

Ash Trees Surgery

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. (Previous inspection November 2014 – Good)

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 inspection at Ash Trees Surgery on 26 April 2018 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. They ensured that care and treatment was delivered according to evidence-based guidelines.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- There was a proactive approach to understanding the needs of different groups of people and to deliver care in a way that met these needs and promoted equality. This included people who were in vulnerable circumstances or who had complex needs.
- Services were tailored to meet the needs of individual people and were delivered in a way to ensure flexibility, choice and continuity of care.
- 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.

We saw some areas of outstanding practice:

- A “Listening Service” was established by the practice. This was a free, confidential service facilitated by a volunteer chaplain listener on a weekly basis. Patients we spoke to on the day of inspection spoke highly of the service. In 2017, the service was used by 80 patients, some of whom attended for multiple sessions.
- A counsellor who was specially trained to support patients who were military veterans held a regular clinic at the practice. At the time of inspection the practice held a register of 20 patients who had served in the military.
- The practice had approached the local Citizens Advice Bureau (CAB) to set up a clinic at the practice. Patients could get advice from (CAB) staff about social issues, such as funding for carers. We spoke to patients who used the service, all of whom found it beneficial and told us it had allowed them to access information or funding they would have struggled to otherwise obtain.

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

- Take steps to ensure the fire alarms at the branch practices are being checked regularly.
- Take measures to ensure the safety of the boiler at the main surgery.
- Investigate the reasons for lower than average results in some areas of the last National GP Patient Survey.
- Document verbal complaints made to the practice so they can be used to look for areas of improvement.

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	Outstanding 
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.

Background to Ash Trees Surgery

Ash Trees Surgery is located in Carnforth and is part of the Morecambe Bay Clinical Commissioning Group. The total patient population is approximately 15,000. There are branch surgeries in Bolton-le-Sands, Halton and Silverdale. We visited the main surgery and the Bolton-le-Sands and Halton branch surgeries during this inspection.

The main surgery building in Carnforth has level access with the reception and some patient rooms on the ground floor. There are reserved rooms on the ground floor for patients who cannot use stairs to access the first floor. There is also a pharmacy on site.

The staff team currently comprises 12 partners and four associate GPs. This includes both male and female doctors. Working alongside the GPs are a practice

manager and assistant practice manager, an advanced nurse practitioner, six nurses, five primary health care support workers, 16 administration/reception staff, and a team of patient advisors and clinical auditors.

The practice population includes lower-than-average numbers of people under the age of 18, and a significantly higher-than-average number of people over the age of 65, in comparison with the national averages.

Surgery opening times at Ash Trees are between 8am and 7.30pm on Monday, 8am and 6.30pm on Tuesday and Friday, and 7.30am to 6.30pm on Wednesday and Thursday. Surgery hours at the branches are more restricted. When the surgery was closed the care and treatment needs of the patients were met by an out-of-hours-provider, Bay Urgent Care.

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 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 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. However, some of these could be improved. For example, we were told that the responsibility for checking the fire alarms at one of the branch practices was held by another business that used the building, but the practice had not taken steps to ensure this was being done on a regular basis.
- 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.

- 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.
- 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 reliable systems for appropriate and safe handling of medicines.

- The systems for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment, minimised risks.
- 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.
- 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.

Track record on safety

The practice had a good track record on safety.

- There were comprehensive risk assessments in relation to safety issues.

Are services safe?

- The practice monitored and reviewed activity. This helped the practice 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 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.

Are services effective?

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

(Please note: Any Quality and Outcomes Framework (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 clinical staff make care and treatment decisions.
- Staff used appropriate tools to assess the level of pain in patients.
- 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 have been 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.
- The practice followed up on older patients discharged from hospital and 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.
- A consultant geriatrician visited the practice weekly to discuss any patients who may benefit from being seen directly by them.

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.
- 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 referred to, and had input into, "Chronic Disease Cafes", which had a positive impact for practice patients. For example, 100% of people who attended the group for diabetic patients reduced their cholesterol, and 75% lost weight.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates were above the target percentage of 90% for immunisations, and above the 95% World Health Organisation target for vaccinations given to two year olds.
- 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):

Are services effective?

- The practice's uptake for cervical screening was 77%, which was slightly below the 80% coverage target for the national screening programme, but above the local clinical commissioning group (CCG) and national averages (local average 74%, national average 72%).
- The practice's uptake for breast and bowel cancer screening was in line, and in some cases above, the national average. For example, 71% of females, aged 50-70, had been screened for breast cancer within six months of invitation, compared to a national average of 62%.
- 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 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.
- The practice's performance in relation to the mental health indicators was above the national average.

- 98% of patients diagnosed with dementia had their care reviewed in a face-to-face meeting in the previous 12 months. This was higher than the national average of 84%.
- 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 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, such as the CCG's Quality Improvement Scheme.

- The practice had achieved 99.5% of the total number of QOF points available, compared to the CCG average of 98.3% and the national average of 95.5%. The practice exception reporting rate was slightly lower than the local and national averages at 9.6%, (CCG average 9.9%, national average 10%).
- 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

Are services effective?

and support for revalidation. The practice ensured the competence of staff employed in advanced roles by auditing 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. 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 had 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. The practice worked very closely with community groups and services, as part of their Integrated Care Community. This included referring patients to “Chronic Diseases Cafes” and services such as a military veterans counsellor.
- 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, through their involvement in stop smoking and tackling obesity campaigns.
- A section of the Ash Trees surgery website hosted self-care videos which aimed to help patients manage a range of conditions. At the time of inspection there were 18 videos available.

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.

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 about the way staff treat people was positive.
- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- We received 29 patient comment cards on the day of inspection, all of which were highly positive about the care and treatment received at the practice.

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 practice worked closely with the local carers' organisation in the area.

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.

Are services responsive to people's needs?

We rated the practice, as well as five of the population groups, as good for providing responsive services . The practice was rated as outstanding in this domain for people whose circumstances make them vulnerable.

Responding to and meeting people's needs

There was a proactive approach to understanding the needs of different groups of people and to delivering care in a way that met these needs and promoted equality. This included people who were in vulnerable circumstances or who had complex needs.

- Services were tailored to meet the needs of individual people and were delivered in a way to ensure flexibility, choice and continuity of care.
- Telephone 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 were more vulnerable or who had 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.
- The practice employed a number of innovative methods to engage with patients and offer them advice and support. For example, the practice operated a patient choir which was run by a member of staff. This encouraged patients to be active in a social enterprise, with the aim of improving their well-being. The choir performed at a Christmas carol concert, held by the practice in a local venue, which was open to all patients. Furthermore, meetings of the patient participation group were open to all patients, not only members of the group, and included a talk by a member of staff or a guest speaker about a particular health issue which patients wanted more information about, for example, caring for a relative with dementia. Patients and staff we spoke to told us these initiatives were well received by patients.

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.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GP and practice nurse also accommodated home visits for those who had difficulties getting to the practice due to limited local public transport availability.
- The practice carried out scheduled weekly visits to approximately 110 patients in three local nursing homes, as well as at two residential homes. Staff from the practice had worked closely with the care homes to reduce unnecessary requests for a doctor by operating these regular, scheduled visits and training staff to understand when a GP needed to be called. They also produced a minor illness booklet for staff at the care home to help them to more effectively manage patients with a minor illness themselves.

People with long-term conditions:

- The involvement of other organisations and the local community was integral to how services were planned and ensured services met people's needs. There were innovative approaches to providing integrated, person-centred care that involved other service providers, particularly for people with multiple or complex needs.
- One of the partners in the practice had a lead role in the local integrated care community (ICC), and as such had led on the creation of "Chronic Disease Cafes" in the area. These were mainly nurse-led, community-based groups run by a local trust for patients with long-term conditions in order to promote healthy lifestyles, although some were run by GPs from the practice. The practice referred eligible patients with conditions affecting their circulation, respiratory conditions, musculoskeletal problems and diabetes to the groups. A review of patient outcomes by the ICC showed that those who attended benefitted from doing so. For example, 100% of patients who attended the group for diabetes reduced their cholesterol.
- 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.

Are services responsive to people's 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 promoted self-care where appropriate, to enable people with long-term conditions to manage them as best they could without needing appointments. A section of the Ash Trees surgery website hosted self-care videos which aimed to help patients manage a range of conditions. At the time of inspection there were 18 videos available. Patients we spoke to on the day of inspection told us they had used these videos instead of booking an appointment with a GP.

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, extended opening hours and telephone appointments.

People whose circumstances make them vulnerable:

- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.
- The practice was able to demonstrate examples of cases where personalised care for vulnerable patients had improved outcomes, for example, reducing the number of inappropriate emergency calls made by patients.
- A "Listening Service" was established by the practice. This was a free, confidential service facilitated by a volunteer chaplain listener on a weekly basis. Appointments were available for patients who felt they would benefit from an opportunity to discuss their concerns related to matters such as illness, the prospect of surgery, a difficult diagnosis or bereavement. Appointments could be made by a GP, nurse or team

member, or by a patient themselves. Patients we spoke to on the day of inspection spoke highly of the service. In 2017, the service was used by 80 patients, some of whom attended for multiple sessions.

- A counsellor who was specially trained to support patients who were military veterans held a regular clinic at the practice.
- The practice had approached the local Citizens Advice Bureau (CAB) to set up a clinic at the practice. Patients could get advice from (CAB) staff about social issues, such as funding for carers. We spoke to patients who used the service, all of whom found it beneficial and told us it had allowed them to access information or funding they would have struggled to otherwise obtain.
- The practice was a collection point for a local food bank, allowing people to donate food for those who needed it.

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 held GP led dedicated monthly mental health and dementia clinics. 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, and in a way and at a time which suited them. People's individual needs and preferences were central to the planning and delivery of care to ensure services were flexible and ensured continuity of care.

- 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 reported that the appointment system was easy to use.
- We saw that the practice continuously monitored their appointment system to ensure that it met patients'

Are services responsive to people's needs?

needs and was sufficient to meet demand. For example, the extended hours opening was changed to offer more early morning appointments in response to patient preference and demand.

- The practice operated a GP buddy system, which meant that when appointments were not available with a patient's regular GP, the GP with whom they were offered an alternative appointment would always be one of a small group of GPs, rather than any doctor within the practice. Despite being a relatively large practice, this system was able to limit the number of doctors a patient would be likely to see and increased continuity of care, and applied to home visits as well as appointments at the practice. Patients we spoke to told us they highly appreciated this system.
- Following patient feedback and a review of demand, the practice had started a "visiting GP" system on Mondays, whereby one GP that day would do all home visits. This had freed up two extra routine appointments per GP.

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 and complaints and also from analysis of trends. They acted as a result to improve the quality of care.

Please refer to the Evidence Tables for further information.

Are services well-led?

We rated the practice 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 their 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 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 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. All staff received regular annual appraisals. 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 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 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

Are services well-led?

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 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 practice was transparent, collaborative and open with stakeholders about performance.
- One of the partners at the practice was the lead GP in the local Integrated Care Community. This allowed the practice to work closely with external partners on a number of initiatives which benefitted patients, such as the "Chronic Disease Cafes".
- The practice employed a number of innovative methods to engage patients and to offer advice and support, such as a patient choir, a practice Christmas carol concert, and open sessions of PPG meetings which included guest speakers talking about health issues of interest to patients. These methods encouraged patients to be active in social enterprise scheme, with the aim of improving their well-being.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement.
- The practice made use of internal and external reviews of incidents and complaints. Learning was 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.