy being written and communicated to staff.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received a high level of safeguarding children training usually only relevant for senior roles. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details displayed on a flow chart were easily accessible in the main office area.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary advanced training to enable them to fulfil this role.

Practice staff said communication between health visitors and the practice was good and any concerns were followed up. For example, if a child failed to attend routine appointments the GP could raise a concern for the health visitor to follow up.

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

There was a chaperone policy, which was visible in consulting rooms. A chaperone is a member of staff or person who acts as a witness for a patient and a medical

Are services safe?

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

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which included inaccessible plug sockets for vaccine fridge to reduce the risk of unplugging the fridge.

Detailed systems were in place to check medicines were within their expiry date and suitable for use. All the medicines and equipment we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

We saw evidence that medicines and prescribing patterns were kept under review as a way of improving patient safety but also as part of the local clinical commissioning group incentive scheme. For example, the practice had reviewed the use of medicines for patients with diabetes, gout, epilepsy and dementia. Practice data showed that 79% of patients who were taking several medicines had attended for a medicines review.

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

All prescriptions were reviewed and signed by a GP or the acute care practitioner before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

The practice held very small stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard operating procedures that set out how they were stored and managed. These were being followed by the practice staff. For example, controlled

drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. There were arrangements in place for the destruction of controlled drugs. The practice did not have a risk assessment to show why they did not store medicines used to counteract the effects of pain relieving controlled drugs but produced this by the end of the inspection.

Patients were pleased with the process of obtaining repeat prescriptions. The practice had established a service for people to pick up their dispensed prescriptions at a pharmacy of their choice and had systems in place to monitor how these medicines were collected. They also had arrangements in place to ensure that people collecting medicines from these locations were given all the relevant information they required.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control nurse who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. The lead infection control nurse had been in post for five months. They had already introduced changes in infection control procedures. These improvements included placing sharps bins on the wall and formalising the cleaning schedule for clinical equipment. The new infection control lead staff had identified that an infection control audit had not been performed since 2012 and had a date planned for this to take place.

An infection control policy and supporting procedures were being updated and were available for staff to refer to. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. Staff were able to describe how they would use these to comply with the practice's infection control policy. There were also flowcharts and a policy for needle stick 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.

Are services safe?

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. All portable electrical equipment was routinely tested and was due to be retested in 2015.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting staff. Written risk assessments were in place if criminal record checks were not required for administration roles.

Staff told us about recent staff shortages and subsequent arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. Staff told us about the arrangement in place to cover each other's annual leave. For example, how blood tests were checked by other GPs in the absence of an individual GP.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. There had been a turnover of three nursing staff in recent months. Three practice nurses had left and three acute care practitioners were recruited to replace them and perform more advanced clinical tasks including prescribing and seeing patients autonomously. Existing staff said this process had been smooth and had added to the team well. The new nursing team included the acute care practitioners who were able to take on some of the roles previously performed by the GPs.

New staff said they had received support and a comprehensive induction which prepared them for their new roles.

Monitoring safety and responding to risk

The practice had systems, a register, processes and policies in place to identify, manage and monitor risks to patients,

staff and visitors to the practice. These included regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy and poster which were displayed for staff to see. There were service contracts with maintenance companies for boiler servicing, lift, front doors, fire alarm, burglar alarm, and fire extinguishers. There had been regular testing of the fire systems.

There was a business continuity plan in place for staff to use in the event of fire, incident or events affected by weather, power failure or faults.

The practice manager showed us the systems, records and processes to identify and reduce risk in the environment. This included contracts for waste management, fire safety, and electrical equipment checks. Staff were aware of their roles in these processes. For example, nurses knew about how to safely dispose of clinical waste and the fire marshals knew how to respond in the event of a fire.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that the emergency medicines and equipment were checked regularly.

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 and hypoglycaemia. The practice did not have a risk assessment to show why they did not store medicines used to counteract the effects of opioids but produced this by the end of the inspection. This risk assessment was provided by the end of the inspection stating that the risk was low because of infrequency of use and locality of paramedic services.

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

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. Patients were pleased with the care, treatment and advice they received. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate. We saw examples of care plans for vulnerable patients or those with long term conditions. These were detailed and provided a holistic approach to the patients' health and well-being.

The practice nurses and GPs lead in specialist clinical areas such as diabetes, heart disease and asthma. Nursing staff were very open about asking for and providing colleagues with advice and support. The new nursing team had experience in managing long term conditions and supported the GPs and acute care practitioners (ACPs). The practice provided evidence to show patients with long term conditions were offered reviews annually or more frequently as required. For example, 76% patients at the practice had attended for a review of their condition in the last year.

The GPs at the practice offered additional services including acupuncture for pain relief and audited this service regularly to monitor its effectiveness.

The practice completed audits to ensure patients were receiving appropriate care and treatment. For example, an audit of the success of contraceptive implants showed that the practice had undertaken 73 implant related procedures and had been successful in all of them.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital, which required patients to be reviewed according to need.

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

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

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, managing child protection alerts, and medicines management.

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

Information from clinical audits was shared with staff. Learning from significant events, clinical supervision and staff meetings were used to review patient outcomes achieved and areas where patient outcomes could be improved. Staff spoke positively about the culture in the practice and said there was an eagerness to learn. There was an expectation that all nursing and medical staff should undertake audit as part of their revalidation or continued professional development. We saw evidence to show this was done.

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. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. Patients told us this worked well and that if it was a blood pressure check they were encouraged to use the machine in the waiting room at their leisure.

Are services effective?

(for example, treatment is effective)

The practice implemented the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as monthly multidisciplinary meetings to discuss the care and support needs of patients and their families.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with annual basic life support and safeguarding training. There was a culture of development at the practice and all staff said they had access to the training they needed to fulfil their roles.

We noted a good skill mix among the GPs. All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff received annual appraisals that identified learning needs from which action plans were developed. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. One of the GPs was undertaking training to become a mentor for trainee GPs.

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 and travel advice. Those with extended roles such as diabetes and asthma were also able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. It received blood test results, X ray results, and letters from the local hospitals including discharge summaries, out-of-hours GP services and the out of hours service both electronically and by post. All staff we spoke with understood their roles

and felt the system in place to communicate blood test results and hospital discharges worked well. There were no instances within the last year of any results or discharge summaries that were not followed up.

The practice held two multidisciplinary team meetings each month to discuss the needs of complex patients. For example a monthly multidisciplinary team meeting was held to discuss and provide care for vulnerable adults. This was attended by hospice staff, district nurses, community psychiatric nurses and the independent living team. A second meeting was held with health visiting staff and midwives to discuss vulnerable children and at risk families. We spoke with a representative from a community health and social care team who said communication with the practice staff was very good.

The staff at the practice worked with other organisations in the community. The GPs liaised with local care homes each day. The practice manager worked closely with three other GP practices in the area to offer support and share resources.

The practice was part of the Symphony Integrated Care project. This was a collaborative multi-agency project to shape the way in which health and social care is provided in the future for the population of South Somerset who have multiple long term conditions.

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. Electronic systems were also in place for making referrals, and the practice used the choose and book system. (The choose and book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use and showed us the back-up system to ensure the appointments had been arranged.

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

Are services effective?

(for example, treatment is effective)

in the system for future reference. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, although not all staff had received training in this subject or were aware of their duties in fulfilling it. The nursing staff said they would refer to the GPs.

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. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions.

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures. We saw evidence this process was used. For other procedures staff used templates on the electronic patient notes which recorded the relevant risks, benefits, and complications of the procedure had been explained to the patient.

Health promotion and prevention

The practice offered patients a health check when they were registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use

their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18-25 and offering smoking cessation advice to smokers. The practice also offered NHS Health Checks to all its patients aged 40-74.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and made sure they had an annual health check. For example 71% of patients with a learning disability had received an annual health check so far this year.

The practice's performance for cervical smear uptake was comparable to other practices in the CCG area. There was a policy to offer written reminders for patients who did not attend for cervical smears and the practice monitored the number of patients who did not attend annually. The nursing team were responsible for following up patients who did not attend screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The practice also offered immunisations where children chose not to get them at school.

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

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the most recent improving practice questionnaire performed by the practice in January 2014. This showed that 227 out of the 257 respondents said the staff at the practice listened to what the patients had to say and 230 out of the 256 respondents were confident in the ability of the GPs.

Patients completed CQC comment cards to tell us what they thought about the practice. We received three completed cards all of which were positive about the service experienced. We looked at the results of the practice's friends and family survey which included comments from patients stating that they thought the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect.

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

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk and was shielded by a wall which helped keep patient information private. A system was in place to allow only

one patient at a time to approach the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

Care planning and involvement in decisions about care and treatment

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

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

Patient/carer support to cope emotionally with care and treatment

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

Notices in the patient waiting room, on the TV screen and patient website also told people how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer.

Staff told us that if families had suffered bereavement, their usual GP provided support. There were posters and leaflets offering advice on how to find a support service.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had a proven track record of responding to patient feedback. The practice used complaints, significant events, surveys, comment cards and face to face meetings to improve the service. We saw many examples of where patient feedback had influenced change.

The patient participation group (PPG) had been a group since 2011 and included approximately 12 members with an additional 80 virtual members who provided feedback by email. We met with representatives of the PPG and they told us the practice manager and a GP had attended each meeting with practice nurses attending where possible. The PPG had influenced past patient surveys, and influenced the introduction of translation services for non-English speaking patients. The PPG had also facilitated patient information evenings on conditions such as diabetes, Parkinson's disease and men's health.

The PPG said the management at the practice were responsive to suggestions made by the group, were approachable and swift to take action when it was identified.

Tackling inequity and promoting equality

The premises and services were purpose built and had been adapted to meet the needs of people with disabilities. There was level access, a passenger lift and several designated accessible toilets which had been fitted with grab rails.

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

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

Access to the service

Patients were pleased with the appointment service at the practice and said they could get a same day appointment if necessary. For example, on the day of our visit, we observed one patient was attending the practice with a minor injury and was waiting to be seen.

Opening hours were planned around the needs of the population. The practice is open between the hours of 8.30am and 6pm. Pre bookable evening appointments were available until 7.30pm each Monday with a GP to promote access to services to patients who worked during normal office hours. Pre booked appointments were also available on Saturday mornings from 8.30am until 11.30am.

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

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns and used this process as a part of its quality monitoring system. The practice's complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice manager was a designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system. Patients we spoke with were aware of the process to follow if they wished to make a complaint.

We looked at the nine complaints received in the last 12 months. The practice manager used the complaint summary to look at trends. We saw that all complaints had been satisfactorily handled and dealt with in a timely way. We saw evidence of learning and changes in systems, policies and processes as a result of complaints.

Are services well-led?

Good 

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care, obtain feedback from patients and promote good outcomes for patients. This had been kept under review at the management meetings.

Staff knew and understood the vision and values and knew what their responsibilities were in relation to these. We were told there had been three or four social events in the past year to boost morale and team working. Staff said that even though there had been staff shortages and changes the vision and values were still current.

Governance arrangements

There were structured meetings to discuss incidents, events, complaints, and clinical matters. There were twice monthly clinical meetings where staff took it in turns to present an audit, report back on some training or arrange an outside speaker to come in. The management team met weekly to discuss business issues and also any current complaints or significant events. In addition the practice held monthly training afternoons which are attended by all staff and are used for team meetings, mandatory and other types of training.

The practice had a number of written and electronic policies and procedures in place to govern activity and these were available to staff. We looked at the safeguarding adult and child policies and whistleblowing policies and saw these had been reviewed within the last year.

The practice had recently, with agreement of the local commission group, opted out of using the Quality and Outcomes Framework (QOF) to measure its performance. QOF data from previous years for this practice and the new data being collected showed it was performing in line with national standards. However, the practice did not have a clear system in place to ensure all standards were being monitored to make sure the standards of care were being maintained whilst the new system was in place. For example, the practice was not collecting data to ensure all patients with severe mental illness were being seen each year for a review.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. We looked at five examples

of clinical audit. For example, the practice looked at the management of patients with diabetes and hospital admission. The practice measured the care and services provided, implemented changes in practice where necessary, and re audited to make sure care and treatment was still appropriate.

The practice manager showed us the systems, records and processes to identify and reduce risk in the environment. This included contracts for waste management, fire safety, and electrical equipment checks. Staff were aware of their roles in these processes. For example, nurses knew about how to safely dispose of clinical waste and the fire marshalls knew how to respond in the event of a fire.

The practice held weekly partners meetings where complaints, significant events and incidents were discussed along with day to day events. The records for these events showed the action and learning that took place. We were told that there was a plan to introduce a more formal three monthly meeting where all staff could attend and hear about any significant events.

Leadership, openness and transparency

Staff described a clear leadership structure, which had named members of staff in lead roles. The practice had a responsibilities list which set out clearly which member of staff was the key contact for each clinical area. For example there was a lead nurse for infection control, a lead GP for safeguarding and a lead GP for training. We spoke with staff and they were clear about their own roles and responsibilities. They all told us there had been a change in some roles but that they still felt valued, well supported and knew who to go to in the practice with any concerns.

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

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

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through a patient survey in March 2013. The survey found that most patients felt that both GPs and nurses gave them enough

Are services well-led?

Good 

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

time, asked about symptoms, listened well and explained tests and treatments. The majority of patients also said the GPs involved them in their care, treated them with care and concern and took their problems seriously. The survey also reported that 95% of the patients who responded felt GPs had helped them to manage their condition.

The practice made recent changes as a result of patient feedback. For example, the patient survey from 2013 had prompted the practice to change the way patients made appointments. This change had not proved popular with patients. The practice had then conducted a focused survey on the appointment system and made changes which included being able to pre book routine and follow up appointments.

The practice had a patient participation group (PPG) which had 12 members. The PPG included representatives from various population groups; including patients with long term conditions, working age patients and patients with mental health needs. The PPG had influenced the recent patient survey by suggesting areas of questioning. The PPG said the practice manager had been approachable and open to suggestions.

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

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at four staff files and saw that regular appraisals took place which included a personal development plan. Nursing appraisals had been recommenced since the arrival of the new lead nurse. Staff told us that the practice was very supportive of training.

The practice was committed to NHS workforce planning. They had employed an apprentice on the administration team who was now fully employed and working towards a medical secretary qualification. The practice was also a GP training practice and had two GP trainees being supported by the GPs at the practice. We spoke with one GP trainee who had been at the practice for four months. They told us they felt well supported, had received an induction and had weekly training sessions with the partners. The lead nurse was in the process of doing a mentorship course to enable to the practice to support student nurses.

The practice had completed reviews of significant events and other incidents. The GPs were in the process of introducing more formal ways of sharing action and learning from these events with the wider staff group to ensure the practice improved outcomes for patients.