Wellington Medical Centre

Quality Report

Wellington Medical Centre
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Website:

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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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection visit to Wellington Medical Centre on 4 November 2014.

We found Wellington Medical Centre provided the care and treatment patients needed to meet their needs. We found patients using this service experienced a good outcome.

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement.
- Patients with long term health care needs were monitored effectively and there was evidence that the practice worked well with other professionals and multidisciplinary teams to ensure their needs were met.
- Patients were positive about the care and treatment they had. Patients said they felt the practice offered an excellent and caring service
- The practice staff worked with organisations outside of health and social care provision. The GP who was the safeguarding lead for the practice was actively involved in building relationships with the local secondary school. This included liaison with teachers and police to improve support to young people in the local area. One GP kept links with the local Stroke Club, another with the League of Friends for the local Community Hospital.
- We found details of the vision and practice values were included in all aspects of business meetings and disseminated to the staff team and aspects shared with the PPG (patient participation group).

However, there were also an area of practice where the provider needs to make improvements.

The provider should:

- There should be a risk assessment process for staff that do not routinely have a Disclosure and Barring checks (DBS) when employed.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep people safe. 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).

Are services effective?

Good

The practice is rated as good for providing effective services. The GPs and nursing were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We heard about practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. There were GP leads or clinicians that had particular interests in specialist clinical areas. For example, respiratory needs of patients including smoking cessation. There were leads for dementia and mental health, paediatrics, and musculoskeletal problems. The practice had a register of patients requiring support for end of life care and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. Each patient had a plan of care in place. We spoke with visiting professionals such as health visitors and community nursing team. We heard how well they worked together and communication was good. We were told that all members of the practice team were approachable, appropriate referrals were made and the professionals felt including in the team.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients told us they had felt involved in planning and making decisions about their care and treatment. We were told that they were not rushed into decision making and full explanation of the plans of care were given to them. When we spoke with patients they were positive about the emotional support provided by the practice. One person informed us how much they had appreciated the full physical and

Summary of findings

emotional support they had from one GP when their health deteriorated. Others described the long term care they and their family had as good.The practice had a focus of providing support to carers, with 'Carer Champions' to seek out and support carers registered at the practice. The practice offered a flexible approach to appointments and treatment. A carers group held meetings at the medical practice every three to four months.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. We found the practice was responsive and flexible to people's needs. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. For example, patients with long term conditions were identified and plans put in place should there be a sudden deterioration in their condition.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's strategy and were incorporated in all aspects of the management and business planning. These values were clearly discussed and included in all aspects of business meetings and disseminated to the staff team and aspects shared with the PPG (patient participation group). The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken.The practice held monthly governance meetings where performance, quality and risks had been discussed.Staff told us about the regular team meetings and the dissemination of information. Staff told us that there was an open culture within the practice and they had the opportunity, and were happy to, raise issues at team meetings.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data, Quality Outcomes Framework (QOF) showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. Longer appointments were also available for people who needed them. This also included appointments with a named GP or nurse. Home visits were made to the 12 care homes within the local community regularly.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Patients with long term conditions were identified and plans put in place should there be a sudden deterioration in their condition. The practice worked with other professionals and providers to ensure that patients were monitored closely and there was a team approach to providing their care. This included using a Telehealth system. Telehealth was where electronic sensors or equipment that monitored vital health signs remotely, were placed in patient homes. Patients who used telehealth also had been given equipment that was used while they were outside their homes. We heard how the practice staff worked with organisations outside of statutory health and social care provision. One GP kept links with the local Stroke Club, another with the League of Friends of the local Community Hospital. This benefitted the patients because the practice was involved with the local community, had a good understanding of the needs of the community and could provide information and support appropriate to meet their patients needs.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. The practice offered a full range of immunisations for children, travel vaccines and influenza vaccinations in line with current national guidance. Staff signposted young people towards sexual health clinics and offered confidential testing packs for sexually transmitted infections. There was multidisciplinary working between GPs, midwives, practice nurses and health visitors.Children at risk were identified early and help offered with other service providers or practitioners such as health visitors. There was a follow

Summary of findings

up procedure for babies, children and young people if they did not attend for scheduled vaccinations, immunisations or appointments. The GP who was the safeguarding lead for the practice was actively involved in building relationships with the local secondary school with teachers and police to improve support to young people in the local area.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). They also offered extended hours appointments two evenings a week until 7.30pm. This meant patients from the working age population or with other responsibilities had access to appointments suitable to their needs. The practice also offered 'well women' and 'well men' health checks. Opportunistic health advice and support was given when patients attended appointments for areas such as smoking cessation. We saw from information provided by the practice that in the 40-75 years age range, in 2013/2014, 359(59%) took up the offer of a health check.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice was able to tell us how they supported people in vulnerable circumstances who may have poor access to primary care. They told us there was no barrier to patients registering with the practice including those with no fixed abode. If patients who had difficulty with normal access and turned up at the surgery without an appointment, then every effort was made to ensure they were seen. The practice kept a register of all patients with learning disabilities who were provided with an annual physical health check The practice had access to online and telephone translation services. Notices in the patient waiting room and the health promotion room signposted people to a number of support groups and organisations. The practice's computer system alerted GPs and nursing staff if a patient was also a carer. Carers were put on list and prioritised for flexible appointment times and offered regular screening and health checks. The practice had three staff who took up the role of Carer Champions to seek out and support carers registered at the practice. A carers group held meetings at the medical practice every three to four months.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice had ways of identifying patients who needed additional support,

and were pro-active in offering additional help. The practice kept a register of all patients with mental health needs and provided with an annual physical health check. Staff undertook testing for memory and dementia screening with older patients. From information supplied by the practice during 2013/2014 244(1.7%) patients were offered initial assessment for cognition testing, 138(0.9%) had an advanced assessment. Staff were provided with training and knowledge to assess and respond to risk experiencing mental illness. There was a system to flag up patients at risk/ poor mental health and those who did not attend for their regular medication or injections.

Summary of findings

What people who use the service say

We received one comment card and a letter from patients. We met and spoke with nine patients during the inspection. We met and spoke with representatives of the patient participation group.

Patients were generally satisfied with the appointments system. They confirmed that they could see a GP on the same day if they needed to and they could see another GP if there was a wait to see the GP of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. For example, one patient we spoke with told us how they needed an urgent appointment for their children on re-registering with the practice. They obtained an appointment two hours later with the GP of their choice.

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

Patients were positive about the care and treatment they had. Patients said they felt the practice offered an excellent and caring service. From the initial first contact patients felt they were involved in their care and treatment. They said staff treated them with dignity and respect. Patients had found staff efficient and friendly.

Areas for improvement

Action the service SHOULD take to improve
The provider should:

- There should be a risk assessment process for staff that do not routinely have a Disclosure and Barring checks (DBS) when employed.

Wellington Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector who was accompanied by a GP Specialist Advisor.

Background to Wellington Medical Centre

Wellington Medical Centre is situated in a central area of Wellington, Somerset. The practice had approximately 14,618 registered patients. The practice provides care and support to patients in nursing homes in the area and has a larger than average population of elderly patients.

The practice is located in purpose built premises with the main patient areas situated on the ground floor. The practice has a variety of consulting rooms, treatment rooms and a treatment suite. The practice is on a general medical service contract with Somerset Commissioning Group. On the same site is a pharmacy and a NHS Dental Service facility.

Wellington Medical Centre is only provided from one location:

Wellington Medical Centre

Mantle Street

Wellington

Somerset

TA21 8BD

Wellington Medical Centre has opted out of providing out-of-hours services to their own patients. This was provided by the Dorset and Somerset Unscheduled Care Service.

The practice supported patients from all the population groups: older people; people with long-term conditions; mothers, babies, children and young people; working-age population and those recently retired; people in vulnerable circumstances who may have poor access to primary care; and people experiencing poor mental health.

Over 33% of patients registered with the practice were working aged from 15 to 44 years, 27.3% were aged from 45 to 64 years old. Just above 12% were over 65 years old. Around 7.3 % of the practices patients were 75-84 years old and 3.6% of patients were over 85. 10.7% patients were less than 14 years of age. Information from the Somerset Clinical Commissioning Group (CCG) showed that 49% of the patients had long standing health conditions, which was below the national average of 53%. The percentage of patients who had caring responsibilities was just over 20.8% which is above the national average of 18.5%. 2.6% of the working population were unemployed which is below the national average of 6.3%. The practice supported 2.7% of its patients who were living in a nursing home which is above the national average of 0.3%. The practice provides support to patients in 12 care homes in the locality.

The practice consisted of 11 partners. Of these 11 GPs there were seven male and four female GPs. The practice was a training practice for GPs and medical students. At the time of this inspection there was one GP registrar at the practice. The GPs provided 73 surgery sessions per week. The practice nurse team consisted of a lead nurse and practice nurse with four health care assistants who provided health screening and treatment five days a week. There was one practice nurse vacancy. The practice was open between the

hours of 8am and 6pm Monday to Friday. The practice was closed for an additional hour between 1pm and 2pm each Wednesday to allow staff training. Late surgeries were available up to 7.30pm two days per week.

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.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

How we carried out this inspection

The practice provided us with information to review before we carried out an inspection visit. We used this, in addition to information from their public website. We obtained information from other organisations, such as the local Healthwatch, the Somerset Clinical Commissioning Group (CCG), and the local NHS England team.

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

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We also looked at how well services were provided for specific groups of people and what good care looks like for them. The population groups were:

- 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.

During our visit we spoke with seven of the GPs, two practice nurses, and two health care assistants. We met with the practice manager, head receptionist and the reception and administration staff on duty. We spoke with nine patients in person during the day. We used information from the one comment card and letter left at the practice premises. We spoke with a community nurse and a health visitor associated with the practice.

We observed how the practice was run, the interactions between patients and staff and the overall patient experience.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, they reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke to were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example it was identified that a patient with learning difficulties, new to the practice, was attending for a vaccination. The staff noticed that the patient had already received vaccination at a previous health provider. The practice identified there was an issue with sharing of information across counties and referred the concern back to the local immunisation department.

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

We spoke with GPs and reviewed information about the clinical and other incidents that had occurred at the practice. We were given information that 23 incidents had occurred during the last 12 months and were reviewed under the practices significant events analysis process. These incidents included missed diagnosis, poor information from hospital discharge, prescriptions and medicines management. Events linked to the administration of the practice and the delivery of the service was also reviewed.

Where events needed to be raised externally, such as with other providers or other relevant bodies, this was done and appropriate steps taken such as seeking information from other care providers and supporting the patients concerned. An example of this was one GP described how an error in prescribing a controlled drug had occurred they had referred the incident to NHS England and the Somerset Clinical Commissioning Group.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed a summary of the significant events that had occurred during the last year and discussed the outcomes and learning from some of the incidents with the GPs. Discussions of significant events was a standing item on the practice continual professional development (CPD) meeting's agenda and the weekly meetings. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used standard significant event audit forms and sent completed forms to the practice manager. These were then presented to the monthly CPD meetings. We looked at information and discussed with GPs incidents that had occurred during the last year. We heard how one complaint had been escalated to a significant event and had been reviewed and responded to appropriately. For example, a complaint about the safety and wellbeing of an elderly relative to remain living in their own home. The GPs had taken professional advice in regard to the patient's mental capacity from the mental health team at the time. However, there were delays in referrals when further issues arose which led to delays in the appropriate action being taken. We heard how the practice had responded to the issues and that the event had highlighted staff awareness of where information was to refer regarding patient assessment for mental capacity. The patient and their family, who had been affected by this event, were given an apology and informed of the actions taken. This was in line with practice policy.

National patient safety alerts were disseminated to practice staff by the practice manager and were raised and discussed at the CPD meetings and disseminated to other staff if relevant to their role.

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 relevant role specific training on safeguarding. 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 were easily accessible.

The practice had an appointed dedicated GP as lead in safeguarding vulnerable adults and children. All other staff had training relevant to their roles, GPs level 2 and administration and receptions staff to level 1 in the protection of children . Refresher training was provided annually When we discussed their training staff we spoke with could demonstrate they had the necessary training to enable them to fulfil this role, such as the lead GP (level 3) in the protection of children. All staff we spoke to were aware who the lead was and who to speak to in the practice if they had a safeguarding concern.

Staff had access to prompts and information electronically and in documentary form to aid them should a concern arise. There was also guidance for responding to concerns for emotional, mental and behavioural issues for children and young people. This information was on display in areas where staff were working with patients and where administrative staff answered telephones so it was readily to hand.

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. We were told GPs shared responsibility for monitoring families at risk with approximately one to two families per GP. At the time of the inspection below 50 children were identified as potentially at 'risk'.

Through discussion with the lead GP we were told that they had a special interest in child protection and improving support for young patients in the local community. They attend monthly multi-disciplinary safeguarding meetings at the local secondary school. They were also on the child and adolescent mental health services (**CAMHS**) board at county level. CAMHS are for children aged 0-18 and their families who are experiencing mental health problems. This was to try and work to reach those patients not eligible to CAMHS. We were told that the same GP worked with other professionals such as teachers, police and health visitors to promote co-working of these different agencies.

There was a chaperone policy, which was visible on the waiting room noticeboard and in some of the consulting and treatment rooms but not all. All nursing staff, including health care assistants, had been trained to be a chaperone.

Medicines management

We looked at the medicines used at the practice. 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 described the action to take in the event of a potential failure.

Processes were in place to check medicines were within their expiry date and suitable for use. Expired and unwanted medicines were disposed of in line with waste regulations. This included a documented audit trail for the management of controlled medicines.

We looked at the system for the management and storage of prescription pads and printer prescription paper. Stocks of prescription pads were stored in areas with security access codes. All blank prescription pads and paper were logged in when received but not necessarily logged out when removed. Therefore there was no audit trail kept of the movement of FP10 prescription pads or paper at the practice. The practice provided a copy of their updated prescription security policy which addressed these concerns.

There was a repeat prescribing policy which gave details of the practices processes including the requirement for regular reviews of patients on long term treatment. Patients could make their requests by a variety of methods and they were provided with information about how to do this in the patient leaflets and the practice website.

The practice had a GP lead for prescribing and medicines management. When we spoke with the lead GP for medicines management they informed us how any concerns in regard to prescription errors were managed and what steps they took to prevent it occurring again. We were told there had not been a medicines audit during the last 12 months except for the routine checks on medicines kept at the practice.

The nursing staff administered vaccines using directions that had been produced in line with legal requirements and national guidance.

Good

Are services safe?

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. The practice had a contract with an external cleaning company for all their cleaning needs. The cleaning company carried out its own audits and quality checks regularly. 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. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the last infection control audit had been carried out in August 2012 where regular training and updates for all staff had been identified as to be provided. An infection control audit was carried out following our inspection showed that training had been provided to all staff. We also read that hand hygiene training and hand washing audit was under development. All other aspects of infection control had been checked and any gaps identified had been assessed and addressed.

An infection control policy and supporting procedures were available for staff reference. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use.

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 and where staff and patients needed to wash their hands. Sinks in consulting and treatment rooms had appropriate elbow operated taps.

There were appropriate systems in place for the disposal of used needles (sharps) and clinical waste. There were foot pedal operated bins and designated clinical waste bins. The practice had a contractual agreement with a clinical waste disposal company who managed the collection and removal of clinical waste.

The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

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 displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example spirometers used for assessing patient's respiratory function. Safety checks were carried out on vaccine fridges on an annual basis.

Staffing and recruitment

We were told about the recent changes in the staff team recently following the amalgamation of the two practices that were based in the health centre. There had been changes to the partnership, clinical staff, and reception and administration staff. We heard how the practice had taken an innovative approach to recruiting nursing and administration staff to post. This was by holding an open evening at the practice which had had a very positive result in the amount of interest shown by the local community.

Records we looked at contained evidence that recruitment checks had been undertaken prior to employment. For example, references, qualifications, and registration with the appropriate professional body. One of the three records did not have evidence of photographic proof of identity included; however there was information to show that a criminal record check through the Disclosure and Barring Service (DBS) had been carried out. The practices' policy was to carry out DBS checks on all clinical staff, but not necessarily the non-clinical staff. There was no overall documented risk assessment to show all aspects of potential risk to their employment had been reviewed.

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. This included a recorded interview and decision making process for all new applicants. New members of staff were given a formal induction appropriate to role which included general employment at the practice, health and safety and job specific. We spoke with the trainee GP currently in post at the practice about the support provided to staff. We were told that they had been provided with three days non-clinical training as part of their induction when they commenced at the practice.

Good

Are services safe?

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. However, nursing staff told us the vacant post in the nursing team although managed, had impacted on other aspects of their work such as attending training or meetings.

The practice used locum GPs as and when required. They provided locums/ the locum agency with information about the agreed activities they had been engaged for. This included detail about the expectations for full or half day cover, the number of surgery sessions and the appointment schedules.

Monitoring safety and responding to risk

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

Environmental and safety risks were identified, assessed, rated and actions recorded to reduce and manage the risk such as fire safety.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. Unplanned admissions and re-admissions for older people were regularly reviewed and improvements made to their care to prevent reoccurrence. Patients from this group and those with long term conditions had a care plan in place to identify potential risk and eliminate them. Staff were alerted to patients at risk on the electronic patient records so that they could respond appropriately and alert GPs or practice nurses as soon as possible to concerns.

Children at risk were identified early and help offered with other service providers or practitioners such as health visitors. There was a follow up procedure for babies, children and young people if they did not attend for scheduled vaccinations, immunisations or appointments. Staff were provided with training and knowledge to assess and respond to risk with patients who experienced mental illness. There was a system to flag up patients at risk from poor mental health and those who did not attend for their regular medication, depot-injections (method of administering slow release medication).

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 in February 2014. 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 the emergency medicines. We discussed the location and security of the emergency equipment with staff and the practice manager because it was not situated centrally and at risk of being tampered with. We were informed following the inspection visit the location would be reassessed and they planned to install tamper proof equipment. We saw from records held all of the emergency equipment and medicines were regularly checked, in date and maintained.

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

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

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We heard about practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. For example, guidelines about low back pain were reviewed; a chiropractor and physiotherapist also attended the meeting to provide supporting information. The staff we spoke with and evidence we reviewed showed that each patient was given support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate.

The practice had a programme of regular assessments and reviews of treatment for patients with long term conditions such as asthma, diabetes, and heart disease. Patients with learning difficulties, experiencing poor mental health or complex needs were identified and were monitored with a plan of ongoing care developed. During 2013 of the 50 patients with learning disabilities 72% had attended for an annual health check. The practice had 82 patients with mental health issues registered in 2013 where attendance for health screening for alcohol, BMI (Body Mass Index) and blood pressure checks had ranged from 75% to 79% had been achieved. The practice had implemented care plans for 62% of this population group.

The GPs told us there were leads or clinicians at the practice that had particular interests in specialist clinical areas. For example, respiratory needs of patients including smoking cessation. There were leads for dementia and mental health, paediatrics, and musculoskeletal problems. We heard about and saw information to show that patient's needs were discussed with clinical leads when the need arose.

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 their assessed need and that age, sex and race was not taken into account in this decision-making.

New patients were required to complete a health questionnaire and offered a health check when they registered. Patients with ongoing treatment plans were placed on the schedules of regular monitoring.

Management, monitoring and improving outcomes for people

Staff at the practice had different roles in the monitoring and improvement of outcomes for patients. These roles included providing regular assessment and reviews of treatment and health promotion. Other roles included ensuring information that was input into the electronic records was correct.

The practice showed us and told us about the clinical audits that had been undertaken in the last year. One example of a recent audit was in regard to the provision of sufficient information to patients before the fitting of contraceptive devices. The audit showed that patients were not always given the necessary information prior to their decision to go ahead with the procedure. From this the practice had instigated a prompt for staff when ordering the devices to ensure patients were provided with the information they need. An audit of the effectiveness of this action had not been completed yet. We saw there had been annual audits of minor operations and surgical procedures at the practice to assess the rate of post-operative infection. We saw that 0.47% of the 437 carried out in 2013/ 2014 had resulted in post-operative infections requiring antibiotic treatment. The audit did not identify the reason for the post-operative infections.

The practice was involved in a pilot, Somerset Practice Quality Scheme, as an alternative to Quality Outcomes Framework (QOF). QOF is a national performance measurement tool. The aim of the pilot was to meet the aims of achieving a sustainable general practice service by working in a federation with other GP services. We were told that administration staff continued to alert GPs where patients had outstanding reviews of care as reminders for these to be competed. We were told the practice continued to use QOF indicators for reasons of quality of patient care and safety for patients with respiratory disease, chronic heart disease, mental health, and diabetes. We saw from information provided by the practice that previous history showed the practice was high performers during 2012/2013 in meeting QOF indicators.

Good

Are services effective?

(for example, treatment is effective)

The practice had a register of patients requiring support for end of life care and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. Each patient had a plan of care in place.

There was an informal system of peer review for GPs within the practice where GPs discussed decision making and plans of treatment. These processes included group and individual discussions with GP leads.

Effective staffing

Practice staff included medical, nursing, managerial and administrative staff. We read an overview of the staff training and saw that all staff were up to date with attendance at mandatory courses such as emergency basic life support. We saw that planning was in place for all staff to revisit training through internal, online and external training providers. All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or were working through the process of revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council). We were told that many had participated in a 360 degree reviews, for the revalidation process.

All staff undertook annual appraisals which identified learning needs from which action plans were documented. Staff interviews confirmed that the practice was proactive in providing training and took an interest in them developing their skills and extending their roles. We were provided with information about the vocational courses staff had achieved and were in the progress of achieving. For example NVQ (National Vocational Qualifications) in business administration and customer service. The practice manager was undertaking a post graduate management diploma.

As the practice was a training practice, doctors who were in training to be qualified as GPs had access to a senior GP throughout the day for support. Feedback from the GP trainee we spoke with about their placement was positive with weekly tutorials in house and monthly tutorials in the local area. We heard how the current GP trainer had a specific interest in substance misuse and was provided with protected time to pursue their studies for this.

Practice nurses and health care assistants had defined duties they were expected to carry out and were able to demonstrate they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology and the ongoing monitoring of patients long term needs conditions.

The GP 'buddy' system for covering GP duties assured continuity of care for patients. It also allowed for pathology and other test results to be reviewed without any delay.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and provide treatment and support to people with long term and complex health needs. We were told about the work the practice did with other health providers and practitioners.

A designated GP was the community hospital lead where they with the support of the other GPs provided GP cover providing medical care to the patients in the 10 bedded unit at the community hospital. In-patients were from other practices and areas and were admitted for various reasons, such as treatment and monitoring. Multidisciplinary working was in place, with weekly meetings including patient's families. The GP lead had scheduled visits to patients there; the duty doctor covered responding to patients needs outside of these periods. We heard how this provision by the practice was audited by Somerset NHS Partnership who commissioned the contract. The information from these three monthly audits that looked at records and medicines management showed the practice was providing the required support to the patients that was proactive rather than crisis management.

We heard how the practice staff worked with organisations outside of health and social care provision. The GP who was the safeguarding lead was actively involved in building relationships with the local secondary school with teachers and police to improve support to young people in the local area. One GP kept links with the local Stroke Club, another with the League of Friends for the local Community Hospital. This benefitted the patients because the practice was involved with the local community, had a good understanding of the needs of the community and could provide information and support appropriate to meet their patients needs.

We were told two GPs were working with the nursing home staff and other professionals in developing care plans for

Good

Are services effective?

(for example, treatment is effective)

patients who were at risk of emergency admission to hospital. One GP was involved in the advisory group for the out of hours service. Another GP sat on the steering committee of the Somerset Independent Living Team (SILT) a multidisciplinary team of social workers, care workers, an occupational therapist and a physiotherapist. SILT provided rapid response care to support vulnerable patients to remain at home or to enable discharge from hospital.

We heard from visiting professionals such as health visitors and community nursing team. We heard how well they worked together and communication was good. We were told that all members of the practice team were approachable, appropriate referrals were made and the professionals felt including in the team. We heard about and read information about the training and development days that associated professionals were invited to participate in training available at the practice.

The practice used an out of hour's service. Information about patients who had attended or required out of hours support was received and responded to by the practice the next working day.

Information Sharing

The practice had told us they had fully migrated to a new system for patient records and the management of the service during the last four months. This meant there was great flexibility for sharing information with other providers and within the practice. The practice now had a fully computerised pathology link for ordering tests and receiving results. Tasks relating to patients care and treatment were readily seen so that missed opportunities for regular screening or sharing of information did not occur.

Plans for development included an electronic prescription service and an appointment system to improve access to services for patients.

Consent to care and treatment

Staff we spoke with were aware of the Mental Capacity Act (2005) and the Children's and Families Act (2014) and their duties to fulfil it. All the clinical staff we spoke to understood the legislation and were able to describe how they implemented it in their practice. The practice had guidelines and information available to staff on their electronic resource they called 'The Tree' to ensure that staff followed the appropriate steps.

Patients with learning disabilities and those with a diagnosis of dementia were supported to make decisions about their care. This was through the use of care plans which they were involved in the development during consultations with their GPs. GPs were aware of processes and systems for best interest decision making and involved others in any assessment of capacity to make decision. This often involved other health care practitioners, the patients' carers and social workers involved in patient's support. Information was recorded in patients' care plans, these were reviewed regularly. Clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, written consent was obtained and scanned into electronic patients records. A patient's verbal consent for examination and tests was documented in the electronic patient notes. Patients we spoke with confirmed that GPs and nursing staff asked for consent before examining them or providing treatment.

Health Promotion & Prevention

The practice provided new patients with an information pack when they first registered with the practice. Included in the information pack was reference to the community pharmacy minor ailments service and the information patients could obtain from their local pharmacy.

The practice offered all new patients registering with the practice a health check with the health care assistant or practice nurse. If health concerns were detected a GP was informed and these were followed up. Patients on repeat medications were automatically requested to make an appointment with a GP for regular health and medication checks.

The practice also offered 'well women' and 'well men' health checks. Health advice and support was given when patients attended appointments for areas such as smoking cessation. We saw from information provided by the practice about the number of patients 40-75 years old who took up the offer of a health check in 2013/2014, 359 (59%) attended. Carers were monitored and given a greater flexibility for appointments.

Good

Are services effective?

(for example, treatment is effective)

The practice had ways of identifying patients who needed additional support, and were pro-active in offering additional help. The practice kept a register of all patients with learning disabilities and with mental health needs and offered them an annual physical health check. There was a method of identifying at risk groups such as those receiving end of life care and those over 75 years of age. Staff undertook opportunistic testing for memory and dementia screening with older patients. From information supplied by the practice during 2013/2014 244(1.7%) patients were offered initial assessment for cognition testing, 138(0.9%) had an advanced assessment.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Staff signposted young people towards sexual health clinics and offered confidential testing packs for sexually transmitted infections. There was multidisciplinary working between GPs, midwives, practice nurses and health visitors.

The practice had implemented a patient health promotion room set aside attached to the waiting room where patients could check their blood pressure and the weigh their babies. Patients had access to health information over the internet, a computer 'pod, and there were leaflets and information available to read or take away about a large range of topics. Patients were signposted to external support groups and provided with information about the support the practice could assist them with. For example advice about self-management of their own long term health needs. Patients' were also provided with information on the television screens and notice boards in the central waiting room.

The practice, with the support of the patient participation group got involved in the 'Spring into Action' health open day held at the practice in March 2014. GPs from the practice and another local practice made themselves available for general health advice and there was information and support from other organisations available. For example those organisations that support people with long term conditions such as dementia, Parkinson's and osteoporosis. There appeared to be information and advice available for all patient groups including young and older people. Information was available about sexual health and drug and alcohol advice.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent information available for the practice on patient satisfaction. This included information from the national patient survey 2012/2013, information from the Patient Participation Group and one comment card and a letter left in the surgery reception. We found that no comments had been left on the NHS Choices website. We met and spoke with nine patients using the practice on the day.

Patients were positive about the care and treatment they had. Patients said they felt the practice offered an excellent and caring service. From the initial first contact patients felt they were involved in their care and treatment. They said staff treated them with dignity and respect. Patients had found staff efficient and friendly.

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. Consultation and treatment room doors were closed during consultations and conversations taking place in these rooms could not be overheard. Confidentiality was maintained in the waiting area and reception desk as the waiting area was a reasonable distance from the desk. Patients who wished to speak privately to the reception staff had the options of using another room to do so if they wished. Telephone calls/ appointment contact was not managed in the reception area – there was a designated room upstairs where conversations could be kept private and not overheard.

There was an automatic check in service which was positioned away from the desk which maintained privacy. Patients were called to the consulting rooms and treatment areas by the electronic system. However, at times we saw GPs and nurses call or collect patients from the waiting room.

Care planning and involvement in decisions about care and treatment

Patients told us they had felt involved in planning and making decisions about their care and treatment. We were told that they were not rushed into decision making and full explanation of the plans of care were given to them. GPs and nursing staff had a good understanding of assessing patients' capacity to be involved in decisions about their care and treatment and they involved others such as carers and advocates when required.

Staff told us that translation services were available for patients who did not have English as a first language. We were told this was rarely used. Information supplied by the practice was that of the 14,400 patients registered they had information of the ethnicity of approximately 11,000. Of those 11,000 patients, English was predominantly their first language.

Patient/carer support to cope emotionally with care and treatment

When we spoke with patients they were positive about the emotional support provided by the practice. One person informed us how much they had appreciated the full physical and emotional support they had from one GP when their health deteriorated. Others described how the long term care they and their family had as good.

Notices in the patient waiting room and the health promotion room signposted people to a number of support groups and organisations. The practice's computer system alerted GPs and nursing staff if a patient was also a carer. Carers were put on list and prioritised for flexible appointment times and offered regular screening and health checks. The practice had three staff who took up the role of Carer Champions to seek out and support carers registered at the practice. A carers group held meetings at the medical practice on the first Monday of every month.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive and flexible to people's needs. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. For example, patients with long term conditions were identified and plans put in place should there be a sudden deterioration in their condition. The practice worked with other professionals and providers to ensure that patients were monitored closely and there was a team approach to providing their care. This included using a Telehealth system. Telehealth was where electronic sensors or equipment that monitors vital health signs remotely, are placed in patient homes, or they have been given equipment that can be used while they are on the move. These readings are automatically transmitted to an appropriately trained person who can monitor the health vital signs and make decision about potential interventions when required. Information was shared with the out-of-hours service to ensure that patients had their care assessed and planned for them.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). A survey had been carried out in regard to telephone access, booking appointments online, and information available to patients in the practice. In response to the comments made the practice sought extra funding and had upgraded the telephone system to allow a better response at peak times of activity at the practice. They had implemented an online system for booking appointments in advance so that patients had the flexibility to do this when the practice was not open. Patients access to information had improved by providing document copies of the health promotion information to them to take away or read more readily than on the television screen in the waiting room. A computer 'pod' had been implemented in the health promotion room to enable access to health advice and support from other providers and support groups. The PPG had re-introduced a newsletter to advice patients of the development of the service and the information available to them.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning and delivery of its services.

The practice was able to tell us how they supported people in vulnerable circumstances who may have poor access to primary care. They told us there was no barrier to patients registering with the practice including those with no fixed abode. If patients who had difficulty with normal access and arrived at the surgery without an appointment, then every effort was made to ensure they were seen. Patients with a mental health diagnosis or learning difficulties were provided with at minimum o an annual health screening so that their well-being was monitored. The practice had access to online and telephone translation services.

The premises and services was purpose built to meet the needs of people with disabilities. There were open corridors, accessible doorways and consulting and treatment rooms had good space and flexibility for wheel chair users, pushchairs and mobility aids. Patient areas were located on the ground floor and were light and spacious. There were offices and facilities for meetings on the first floor. Suitable accommodation was available for the practice to host other professionals and services at the practice including the community nursing team, midwifes and health visitors. This meant patients had better access to these services and communication with the practice was maintained. There was a lift to the second floor and accessible toilets on both levels which meant there were no limitations for employees and visitors with restricted mobility.

Access to the service

Appointments were available from 8:30 am to 6pm on weekdays. They also offered extended ours appointments two evenings a week until 7:30pm. This meant patients from the working age population or with other responsibilities could had access to appointments suitable to their needs. They were closed every Wednesday for one hour between 1pm and 2pm for staff training.

Comprehensive information was available to patients about appointments on the practice website and in the leaflets and information provided to patients when they registered. This included how to arrange urgent appointments and home visits and how to book appointments through the website. Patients were told about the telephone consultations with GPs were also available for medical and medicine queries, and

Good

Are services responsive to people's needs?

(for example, to feedback?)

discussions about test results. Detail about the availability of the GPs was provided to patients so that they could plan ahead and chose to book an appointment with their preferred or their named GP. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for people who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to the 12 local care homes regularly and to those patients who needed one. The practice worked in conjunction with the local independent living team to enable continuity of care for people who could not attend the health centre.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. For example, one patient we spoke with told us how they needed an urgent appointment for their children on re-registering with the practice. They obtained an appointment two hours later with the GP of their choice.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There 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 with posters displayed and summary leaflets in the waiting area and in the health promotion room. Information was also on the website and included in the patient pack when new patients registered. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at complaints received during 2013/2014 and up to the date of the inspection. During 2013/2014 there were 12 events which were managed as complaints. Ten events/ complaints were upheld or partially upheld. They ranged from clinical decisions to administration errors and to advice given by reception staff. Each one resulted in some action being taken to prevent a reoccurrence or to improve practice. From April 2014 there had been 11 events managed as complaints received by the practice and of those the practice had logged seven as formal complaints and four as informal comments that were managed under the complaints process. Some were either escalated as significant events to be reviewed and managed in this way. We saw from information that all of the events/ complaints were satisfactorily handled, dealt with in a timely way, there was openness and transparency with dealing with the compliant.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on. For example patients not knowing who they are speaking to, the outcome from this was staff were reminded to give their name when answering the phone and at the reception desk. Identity badges for all staff were in the process of being obtained.

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 and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's strategy and were incorporated in all aspects of the management and business planning. These values were clearly discussed and included in all aspects of business meetings and disseminated to the staff team and aspects shared with the PPG (patient participation group).

We spoke with staff and they all knew and understood the aims and objectives of the organisation and knew what their responsibilities were in relation to these. This could be in their commitment to improving providing a positive patient experience and outcome whatever their role. An example of this we observed how staff responded to patients queries at reception and when speaking to them on the phone. Staff were polite and respectful and sought to solve or respond appropriately and quickly to patients concerns.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at a sample of these policies and procedures. All policies and procedures we looked at had been reviewed annually and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and the senior partner was the lead for safeguarding. All the members of staff we spoke with were clear about their own roles and responsibilities. Feedback from the administration and nursing staff showed us they felt valued, well supported by the practice partnership and knew who to go to in the practice with any concerns.

The practice was involved in a pilot, Somerset Practice Quality Scheme, as an alternative to Quality Outcomes Framework (QOF) to meet the aims of achieving a sustainable general practice service by working in a federation with other GP services. QOF is a national performance measurement tool. We were told how administration staff continued to alert GPs where patients had outstanding reviews of care as reminders for these to be competed. We were told the practice continued to use QOF indicators for reasons of quality of patient care and safety for patients with respiratory disease, chronic heart disease, mental health, and diabetes. We saw the outcome of this information was regularly discussed at team meetings and action plans were produced to maintain or improve outcomes.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, an audit of the fitting of contraceptive devices and infections following minor surgery at the practice.

The practice held monthly governance meetings. We looked at minutes from the last four meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

Staff told us about the regular team meetings and the dissemination of information. They told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, including the recruitment and disclosure and barring policy to ensure safe and equitable procedures were in place. We were told about staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, compliments and complaints received. We looked at the results of the last patient survey and saw as a result of this the practice had introduced improvements to different aspects of communication at the practice. This had included the telephone system and greater flexibility to booking appointments. We spoke with patients they told us they had found it easier to contact the practice to make an appointment; they did not need to wait in a queue for too long.

The practice had an active patient participation group (PPG) of which the patients involved remained determined

Are services well-led?

Good

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

to increase patient involvement in the practice and were actively seeking new patients to join. The PPG included representatives from various population groups; and they were taking steps to encourage patients from the younger age group to join. The PPG had carried out regular surveys and met every quarter. Information from the last patient survey was shared with us. The results and actions agreed from these surveys were available on the practice website.

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

The practice had a whistleblowing policy which was available to all staff in the staff handbook on display and electronically on any computer within the practice.

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 three staff files and saw regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had training and meetings where guest speakers and trainers attended.

The practice was a GP training practice and a training practice for medical students. Two of the GPs were GP trainers and the practice always had one GP trainee placed with them at all times.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients. For example, how staff responded and supported a patient with mental health concerns whilst waiting to be contacted by the mental health crisis team. The outcome of this was raising and bringing attention to the practice policy on supervision of high risk patients with staff and a reminder for all members of the team to improve communication to ensure the plans for patients are shared.