The Wembley Practice

Inspection report

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

Ratings

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

Overall summary

This practice is rated as Good overall. (No previous inspection)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? - Good

We carried out an announced comprehensive inspection at The Wembley Practice as part of our inspection programme.

At this inspection we found:

- The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. 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 strong focus on continuous learning and improvement at all levels of the organisation. The practice used innovative and proactive methods to assure effective communications across the organisation. For example, the provider had initiated an online networking tool to share learning, information, ideas including social events and peer support. The provider was using this online tool to monitor the performance and utilising the resources, such as managing staffing levels when the demand increased for appointments.
- The provider sent monthly staff newsletters. This provided them with any information about the practice including clinical updates, staffing matters, training opportunities and any changes within the practice group.
- Staff had access to a suite of bespoke training materials to cover the scope of their work and meet their learning needs. This included access to a corporate learning and development portfolio featuring face-to-face, web-based and blended training programs tailored for each staff role. For example, fortnightly web-based training for healthcare assistants and nurses' development support, bi-monthly development for practice management, fortnightly consultant led development program for clinicians and monthly face-to-face training for the physician associate and pharmacist.
- The practice used innovative and proactive methods to improve patient outcomes and worked with other local and national healthcare providers to share best practice. This included arranged events such as a health and wellness day and a diabetes prevention week.
- An interactive online messaging system, 'message my GP' was available for patients to direct non-urgent queries to a GP, with a response turnaround of up to 48 hours.
- The practice used information technology systems to monitor and improve the quality of care. The electronic dashboard used across the provider group was an effective tool for understanding the practice's comparative performance across a range of clinical indicators and had provided access to bespoke searches relevant to medicines management and effective care. This enabled the practice to readily identify when follow up tests and screening were due in the management of patients with long term conditions and those experiencing poor mental health.
- The practice had strong visible and clinical managerial leadership and governance arrangements.

We saw an area of outstanding practice:

- The provider worked in collaboration with a social enterprise and set up a website facility called 'Talking from the heart', which was aimed at patients from ethnic minorities suffering from mental health conditions. This was set up due to the stigma surrounding mental health and communication problems in some communities, which often meant patients did not seek support. In collaboration with several ethnic minority groups and mental health professionals, they developed four short films in three spoken languages, which could be used by primary care practitioners with their patients or with community groups. The films combined medical and religious advice and addressed stigma.

Overall summary

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

- Take action to ensure the practice safeguarding leads are recorded clearly in all the safeguarding policies.
- Monitor and continuously review the system in place for checking vaccine fridge temperatures.
- Continue to monitor and improve on child immunisation uptake.
- Continue to monitor and improve the uptake for cervical, bowel and breast cancer screening.
- Review exception reporting and take appropriate action where progress is not achieved as expected.

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

Population group ratings

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

Our inspection team

Our inspection team was led by a CQC lead inspector. The team included a GP specialist adviser and a practice manager specialist adviser.

Background to The Wembley Practice

The Wembley Practice is a GP practice located at the Westmore Unit, Wembley Centre for Health and Care, Wembley, London. The practice lies within the administrative boundaries of Brent Clinical Commissioning Group (CCG) and provides primary medical services to approximately 10,744 patients and holds an Alternative Provider Medical Services (APMS) contract.

The Wembley Practice is managed by the provider organisation AT Medics Limited. The management contract commenced in January 2017, following the relocation of Brent GP Access walk-in centre to a different wing of the centre. AT Medics Limited is run by six GP directors who are all practicing GPs and they manage over 30 GP locations across London.

The surgery is situated on the ground floor, a wing of the large, modern, purpose-built health centre where the previous Brent GP access walk-in centre was situated. It consists of nine clinical rooms, a dedicated reception and back office and a range of offices. The centre comprises four other GP practices, a pharmacy, a dental clinic and other community services. It is located in a residential area, near the busy A404 Wembley High Road. The health centre building is owned and managed by NHS Property Services. Accessible facilities are available throughout the building. There is a public pay and display car parking facility.

The practice population is ethnically diverse with a large proportion (68%) from an Asian background. Less than 2% of the population are aged over 65. The practice area is rated in the fifth most deprived decile of the national Index of Multiple Deprivation (IMD). People living in more deprived areas tend to have a greater need for health services.

The practice team comprises of how two female and two male GPs who collectively work a total of 22 sessions a week. Also employed are two physician associates (physician associates support doctors in the diagnosis and management of patients), a clinical pharmacist, one full-time practice nurse, two full-time healthcare assistants, a phlebotomist, a practice manger and 10 reception and administration staff. They were supported by a AT Medics clinical director and a director of operations and business development.

The practice opening hours are between 8am and 6.30pm Monday to Friday and extended hours are offered on Saturday between 9am and 1pm. Pre-bookable appointments can be booked up to four months in advance. When the practice is closed, patients are

advised to contact NHS 111 or the GP access hub located in the health centre. The details of the out-of-hours service are communicated in a recorded message accessed by calling the practice when it is closed and on the practice website.

The practice provides a wide range of services including chronic disease management, flu immunisations, childhood immunisations, child health surveillance, cervical screening, phlebotomy, maternity services and health checks for patients 40 years plus. The practice is registered with the Care Quality Commission (CQC) to provide the regulated activities of diagnostic and screening services; family planning; surgical procedures, maternity and midwifery services and treatment of disease, disorder or injury.

The practice has not previously been inspected by the CQC.

Good

Are services safe?

We rated the practice as good for providing safe services.

Safety systems and processes

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

- The practice had systems to safeguard children and vulnerable adults from abuse. For example, there was a child and adult safeguarding policy in place with a separate contact details list. All staff received up-to-date safeguarding and safety training appropriate to their role and they knew how to identify and report concerns. Reports and learning from safeguarding incidents were available to staff. Staff who acted as chaperones were trained for their role and had received a DBS check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- Staff took steps, including working with other agencies, to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The practice carried out appropriate staff checks and on an ongoing basis.
- There was an effective system to manage infection prevention and control.
- The practice had arrangements to ensure that facilities and equipment were safe and in good working order.
- Arrangements for managing waste and clinical specimens kept people safe.

Risks to patients

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

- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness, busy periods and epidemics.
- There was an effective induction system for temporary staff tailored to their role.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections including sepsis. At the time of inspection, the non-clinical staff we spoke to regarding sepsis were not aware of how to identify the presentation by an acutely unwell patient; however, following inspection, the practice ensured that all non-clinical staff had received training in sepsis management.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

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

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

Appropriate and safe use of medicines

The practice had systems for appropriate and safe handling of medicines; although the system for vaccines required monitoring.

- The systems for managing and storing medicines, including medical gases, emergency medicines and equipment, minimised risks. There was a system in place for managing vaccines, including daily vaccines fridge temperature checks, however on the day of inspection we found that vaccines fridge temperature monitoring checks had been omitted on two occasions. The practice was made aware of this and a significant event form was completed. Changes were made to minimise the risk of further omissions by ensuring that each room where the two vaccines fridges were stored, had a named accountable person responsible for the daily fridge temperature checks. This was to be followed up by the evening staff would carry out checks at the end of the day to ensure that the checks were completed.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with current national guidance. The practice had reviewed its antibiotic prescribing and acted to support good antimicrobial stewardship in line with local and national

guidance. Prescribing data for 2016/17 showed a very high prescribing rate of 1.99, when compared to the local average of 0.71 and the national average of 0.98. However, this was due to the practice being a former walk in centre, which carried out prescribing activity; therefore, all prescribing prior to January 2017 when the practice took over, was attributed to this facility. The removal of the walk-in centre in January 2017 showed a reduction in prescribing activity.
- There were effective protocols for verifying the identity of patients during remote or online consultations.
- Patients' health was monitored in relation to the use of medicines and followed up appropriately. Patients were involved in regular reviews of their medicines.

Track record on safety

The practice had a good track record on safety.

- There were comprehensive risk assessments in relation to safety issues.
- The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture of safety that led to safety improvements.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

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

Please refer to the Evidence Tables for further information.

Good

Are services effective?

We rated the practice and all of the population groups as good for providing effective services overall .

(Please note: Any Quality Outcomes (QOF) data relates to 2016/17. QOF is a system intended to improve the quality of general practice and reward good practice.*)*

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.
- The practice used technology to improve treatment and support patients' independence. For example, there was an interactive on-line messaging system on their website, 'message my GP', which was available for patients to direct non-clinically urgent queries to their GP, with a response turnaround of up to 48 hours.
- The practice benefited from a corporate business intelligence tool, 'EZ Analytics', which enabled monitoring and improvement in the quality of care of over 700 clinical and non-clinical indicators, as well as corporate and operational performance indicators.
- The practice also benefited from 'EZ checklist', a tool that provided access to bespoke searches relevant to medicines management and effective care. This enabled the practice to readily identify when follow up tests and screening were due in the management of patients with long term conditions and those experiencing poor mental health. The practice demonstrated that the system and continuous patient recall had improved compliance of tests and screening since January 2017, when they had taken over the practice.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

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 medication.
- Patients aged over 75 were invited for a health check. If necessary, they were referred to other services such as voluntary services and supported by an appropriate care plan. Over a 12-month period the practice had carried out 57 health checks, 87% of the over 75 practice population.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice had arrangements for adults with newly diagnosed cardiovascular disease including the offer of high-intensity 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 they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- The practice held a Diabetes Prevention Week in April 2018, for patients to learn if they were at risk of Type two diabetes, by taking an online test or at the practice. Patients found to be at risk were signposted to the NHS Diabetes Prevention programme.

Good

Are services effective?

- Data provided by the practice showed between August 2017 and March 2018, showed the practice was the highest achiever in the GP locality network for diabetes and reached a triple target achievement, from 23% in August 2017 to 44% in March 2018, for the nine diabetes key processes, which reduced complications and mortality. for the nine diabetes key processes, which reduced complications and mortality.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. QOF data for 2016/17 showed the uptake rates were below the target rate of 90% and above. For example, uptake rates for two-year olds ranged between 88% and 89%. The practice carried out daily immunisation clinics and child immunisation data provided by the practice showed between July 2017 and April 2018, uptake rates for two-year olds ranged between 90% and 93%, which was higher than the target rate.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation.

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

- The practice's uptake for cervical screening for 2016/17 was 54%, which was lower than the national average of 72%. The practice told us that they had a large proportion of young patients, most of whom were not sexually active and this affected cervical screening uptake. The practice nurse told us that they followed up non-attenders by encouraging them to re-book another appointment to discuss any concerns they may have. An alert was placed on their records and there was daily monitoring of uptake. Data provided by the practice showed their uptake rate for May 2018 had increased to 80%.
- The practices' uptake for breast and bowel cancer screening was below 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 including NHS checks for patients aged 40-74. 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.
- The practice participated in an enhanced service for patients with learning disabilities. They worked in collaboration with the CCG on campaigns such as the "The Big Health Check Day", which provided a range of services, for people with learning disabilities and their families. Fourteen patients on the learning disabilities register had their holistic review which was carried out either at the surgery or in the patient's home, if more appropriate. Patients with a learning disability were ooffered annual health checks.
- The practice was part of a federation of local practices and used the Whole Systems Integrated Care (WSIC) for vulnerable patients. This was designed to focus on individuals and their needs and implementing care plans by bringing together different parts of the health and social care system, to provider better communication and information sharing.

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

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services. There was a system for following up patients who failed to attend for administration of long term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.

Good

Are services effective?

- 86% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This is comparable to the national average of 84%.
- 97% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This is comparable to the national average of 90%.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example, 94% of patients experiencing poor mental health had received discussion and advice about alcohol consumption. This is comparable to the national average of 91%.
- 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 provider worked in collaboration with a social enterprise and commissioned a resource project called 'Talking from the heart', which was aimed at providing support and practice resources for patients from ethnic minorities suffering from mental health conditions.

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. Where appropriate, clinicians took part in local and national improvement initiatives. The diabetes audit was carried out to assess whether they were achieving the required standard of 80% in reducing diabetic complications in type two diabetes patients, in performance areas which included foot examinations and body mass index (BMI) checks. The first cycle audit showed the practice was performing below the required standard of 80% in five out of nine performance areas. The practice made changes which included formulating a management plan and allocating a clinician, as well as a lead administrator to coordinate the recall process. Alerts were added to the patient records and patients who had not received a blood test or foot check in the last 12 months were recalled, all intervention actions were followed up and data was shared in clinical and practice meetings. There was an improvement after the second cycle audit as the practice had met the required standard of 80% in all nine performance areas.

The most recent published QOF results showed the practice had achieved 99.5% of the total number of points available, which was above the CCG and the national average of 96%.

- The overall exception rate was 14%, when compared to the CCG and national average of 6%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate).
- Exception reporting rates for clinical areas such as coronary heart disease, stroke, Chronic Obstructive Pulmonary Disease (COPD), depression and diabetes were above local and national averages. For example, exception reporting rates for depression were 59%, when compared to the local average of 22% and the national average of 23%. The practice explained that they had high exception reporting due to the large number of new patient registrations since they took over the practice in January 2017. They told us that in the last quarter of the year, they had registered a total of 631 new patients.
- The practice used information about care and treatment to make improvements.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

- Staff had appropriate knowledge for their role, for example, to carry out reviews for people with long term conditions, older people and people requiring contraceptive reviews.
- Staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.
- The practice understood the learning needs of staff and provided 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. This included an induction process, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. The induction process for

Good

Are services effective?

healthcare assistants included the requirements of the Care Certificate. The practice ensured the competence of staff employed in advanced roles by audit of their clinical decision making.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

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

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

Helping patients to live healthier lives

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

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their own health, for example through social prescribing schemes.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and 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.
- Results from the National GP Patient Survey showed patients felt they were treated with compassion, dignity and respect. The practice was comparable with others both locally and nationally for its satisfaction scores with GPs and nurses.

Involvement in decisions about care and treatment

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

- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.
- The practice proactively identified carers and supported them.
- Results from the National GP Patient Survey showed patients felt they were involved in decisions about their care and treatment. The practice was in line with local and national satisfaction scores for consultations with nurses and GPs.

Privacy and dignity

The practice respected patients' privacy and dignity.

- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Staff recognised the importance of people's dignity and respect. They challenged behaviour that fell short of this.

Please refer to the Evidence Tables for further information.

Good

Are services responsive to people's needs?

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

Responding to and meeting people's needs

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

- The practice understood the needs of its population and tailored services in response to those needs.
- Telephone and web GP 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.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or supported living scheme.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.

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 local district nursing team to discuss and manage the needs of patients with complex medical issues.
- The practice held monthly diabetes clinics.

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.

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

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care; for example, they offered email and telephone consultations and Saturday appointments.
- The practice offered out of area registrations which enabled patients who worked in the area to access convenient services.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including travellers, homeless people and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice. Registered patients with no fixed abode could use the practice address.
- Patients with learning disabilities were offered home visits if they had difficulty attending the practice. Longer appointments were offered.

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

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice carried out mental health and dementia reviews. Patients who failed to attend were proactively followed up by a phone call from a GP.

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.

Good

Are services responsive to people's needs?

- Patients with the most urgent needs had their care and treatment prioritised.
- Patients reported that the appointment system was easy to use.

Listening and learning from concerns and complaints

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

- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. The practice learned lessons from individual concerns, complaints and from analysis of trends. It acted as a result to improve the quality of care. For example, all staff attended a training session held by a representative for guide dogs for the blind following a patient complaint.

Please refer to the Evidence Tables for further information.

Good

Are services well-led?

We rated the practice and all of the population groups as good for providing a well-led service.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality, sustainable care.

- There was a clear vision and set of values. The practice had a realistic strategy and supporting business plans to achieve priorities. The practice developed its vision, values and strategy jointly with patients, staff and external partners.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The practice planned its services to meet the needs of the practice population.
- The practice monitored progress against delivery of the strategy.

Culture

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

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- The practice focused on the needs of patients.
- Leaders and managers acted on behaviour and performance consistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted innovative, interactive and co-ordinated person-centred care.

Good

Are services well-led?

- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control.
- Practice leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Practice leaders had oversight of national and local safety alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.
- The practice had plans in place and had trained staff for major incidents.
- The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

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

Engagement with patients, the public, staff and external partners

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

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

Continuous improvement and innovation

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

- There was a focus on continuous learning and improvement.
- Staff knew about improvement methods and had the skills to use them.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.

Good

Are services well-led?

- 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.