Wincanton Health Centre

Inspection report

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

Ratings

Overall rating for this location	Requires improvement
Are services safe?	**Requires improvement**
Are services effective?	**Requires improvement**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Good**

Overall summary

This practice is rated as requires improvement overall. (Previous rating September 2014 under a previous provider – Good)

The key questions at this inspection are rated as:

Are services safe? – Requires improvement

Are services effective? – Requires improvement

Are services caring? – Good

Are services responsive? – Good

Are services well-led? - Good

We carried out an announced comprehensive inspection at Wincanton Health Centre on 13 July 2018. This inspection was part of our inspection programme and to check that the new provider, Symphony Healthcare Services, was continuing with providing a Good service since they had assumed responsibility for the service in October 2017.

At this inspection we found:

- The practice had systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice did not always use their systems to review these incidents so that they learned from them and improved their processes.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence- based guidelines.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Patients found the appointment system easy to use and reported that they were able to access care when they needed it.
- There was a focus on continuous learning and improvement at all levels of the organisation.
- There was an active Patient Participation Group that worked with the practice to provide support to the local community.
- Daily scheduled phone calls were made to each care or nursing home by a GP to manage concerns and problems. Paramedics and the practice pharmacist regularly visited these homes to provide support and advice.
- There were new policies and procedures and a new system of governance which needed to have time to be fully implemented and embedded.

The areas where the provider **must** make improvements as they are in breach of regulations are:

- The provider must have the necessary information available to support that staff have been recruited appropriately and suitable for their role and that the information regarding their immunisation status is sought and kept.
- The provider must monitor and address the gaps in clinical staff available required to maintain meeting the patient's needs including patients with long term conditions and mental health needs.
- The provider must have safe systems in place for fire safety, training for persons undertaking risk assessments, infection control and chemicals stored and used at the practice.
- The provider must continue with assessing and putting actions in place to ensure medicines are stored safely and that sufficient stock of Oxygen is kept at the practice.
- The provider must continue to review the safe storage and handling of prescription stationery.

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

- The provider should continue with having an effective system for responding and investigating significant events.
- The provider should continue to review and embed policies and procedures.
- The provider should continue with a full programme to provide staff with the necessary training for health and safety.
- The practice should continue to proactively identify carers and respond to patient feedback regarding access.
- The practice should continue to resolve meeting the needs of the patients with long term conditions and with mental health concerns.

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

Please refer to the detailed report and the evidence tables for further information.

Population group ratings

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

Our inspection team

Our inspection team was led by a Care Quality Commission (CQC) lead inspector**.** The team included a GP specialist adviser and a 2nd CQC inspector.

Background to Wincanton Health Centre

Symphony Health Services (SHS) is the registered provider of Wincanton Health Centre. SHS is a NHS health care provider, based in Somerset that was developed as part of the South Somerset Symphony Programme – a project which aims to create new and innovative ways to delivering high quality care to patients and strengthening and supporting primary care in the local area. At the time of this inspection, SHS were delivering services from eight registered locations and one branch surgery. SHS have been providing a service from Wincanton Health Centre since October 2017. Wincanton Health Centre service is provided from one address; Dykes Way, Wincanton, Somerset, BA9 9FQ, and delivers a primary medical service to approximately 8,875 patients. The practice is situated in a purpose-built building in a residential area of the town of Wincanton. Information about Wincanton Health Centre can be found on the practice website www.wincantonhealth.co.uk.

According to information from Public Health England, the practice area population is in the seventh least deprived decile in England. The practice population of children and those of working age is similar to local and national averages. The practice population of patients living with a long-term condition was similar to local and national averages at 67%, the CCG being 58% and national being 54%. Of patients registered with the practice, 98% are White or White British, 1% are Asian or Asian British, 0.1% are Black or Black British, 0.7% are mixed British and 0.1% considered themselves as 'Other'.

The practice team is made up of two salaried GPs one being the Registered Manager. Overall the practice has the equivalent of just over 1.44 WTE (whole time equivalent) GPs at the practice (one male and one female). Two salaried part-time GPs had recently been employed and will be starting in the practice at the end of July 2018.There are three advanced nurse practitioners (ANP), three practice nurses and three health care assistants. The practice has additional clinical specialist staff including two paramedic practitioners, and one practice pharmacist. There are four health coaches. The practice manager is supported by administrators, secretaries, and reception staff.

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

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

Requires improvement

Are services safe?

We rated the practice as requires improvement for providing safe services.

This was because:

The provider did not hold the necessary information available to support that staff have been recruited appropriately for their role and that the information regarding their immunisation status is sought and kept. There were not safe systems in place for fire safety, training for persons undertaking risk assessments, infection control and chemicals stored and used at the practice. The provider did not have sustained systems so that medicines are stored safely and that sufficient stock of Oxygen is kept at the practice and safe storage and handling of prescription stationery. Risk assessments were not in place for no following UKRC (UK Resuscitation Council) recommended emergency medicines.

Safety systems and processes

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

- The practice had appropriate systems to safeguard children and vulnerable adults from abuse. All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Learning from safeguarding incidents were available to staff. Staff who acted as chaperones were trained for their role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.)
- Staff took steps, including working with other agencies, to protect patients from abuse, neglect, discrimination and breaches of their dignity and respect.
- The practice carried out appropriate staff checks at the time of recruitment and on an ongoing basis. Work was in progress to bring employment information up to date regarding staff transferred to the provider organisation such as training, skills and qualifications.
- There was an effective system to manage infection prevention and control. Minor changes were needed to ensure that the cleaning team were following good infection control practices. Steps were taking place to assure that the practice had the correct and up to date information regarding staff's immunisation status.
- The practice had arrangements to ensure that facilities and equipment were safe and in good working order.
- Arrangements for managing waste and clinical specimens kept people safe.

Risks to patients

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

- Some arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness, busy periods and epidemics. However, the reduction in GP availability latterly had impacted on how the service was delivered, such that there was not a GP present at all times when the practice was open. We were told that staff could call a GP at another location for advice.
- There was an effective induction system for temporary staff tailored to their role.
- The practice had the necessary equipment to deal with medical emergencies, although concerns were raised regarding the availability of Oxygen. Staff were suitably trained in emergency procedures. The practice had not risk assessed that the emergency medicines did not meet with the United Kingdom Resuscitation Council (UKRC)guidance.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections including sepsis.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

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

- The care records we saw showed that information needed to deliver safe care and treatment was available to staff.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made timely referrals in line with protocols.

Appropriate and safe use of medicines

Requires improvement

Are services safe?

The practice had some systems for the safe handling of medicines.

- There were some systems for managing and storing medicines, medical gases, emergency medicines and equipment to minimise risks. However, some medicines were not stored securely and allowed the potential of access by unauthorised staff and the storage of some vaccines had the potential to compromise them being kept at the optimum temperature. We were told following the inspection that this had been addressed.
- Staff prescribed and administered or supplied medicines to patients and gave advice on medicines in line with current national guidance. The practice had reviewed its antibiotic prescribing and taken action to support good antimicrobial stewardship in line with local and national guidance.
- Patients' health was monitored in relation to the use of medicines and followed up on appropriately. Patients were involved in regular reviews of their medicines.
- There were some systems for the logging and monitoring of the prescription stationery used in the practice. However, when staff logged the return of stationery to safe storage at the end of the working day there was no auditable system of tracking where this was used in the premises. Staff were leaving prepared prescriptions ready for patient collection to take to the pharmacy of their choice unsecured overnight. We were told following the inspection this had been addressed.

Track record on safety

The practice had a good track record on safety.

- There were risk assessments, with the exception of COSHH (Control of substances hazardous to health, in relation to safety issues, and emergency medicines.
- The practice monitored and reviewed safety using information from a range of sources.
- The provider had carried out regular audits for health and safety, however there was no trained health and safety staff lead at the practice or within the organisation.

Lessons learned and improvements made

The practice had a system where they learned and made improvements when things went wrong.

- Staff understood their duty to raise concerns and report incidents and near misses.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice.
- The practice acted on and learned from external safety events as well as patient and medicine safety alerts.

Please refer to the evidence tables for further information.

Requires improvement

Are services effective?

We rated the practice as requires improvement for providing effective services. We rated the population groups Long term conditions and Mental health as requires improvement, the population groups of Older people, Families, Children and young people, Working age people (including those recently retired and students) and People whose circumstances may make them vulnerable as good.

This was because :

The practice were unable to evidence patients were receiving the care and treatment in line with national guidance. There were vacancies in clinical staffing required to maintain meeting the patient's needs including patients with long term conditions and mental health needs.

Effective needs assessment, care and treatment

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

- Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

The practice had opted out of fully using the national Quality and Outcomes Framework (QOF) and were using some indicators to provide a baseline or register of patients identified as being at higher risk and need for support. This meant there were gaps in comparable data with other GP services to establish their effectiveness and they were unable to evidence patients in these groups received care and treatment in line with national guidance. The practice used an alternative quality improvement scheme implemented by Somerset Clinical Commissioning Group, the Somerset Practice Quality Scheme (SPQS).

Older people:

- Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. The practice used an appropriate tool to identify patients aged 65 and over who were living with moderate or severe frailty. Those identified as being frail had a clinical review including a review of medicines.
- The practice worked closely with the two residential homes in Wincanton. Daily scheduled phone calls were made to each home each morning by a GP to manage concerns and problems. Paramedic practitioners and the practice pharmacist regularly visit the homes to provide support and advice.
- The practice work with the local Complex Care team to improve the management of patients with fragility.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.

People with long-term conditions:

This population group was rated requires improvement for effective because:

- There was information to show that patients with long-term conditions did not always have a structured annual review in a timely way to check their health and medicines needs were being met.
- For those patients identified with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long term conditions had received specific training. The practice was currently using bank nurses for the care for patients with a long term respiratory condition.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- Most adults with newly diagnosed cardiovascular disease were offered statins for secondary prevention. People with suspected hypertension were offered ambulatory blood pressure monitoring and patients with atrial fibrillation were assessed for stroke risk and treated as appropriate.
- The practice was able to demonstrate how it identified patients with commonly undiagnosed conditions, for example, diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.

Requires improvement

Are services effective?

- The practice's performance on quality indicators (QOF) 2016/2017 for long term conditions was mixed compared to local and national averages. Additional information supplied by the organisation showed that they are on target or above for some areas and below target to the national averages for others. They were aware of the issues and have attributed this to the changes in staffing levels and have a programme in place to address the concerns.

Families, children and young people:

- Childhood immunisation uptake rates were above the target percentage of 90%.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation.
- The practice has regular monthly children's multi-disciplinary team meetings to discuss patients at risk or the potential of risk.

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

- The practice's uptake for cervical screening was 74%, which was below the 80% coverage target for the national screening programme, but above the national average of 72%.
- The practice's uptake for breast and bowel cancer screening was above the national average.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example, before attending university for the first time.
- Patients had access to appropriate health assessments and checks. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.

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

This population group was rated requires improvement for effective because:

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services. There was a system for following up patients who failed to attend for administration of long term medicines.
- Patient outcome indicators for this population group were below the national averages.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- The practice offered annual health checks to patients with a learning disability. However, an audit of health checks for patients with a learning disability showed that they were behind in achieving this with all their patients. A programme of review was in progress utilising the support from the health coach team to provide support to patients to attend.

Monitoring care and treatment

The practice had a programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.

The practice's performance on quality indicators (QOF) 2016/2017 for long term conditions was mixed compared to local and national averages. Additional information supplied by the organisation showed that they are on target or above for some areas and below target to the national averages for others for reviews of patients with diabetes, asthma and mental health.

Where the practice did not use the QOF as a measure to check that specific areas of care and support were achieved with patients they had a programme of priority areas which they had identified as part of their participation in SPQS. These were for 2018/2019:

- Improved diabetic care
- Dementia
- Bone health
- Patients over the age of 65 risk of falls
- Increase the number of patients attending for an annual review of hypertension
- Increase the number of patients with a learning disability attending for an annual review

The practice used information about care and treatment to make improvements. Where appropriate, clinicians took part in local and national improvement initiatives.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. However, the practice had identified they did not have enough GPs employed (1.40 FTE) to meet patients' needs and was expecting two new part-time GPs to commence working at the practice at the end of July beginning of August 2018 which would raise the number to 2.68 FTE.

- Staff had appropriate knowledge for their role, for example, to carry out reviews for people with long term conditions, older people and people requiring contraceptive reviews.
- Staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.
- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with ongoing support. There was an induction programme for new staff. This included one to one meetings, appraisals, coaching and mentoring. There was no formal system for clinical supervision and revalidation for practice nurses and advanced nurse practitioners in the practice.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

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

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

Helping patients to live healthier lives

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

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their own health, for example through social prescribing schemes. Key activities have included 'Thincanton' a 12-week weight loss group, the creation of support groups such as for Fibromyalgia (widespread stiffness, pain and extreme tiredness), working and communicating with other organisations in the local area such as charitable organisations providing a broad range of support for people of all ages.
- Staff discussed changes to care or treatment with patients and their carers as necessary.

Requires improvement

Are services effective?

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

Consent to care and treatment

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

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately.

Please refer to the evidence tables for further information.

Good

Are services caring?

We rated the practice as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from patients was positive about the way staff treat people.
- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- The practice's GP patient survey results (2017) were in line with local and national averages for questions relating to kindness, respect and compassion.

Involvement in decisions about care and treatment

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

- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.
- The practice identified carers and supported them.
- The practices GP patient survey results (2017) were in line with local and national averages for questions relating to involvement in decisions about care and treatment.

Privacy and dignity

The practice respected patients' privacy and dignity.

- When patients wanted to discuss sensitive issues, or appeared distressed reception staff offered them a private room to discuss their needs.
- Staff recognised the importance of people's dignity and respect. They challenged behaviour that fell short of this.

Please refer to the evidence tables for further information.

Good

Are services responsive to people's needs?

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

Responding to and meeting people's needs

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

- The practice understood the needs of its population and tailored services in response to those needs.
- Telephone, GP and web consultations were available which supported patients who were unable to attend the practice during normal working hours.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services.
- The practice provided effective care coordination for patients who are more vulnerable or who have complex needs. They supported them to access services both within and outside the practice.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services. Such as the local complex care hub teams, a collaboration between health and social services (including district nursing, elderly mental health, adult social care teams) joined the practice twice weekly to discuss and share care planning.
- Health coaches provided support to patients across all of the patient population groups to provide information, signpost to external support and information and to promote patients taking the lead in managing their own health and wellbeing.
- The practice offered a minor injury service led by the ANPs for people living and working in the area.

Older people:

- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GP, practice nurse and paramedic practitioners also accommodated home visits for those who had difficulties getting to the practice due to limited local public transport availability.
- Patients were offered a 15-minute appointment to ensure their care needs were met.
- Influenza vaccinations were provided on a domiciliary basis to sheltered housing schemes and to patients that are not housebound.
- Health coaches link with coffee mornings at sheltered housing complexes for liaison purposes.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- The practice held regular meetings with the complex care team to discuss and manage the needs of patients with complex medical issues.
- The practice ensure that advanced care planning and treatment escalation plans are in place and introduced "Just-in-case" (key medicines for symptom control) boxes at an early stage where appropriate to ensure adequate symptom control in patients deteriorating unexpectedly.
- Health coaches worked with patients using motivational interviewing and goal setting to maximise self-care. The practice used outcome measures (Patient Activation Measure scores - the knowledge, skills and confidence a person has in managing their own health and care) to support this work.
- The practice health coaches ran a weight reduction programme twice a year including education and support from outside speakers.
- The practice had started a low carbohydrate programme, with one to one support for looking at getting Type 2 diabetics into remission and preventing pre-diabetics from becoming diabetic.
- The practice supports the local community and hosts public health education events which has included diabetes, heart disease, men's health and mental health.

Families, children and young people:

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.

Good

Are services responsive to people's needs?

- The Health coaches linked with the Balsam Centre (healthy living centre) to look at developing youth services in the local area.

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

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- They provided extended hours appointments on a Wednesday evening and every fourth Friday evening with sessions provided by a GP, nurse practitioner and a practice nurse. They worked with other practices in the locality to provide access every other weekday evening and on Saturday mornings.
- They have recently implemented the use of e-consult to enable patients to access advice from the GPs remotely whenever is convenient for them.
- The practice ran a campaign to encourage patients to use the electronic prescription requests. They stopped accepting telephone requests for prescriptions on safety grounds and in line with national guidance, however they routinely issue two months of medication (where safe and appropriate) to improve convenience and compliance.

People whose circumstances make them vulnerable:

- The practice knew of the patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. The practice told us this was through the recording process in patients records which flagged up if patients were in this category. The practice had not fully instigated a formal register for all of the patients in these circumstances.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.
- One to one health coach support was offered to vulnerable patients where appropriate.
- Those patients with substance misuse were seen and given signposting advice.
- The practice had a dedicated practice cancer nurse which meant there was continuity of care between other services in regard to patients care planning, treatment and support.

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

- Staff had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- Patients experiencing poor mental health, including dementia who failed to attend were proactively followed up by a phone call from a health coach and if there were concerns referred to the clinical team.
- Patients currently had access to a community psychiatric nurse who was on secondment to the practice which meant that they were able to gain access to support without a complex referral process or attend other locations.
- The practice staff have trained as dementia friends and were behind and involved in the project for the development of Wincanton as a dementia friendly place.
- The practice told us they were working towards the development of safe places for people with dementia in distress. Their health coach team established "Memory Lane" a drop in, safe place for patients with cognitive problems.

Timely access to care and treatment

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

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- Patients have mixed opinions regarding the appointment system being easy to use.
- The practice's GP patient survey results (2017), prior to the change in provider, were in line with local and national averages for questions relating to access to care and treatment.

Listening and learning from concerns and complaints

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

Good

Are services responsive to people's needs?

- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. The practice learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care.

Please refer to the evidence tables for further information.

Good

Are services well-led?

We rated the practice as good for providing a well-led service.

Leadership capacity and capability

The leadership team had changed since Symphony Health Services (SHS) took over the running of the practice in October 2017. Changes meant that one member, a GP, of the previous partnership and management team remained. All staff were now salaried with a lead GP who was also the registered manager, there was a new lead for nursing staff and a new practice manager. SHS told us they were in the process of establishing and providing administration and governance support including HR, maintenance, finance and quality assurance processes. At the time of this inspection some aspects were being assessed and in the process of being addressed others were established such as finance administration.

At practice level, leaders were establishing their roles and developing the skills to have the capacity and knowledge to deliver high-quality, sustainable care under the framework of SHS, the provider.

- Leaders were working with the provider to identify issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.

Vision and strategy

The provider had a vision "to provide healthcare which is available to a whole population and create a partnership between patient and health profession which ensures mutual respect, holistic care and continuous learning and training."

- The practice team had an understanding of the vision of what the provider was aiming to achieve and were involved in the changes being made to deliver high quality, sustainable care.
- The strategy was in line with health and social care priorities across the region. The practice planned its services to meet the needs of the practice population.
- The provider monitored progress against delivery of the strategy.

Culture

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

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- The practice staff were focused on meeting the needs of patients.
- Leaders and managers acted on staffs behaviour and performance that was inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. There was a programme for staff to receive regular annual appraisals. Staff were supported to meet the requirements of professional revalidation where necessary.
- There was an emphasis on the safety and well-being of all staff. Although clinical staffing levels had impacted upon staff having the right support at the right time within the practice location.
- The practice actively promoted equality and diversity. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

Governance arrangements

Most arrangements were in the process of being either implemented or embedded to ensure clear responsibilities, roles and systems of accountability to support good governance and management both at practice and provider level. The provider had implemented new areas of governance and assessment of the quality of the services provided such as oversight, audit and support although it was too early to show that this was effective.

- The governance and management of joint working arrangements across the provider organisation and with the local area shared services such as the complex care team promoted co-ordinated person-centred care.

Good

Are services well-led?

- Staff were clear on their roles and accountabilities in respect of safeguarding and infection prevention and control. However, in other aspects such as recruitment, health and safety and management of the location these were still being formalised.
- The provider had implemented a portfolio of new and updated corporate policies, procedures and activities to ensure safety and assure themselves that they were operating as intended. These were in the process of being adopted at the practice fully and there were some systems in place to monitor they were being effectively adhered to.

Managing risks, issues and performance

There were processes for managing risks, issues and performance.

- There was a process to identify, understand, monitor and address current and future risks including risks to patient safety. Additional training and support was needed at practice and provider level to ensure health and safety monitoring was carried out by trained and knowledgeable persons.
- The provider was aware of the shortfalls in clinical cover, GP and nursing staff, and was implementing plans to address this with the employment of two new GPs and seeking additional nursing staff.
- The practice had processes to manage current and future performance. The provider had set up a focussed quality monitoring system at practice and provider level for monthly reporting on key areas which included safety alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.
- The practice had plans in place and had trained staff for major incidents.
- The provider considered and understood the impact on the quality of care of service changes or developments.

Appropriate and accurate information

The practice operated on appropriate and accurate information.

- Quality and operational information was used by the provider to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The provider used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses such as clinical staffing levels.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

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

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There was evidence at practice level and provider level there were systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement. This included working with the Patient Participation Group (PPG) and other local organisations to provide additional support to the local community. The provider also used learning from Wincanton and the other services to develop systems to improve the outcomes for patients. For example, a prescription hub with appropriately trained staff to monitor and process repeat prescriptions so that patient's requests were dealt with in a timely way and support given when needed.
- Staff knew about improvement methods and had the skills to use them.

Good

Are services well-led?

- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements. These were shared across the organisation by the provider to improve outcomes for patients and for staff, working practices.
- The practice had just commenced participating in an e-consult service pilot funded by the clinical commissioning group.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.

Please refer to the evidence tables for further information.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered persons had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular: The provider must have safe systems for fire safety, training for persons undertaking risk assessments, infection control and chemicals stored and used at the practice. The provider must have information available to support staff have been recruited appropriately and suitable for their role and that the information regarding their immunisation status is sought and kept. The provider must monitor and address the gaps in clinical staff available required to maintain meeting the patient's needs.There was no proper and safe management of medicines. In particular:The provider must continue with assessing and putting actions in place to ensure medicines are stored safely and that sufficient stock of Oxygen is kept at the practice.The provider must continue to review the safe storage and handling of prescription stationery.This was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.