Priory Medical Centre

Inspection report

Priory Medical Centre
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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?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Overall summary

This practice is rated as Good overall. (Previous inspection 07 2016 – Good)

The key questions are rated as:

Are services safe? – Requires Improvement

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 Priory Medical Centre on 1 May 20178 as part of our inspection programme.

At this inspection we found:

- The practice had systems to manage risk so that safety incidents were less likely to happen. However we found that learning from incidents and complaints could be improved.
- 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 difficult to use in particular their ability to get through to the practice by telephone. Patients reported that they were able to access urgent care when they needed it, but that it was difficult to book a routine appointment.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.
- The practice had considered succession planning and the issues that the local area faced. They had a broad range and skill mix of staff.
- The practice were responding to an increase in patient demand and a reduction in the number of GPs by re-shaping services with a multi-disciplinary team.
- Priory Medical Centre was part of a Group known as Priory Medical Group (PMG). PMG were part of a federation that provided care to 130,000 patients and were committed to working at scale with other providers to meet the needs of the population of York. The practice followed the Primary care home model which was developed by the National Association of Primary Care (NAPC), the model brought together a range of health and social care professionals to work together to provide enhanced personalised and preventative care for their local community.

We saw areas of outstanding practice:

The practice had developed a wound care protocol in collaboration with the Clinical Commissioning Group. This had been shared across the locality and had resulted in an improved service to patients and a reduced prescribing cost to the NHS.

PMG employ a range of health care professionals (for example: registered nurses, care workers, physiotherapist and occupational therapists) to work as York Integrated Care Team (YICT). They also work with Social services and voluntary organisations. Their innovative and person centred approach, contacting patients who may be in need of support, assured appropriate support such as short term care and regular reviews. The team reviewed all hospital admissions and discharges each day for patients in the federation practices and another rural practice. They worked with patients to review reasons for admissions and to plan care and support to minimise the risk of readmission. They also reviewed discharges to ensure that the patient had the care and support they needed to enable them to remain independent for longer. We saw evidence that each month 13 – 28 patients avoided admittance to hospital with this support.

The nursing team were innovative and forward thinking. They had won and been nominated for several awards following improvements to the quality of care for patients in wound care and early identification of pre-diabetes. The awards included General Practice Nursing Team of the Year wound care team finalists 2017, General Practice Nursing Team of the Year dermatology team finalists 2017, and General Practice Nursing awards 2018 People's Choice award finalist. The Nurse Manager had received an invitation to Buckingham Palace in March 2018 in recognition of services for engagement in front line nursing.

The areas where the provider should make improvements are:

Review and improve the system in place and assure themselves there is oversight for checking emergency medicines and equipment.

Overall summary

Implement an action plan to ensure that issues identified during infection control audit are dealt with within an agreed timescale.

Develop a culture of significant event identification, analysis and dissemination of learning to all staff.

Improve the process for analysis and dissemination of learning to all staff from complaints.

Identify and increase the number of patients on the palliative care register to include all patients who have a life-limiting illness.

To improve patient access to routine appointments and named clinicians to improve continuity of care and choice for patients.

Review the higher than average Quality and Outcomes Framework exception reporting figures to assure themselves that these are accurately exception reported.

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 second CQC inspector.

Background to Priory Medical Centre

Primary Medical Centre is situated at Cornlands Road, Acomb, York, YO24 3WX. It is part of a larger group with nine locations and the Provider is Priory Medical Group (www.priorymedical.com). There are currently approximately 57,700 patients registered with the group and 10202 on the practice list at Priory Medical Centre. The provider is in the process of changing their registration with the Care Quality Commission to be that of one location with 8 branches as all patients registered with the group can access all locations. The head office is based at Cornlands Road which houses the patient call handling team, administration team, management team, human resources team and urgent care centre, as well as staff providing care for routine appointments. This was the only location that we inspected on the day.

Priory Medical Centre is open from 8.30am-6pm Monday-Friday. The telephone lines are open from 8am until 6pm. There are extended opening and Saturday morning appointments available Monday to Thursday from 6.30pm until 8pm and on Saturday morning from 8.30am -11.15am which are pre-bookable. The group operate two Urgent Care Centres, one in the east and one in the west of the city. Patients who require an urgent same day appointment ring the central call handling team based at Priory Medical Centre and are booked into the nearest Centre for them. The practice website and leaflet offers information for patients when the surgery is closed. They are directed to the Out of Hours Service provided by Northern Doctors Urgent Care.

The practice provides Primary Medical Services (PMS) under a locally agreed contract with NHS England. The practice is registered with the Care Quality Commission to provide the following regulated activities:

•Treatment of disease, disorder or injury

•Diagnostics and screening procedures

•Surgical Procedures

•Family Planning

The practice is housed in a modern purpose built premises and is a teaching practice for medical students who are studying at Hull and York Medical School (HYMS). It is also a training practice for qualified doctors training to be GPs.

The Public Health General Practice Profile shows that approximately 6.4% of the practice population are of Black and Minority Ethnicity. The level of deprivation within the group population is rated as eight, on a scale of one to ten. Level one represents the highest level of deprivation, and level ten the lowest.

The age/sex profile of the practice is largely in line with national averages. The average life expectancy for patients at the practice is 79 years for men and 83 years for women which is the same as the national averages.

At this inspection we checked, and saw that the previously awarded ratings were displayed, as required, on the practice website and in the practice premises.

Requires improvement

Are services safe?

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

Safety systems and processes

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

- The practice had appropriate systems to safeguard children and vulnerable adults from abuse. All staff received up-to-date safeguarding and safety training appropriate to their role. 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 at the time of recruitment and on an ongoing basis.
- There was a system to manage infection prevention and control; however there was no action plan to ensure that identified issues were followed up. Following the inspection we were told that any infection prevention and control issues that required immediate attention would be actioned.
- The practice had arrangements to ensure that facilities and equipment were safe and in good working order but we found evidence that some checks had not been completed.
- 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, however some were not adequate.

- 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 and further training was planned in this area following an incident.
- 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

There were gaps in practice systems for the safe handling of medicines.

- The systems for managing and storing medicines, including emergency medicines and equipment, were not effective. This was because the system in place to ensure the emergency medicines and de-fibrillator were checked was not robust. We also found evidence of out of date eye care medicine.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with current national guidance. The practice had reviewed its antibiotic prescribing and taken action to support good antimicrobial stewardship in line with local and national guidance.
- 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 on appropriately. Patients were involved in regular reviews of their medicines.
- Systems for prescription safety were in place. However we saw a supply of prescription pads was not stored appropriately.

Requires improvement

Are services safe?

Track record on safety

We identified some gaps in the safety record in the practice.

- There were some issues in relation to safety issues. Risk assessments in relation to health and safety issues in the practice premises were in evidence. However we found that the practice did not have an up to date legionella risk assessment. We were told that this would be done following the inspection. We were provided with evidence following the inspection of an internal legionella risk assessment but this did not meet the current Health and Safety Executive requirements.

Lessons learned and improvements made

The practice displayed limited learning and implementation of 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. However we found that only 4 significant events had been reported. Some staff told us that learning from the significant events was not routinely shared with them and that meetings where significant events were discussed were infrequent. We were told that the practice had only held 2 meetings in the last twelve months but that relevant staff were emailed the outcomes of investigations. We were told that the minutes from these meetings were available on the computer for staff to access but did not see evidence of this on the day. Following the inspection we were provided with evidence of a new significant event policy to help address these issues.
- There were systems for reviewing and investigating when things went wrong. However the practice had limited evidence of learning and sharing lessons and did not identify themes. There was a system in place for complaint handling and complaints we examined on the day were dealt with appropriately.
- 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 care.

(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.
- Online consultations (E consult) were planned to be rolled out this year in 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 were frail or may be vulnerable received a full assessment of their physical, mental and social needs. The practice used an appropriate tool to identify patients aged 65 and over who were living with moderate or severe frailty. Those identified as being frail had a clinical review including a review of 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 offered 361 patients a health check. 423 of these checks had been carried out. This difference in numbers was because the practice did not send invite letters to Nursing / Residential homes. These patients were on the York Integrated Care Team case load so were reviewed at least annually. Also a number of over 75's presented for review prior to being invited and therefore were not sent an invite by letter.
- The practice followed up on older patients discharged from hospital. This was done every day in the practice by the York Integrated Care Team. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- Evidence provided by the York Integrated Care Team showed that this daily intervention prevented between 6-28 hospital admissions each month.
- 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.
- Evidence provided by the York Integrated Care Team showed that daily review of patients with long term conditions who had been discharged from hospital or referred to the team by other services prevented between 6-28 hospital admissions each month.
- 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) they had also taken part in a project to identify patients who were at risk of diabetes.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were in line with the target percentage of 90% or above.

Good

Are services effective?

- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation.
- The practice provided education on healthy eating at a local primary school.

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

- The practice's uptake for cervical screening was 74%, which was in line with the 72% coverage target for the national screening programme.
- The practices' uptake for breast and bowel cancer screening was in line the national average.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks. Checks for patients aged 40-74 were done by the Local Authority. 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):

- 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.
- 81% 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.
- 93% 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.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example 93% of patients experiencing poor mental health had received discussion and advice about alcohol consumption. This is comparable to the national average.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- The practice offered annual health checks to patients with a learning disability.

Monitoring care and treatment

The practice had a programme of quality improvement activity and routinely reviewed effectiveness and appropriateness of the care provided. Where appropriate, clinicians took part in local and national improvement initiatives. This included a pre-diabetes project and de-prescribing initiative.

- The Quality and Outcomes Framework (QOF) allows practices to exception-report (exclude) specific patients from data collected to calculate achievement scores. Exception reporting in the clinical domain was slightly higher than the national average at 13.1% (national average 9.6%). Patients can be exception-reported from individual indicators for various reasons, for example if they are newly diagnosed or newly registered with a practice, if they do not attend appointments or where the treatment is judged to be inappropriate by the GP (such as medication cannot be prescribed due to side-effects). They can also be exception-reported if they decline treatment or investigations. The practice had higher rates for QOF exceptions than local CCG and national averages for some conditions. This was particularly evident in patients with diabetes where the

exception reporting was 18.3% compared to the national average of 11.4%. At the inspection we looked at cardiovascular disease Primary Prevention exception reporting and found that this was done appropriately.
- 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 healthcare assistants included the requirements of the Care Certificate. The practice ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

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

- We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for people with long term conditions and when coordinating healthcare for care home residents. As innovators of the York Integrated Care Team they shared information with, and liaised, with community services, social services and carers for housebound patients and with health visitors and community services for children who have relocated into the local area.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- 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. We saw that the practice had only identified 3 patients on the palliative care register, those with a diagnosis of cancer. No other patients with palliative conditions had been identified for inclusion in the register. Following the inspection we were provided with evidence that the practice were aware of this and had a plan in place to address it.
- Staff encouraged and supported patients to be involved in monitoring and managing their own health, for example through social prescribing schemes.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.

Consent to care and treatment

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

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.

Good

Are services effective?

- 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.

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 percentage of respondents to the GP patient survey who stated that they would definitely or probably recommend their GP surgery to someone who has just moved to the local area was 86% compared to the national average of 79%.

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.
- The percentage of respondents to the GP patient survey who stated that the last time they saw or spoke to a nurse, the nurse was good or very good at involving them in decisions about their care was 91% compared to the national average of 85%, and the same results for GPs were 87% compared to the national average of 82%.

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. They had responded to this need by reshaping services. They had developed two urgent care centres in the group in different localities with multi-disciplinary teams. They also had a routine appointment team and were responding to patient need by increasing the workforce to include mental health specialists and physicians associates later in the year.
- PMG employ a range of health care professionals (for example: registered nurses, urgent care practitioners, advance nurse practitioners, care workers, physiotherapist and occupational therapists) to work as York Integrated Care Team (YICT). They also worked with social services and voluntary organisations. Their innovative approach, contacting patients who may be in need of support, assured appropriate support such short term care could be provided. This integrated person-centred care had enabled patients more choice with their care and support. The team reviewed all hospital admissions and discharges each day.
- The nursing team were innovative and forward thinking. They had won and been nominated for several awards for improving quality of care for patients, including Locality Health Care Practitioner of the Year finalist 2017, General Practice Nursing Team of the Year wound care team finalists 2017, the Nursing in Practice Nurse of the Year finalist 2017, General Practice Nursing Team of the Year dermatology team finalists 2017, General Practice Team of the Year diabetes finalist 2016 and General Practice Nursing awards 2018 People's Choice award finalist. The Nurse Manager had received an invitation to Buckingham Palace in March 2018 in recognition of services for engagement in front line nursing.
- The practice had received negative feedback regarding patient's ability to access routine appointments and a named clinician. Patients also reported that it was difficult to get through by telephone to the practice. This was corroborated by the patient survey results; for example the percentage of respondents to the GP patient survey who gave a positive answer to "Generally, how easy is it to get through to someone at your GP surgery on the phone?" was 63% compared to the national average of 71%.
- The practice had actions in place to address these issues such as increasing the number of telephone lines; releasing GPs back into routine work and recruiting more staff.
- The practice were pro-active in planning their workforce with regard to future risks regarding an older workforce/ lack of recruitment to General Practice. The practice participated in the General Practice Nurse scheme and the Health Care Assistant Apprenticeship scheme. This aimed to recruit staff into General Practice.
- Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services.
- The practice provided effective care coordination for patients who are more vulnerable or who have complex needs. They supported them to access services both within and outside the practice, with services such as Citizens Advice clinics on site and services for patients with substance misuse problems.
- 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 in a care home or supported living scheme. However we were told that patients found it difficult to see a named GP.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GP also accommodated home visits for those who had difficulties getting to the practice due to limited local public transport availability.
- There was a medicines delivery service for housebound patients.
- The nursing team had developed an evidence based wound care protocol and standard operating procedure following an audit of wound dressings. This enabled

patients to have access to the appropriate dressing for their needs, which helped ensured evidence based care and treatment and optimised wound healing. It also cut costs to the practice with regard to excess stock. They worked in collaboration with the CCG to develop an online system for ordering the dressings which was more cost effective for the NHS and this was rolled out to other practices in the Vale of York area. We saw evidence that spending on dressings at one practice in the group had reduced in one month by £651.92.

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 ran a pre-diabetes programme and opportunistically screened patients for diabetes. If they were found to be at risk of developing the disease they were offered an educational session with diet and lifestyle advice.

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.
- The nursing team had instigated and piloted self-administration of a contraceptive injection, which enabled patients to do this at home themselves with initial support from the nursing team.

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

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, extended opening hours and Saturday appointments.
- The practice were piloting online consultations and hoped to offer them to patients later in the year.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.
- Patients were able to self-refer to counselling services.
- The practice operated a violent patient scheme for patients who had been removed from other practices. There were five patients on the register for this service.

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.

Timely access to care and treatment

Patients told us it was difficult to access routine care and treatment from the practice within an acceptable timescale for their needs.

- Patients reported a long wait for routine appointments.
- Waiting times, delays and cancellations were managed by the practice with an action plan to recruit more staff and improve the telephone system.
- Patients with the most urgent needs had their care and treatment prioritised.
- Patients reported that the appointment system was difficult to use with regard to getting through by telephone.

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.
- The complaint policy and procedures were in line with recognised guidance. However the practice did not have a robust system in place to disseminate learned lessons from individual concerns and complaints to staff. We found that there was no evidence of analysis of trends.

Good

Are services responsive to people's needs?

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.
- Most 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.

- Most staff stated they felt respected, supported and valued. They were proud to work in the practice.
- Some staff told us that they would like to have more meetings, including a whole team meeting.
- 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. 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.
- 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 interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control.
- Practice leaders had established policies, procedures and activities to ensure safety but did not always assure themselves that they were operating as intended.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance. We found that increased oversight was necessary by the management team with regard to some monitoring of safety issues.

- There were processes 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. However, the practice could not

Good

Are services well-led?

demonstrate performance of some employed clinical staff as they had not audited their consultations, prescribing and referral decisions, but planned to implement this following the inspection. 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. The practice could provide evidence of prescribing audits and 3 clinical one cycle audits. The practice could also demonstrate quality improvement activity in relationship to the telephone system, which included adding more lines and call handlers and this was an ongoing action.
- 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 but some staff said they did not have sufficient access to information and that communication could be improved with more regular meetings.
- The practice used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

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

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. There was an active patient participation group.
- 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 had limited evidence of making use of internal and external reviews of incidents and complaints. Although there was a system in place for patients to complain to a central complaints team and a policy outlining correct procedures to be followed we found that there was limited evidence of learning being shared and used to make improvements.
- 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..