Lion Health

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	Outstanding ☆
Are services safe?	**Good** ●
Are services effective?	**Outstanding** ☆
Are services caring?	**Good** ●
Are services responsive?	**Good** ●
Are services well-led?	**Outstanding** ☆

Overall summary

This practice is rated as outstanding overall. (Previous rating March 2015 – Good)

The key questions at this inspection are rated as:

Are services safe? – Good

Are services effective? – Outstanding

Are services caring? – Good

Are services responsive? – Good

Are services well-led? - Outstanding

We carried out an announced comprehensive inspection at Lion Health on 2 July 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. 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 same day care when they needed it. However, patient feedback on telephone access was generally negative.

• There was a strong focus on continuous learning and improvement at all levels of the organisation.

We saw areas of outstanding practice:

• The practice had a dedicated advanced nurse practitioner (ANP) for patients in care homes and acutely unwell patients.

• The practice had adopted an 'assertive outreach' strategy to improve the uptake of long-term condition clinics. This involved proactively reaching out to patients based on clinical need; for example, online monitoring for working age people.

• 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 took a proactive approach to reduce suicide cases by holding an educational event with an external speaker and had internally reviewed cases to identify any learning.

• There was an extensive programme of governance meetings that included all staff and extended to a wide range of healthcare professionals. The programme of multidisciplinary team meetings (MDT) included dedicated time set aside from the main MDT meeting to discuss and review the care and treatment for palliative patients, patients with poor mental health and patients with respiratory conditions. As an example of good practice, the local CCG shared learning from this practice model with other practices within the CCG and had been used as a demonstrator site for other CCGs.

• The practice had developed their approach for managing patients with long-term conditions with the introduction of a dedicated administrative team and a patient centred approach to improving attendances for reviews. The non-attendance rate and the average attendance rate had both halved since 2016 and 80% of patients with a long-term condition had all components reviewed at one appointment. The percentage of patients on each long-term register who had received at least annual reviews was consistently high. The practice had written their own protocols for long-term condition management that provided comprehensive and effective treatment and care.

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

• Ensure that the new telephone system improves access for patients.

Professor Steve Field CBE FRCP FFPH FRCGP

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 Care Quality Commission (CQC) lead inspector**.** The team included a GP specialist advisor and a practice manager advisor.

Background to Lion Health

Lion Health is situated in the town of Stourbridge and is part of the NHS Dudley Clinical Commissioning Group (CCG). Services are provided under a general medical service (GMS) contract with NHS England.

In April 2018, the practice completed a merger with another local practice, Norton Medical Practice. The practice moved to its current site in 2014, a modernised facility housed in a former foundry and owned by Primary Healthcare Properties. The premises houses 36 consulting rooms, a nursing suite, minor surgery unit, physiotherapy suite, gym, lecture theatre, teaching facilities and an independent pharmacy. The building has three levels and patient services were mostly provided on the ground and first floor. There is direct access to the practice by public transport from the surrounding areas. Parking facilities are available on site. The practice website can be found at www.lion-health.co.uk

There are approximately 31,650 registered patients, predominantly of white British background. The practice serves a large residential area and the population age demographics show a mean age of 43 compared to the England mean age of 39. Unemployment levels are lower than national averages.

When the practice is closed, patients can access out of hours services (provided by Malling Health at Russells Hall Hospital) services by telephoning NHS 111.

Staffing consists of:

• 11 GP partners and eight salaried GPs (approximately 17 whole time equivalent).

• Four advanced nurse practitioners and seven nurses (approximately 11 whole time equivalent).

• Seven healthcare assistants (approximately five whole time equivalent).

• A practice manager and two other operational managers that support the running of the practice.

• An experienced team of reception/administration staff.

• Two GP registrars

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

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 appropriate systems to safeguard children and vulnerable adults from abuse. All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Learning from safeguarding incidents were available to staff. Staff who acted as chaperones were trained for their role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.)

• Staff took steps, including working with other agencies, to protect patients from abuse, neglect, discrimination and breaches of their dignity and respect.

• The practice carried out appropriate staff checks at the time of recruitment and on an ongoing basis.

• 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.

• When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

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

• The care records we saw showed that information needed to deliver safe care and treatment was available to staff.

• The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.

• Clinicians made timely referrals in line with protocols.

Appropriate and safe use of medicines

The practice had reliable systems for appropriate and safe handling of medicines.

• Antibiotic prescribing was in line with local and national averages.

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

• Staff prescribed and administered 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.

• The practice used technology 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.

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 carried out a general risk assessment for the premises as well as individual risk assessments for all identified hazards.

Good

Are services safe?

• The practice monitored and reviewed safety using information from a range of sources.

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

Outstanding ☆

Are services effective?

We rated and the working age people (including those recently retired and students and families, children and young people population groups as outstanding for providing effective services overall the practice making the overall rating for the practice outstanding for providing effective services.

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.

• The practice had written individual protocols for treatment of long-term conditions.

• 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 long-term condition administration team used the clinical system to tailor care for individual patients and clinicians who performed home visits had mobile access to the clinical system.

• Staff advised patients what to do if their condition got worse and where to seek further help and support.

• The practice was working in partnership with Dudley Clinical Commissioning Group (CCG) in developing and delivering the long-term condition framework. The CCG had used the practice as an example of good practice to other CCGs.

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.

• The practice followed up 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.

• The practice had a dedicated advanced nurse practitioner (ANP) for patients in care homes and acutely unwell patients.

• A dedicated nurse provided opportunistic support for difficult to reach housebound patients.

• Proactive reviews were carried out on all patients aged 75 and over who had not attended the practice in the previous 12 months.

People with long-term conditions:

• The practice had developed their approach for managing patients with long-term conditions with the introduction of a dedicated administrative team and a patient centred approach to improving attendances for reviews. The non-attendance rate and the average attendance rate had both halved since 2016 and 80% of patients with a long-term condition had all components reviewed at one appointment. The percentage of patients on each long-term register who had received at least annual reviews was consistently high.

• 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.

• Adults with newly diagnosed cardiovascular disease were offered statins for secondary prevention. People with suspected hypertension were offered ambulatory blood pressure monitoring and patients with atrial fibrillation were assessed for stroke risk and treated as appropriate.

• The practice was able to demonstrate how it identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension)

Outstanding ☆

Are services effective?

• The practice was proactive in supporting patients to manage their long-term conditions. Their quality performance indicators for patients with diabetes showed year on year improvement.

• The practice had adopted an 'assertive outreach' strategy to improve the uptake of long-term condition clinics. This involved proactively reaching out to patients based on clinical need; for example, online monitoring for working age people.

Families, children and young people:

• Childhood immunisation uptake rates were consistently higher than the target percentage of 90% or above. The uptake rates were achieved with a proactive recall system to support the public health patient recall system and an integrated approach that included the health visitor.

• 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 and extensive family planning service that consisted of multiple weekly clinics for a wide range of treatments.

• Safeguarding meetings were held monthly.

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

• The practice's uptake for cervical screening was 87%, which was above the 80% coverage target for the national screening programme.

• The practice's uptake for breast and bowel cancer screening was significantly above the national average.

• The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.

• Patients had access to appropriate health assessments and checks 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. Multidisciplinary team meetings were held specifically to discuss patients who required palliative care.

• 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 GPs proactively supported patients with a learning disability to apply for personal independence payments.

• The practice offered annual health checks to patients with a learning disability.

• The GPs provided their own mobile numbers to give rapid access to patients nearing the end of their life.

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 proactive and effective system for following up patients who failed to attend for administration of long term medication.

• 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 provided information on local support services and numbers on an information card that could easily fit into a wallet or purse.

• The practice adopted a proactive approach to understand what could be done to reduce cases of suicide. A recent example was a talk from a consultant psychiatrist about how the practice could proactively prevent suicide. The educational lead had followed this educational session up with an internal session that looked at case reviews of suicide victims.

Monitoring care and treatment

Outstanding ☆

Are services effective?

The practice had a comprehensive programme of quality improvement activity and extensively reviewed the effectiveness and appropriateness of the care provided. Where appropriate, clinicians took part in local and national improvement initiatives.

• The Dudley Quality Outcome for Health Framework results were consistently high.

• The practice did not except any patients from the recall list.

• The practice used information about care and treatment to make improvements.

• The practice was actively involved in quality improvement activity. Where appropriate, clinicians took part in local and national improvement initiatives.

• The system for monitoring care and treatment devised by the practice had been used as an example of good practice to other CCGs and parts of the system were adopted by Dudley CCG.

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. The practice consistently demonstrated how staff were supported, encouraged and given opportunities to develop. Feedback from staff was very positive.

• The practice provided staff with ongoing support. There was an induction programme for new staff. This included one to one meetings, appraisals, coaching and mentoring, clinical supervision and revalidation. The pre-appraisal questionnaire included feedback from five people nominated by the appraisee. GPs and nurses coordinated their appraisals to be approximately one month before their external appraisals for revalidation.

• There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

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

• We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.

• The practice shared clear and accurate information with relevant professionals when discussing care delivery for people with long-term conditions and when coordinating healthcare for care home residents. They shared information with, and liaised, with community services, social services and carers for housebound patients and with health visitors and community services for children who 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.

• The practice had established multidisciplinary healthcare team (MDT) meetings for specific conditions; for example, respiratory, that fed into the main MDT meetings.

• A new approach adopted by the practice to encourage patients with long-term conditions to attend for reviews had reduced non-attendance rates from 15% to 7%, approximately 50% of patients who historically had not engaged had been reached, 80% of patients had all long-term condition components reviewed at one appointment, and the average attendance rate for long-term condition monitoring had reduced from 2.27 to 1.14 per annum.

Outstanding ☆

Are services effective?

• Specific teams were assigned governance over non-attendances by a cohort of patients. There were teams for managing children, patients with learning disabilities, vulnerable patients, patients experiencing poor mental health and patients with dementia. The teams adopted a proactive approach to any incident when an appointment was not attended, following up with telephone calls, letters and/or visits as necessary and appropriate to the patient. This included hospital appointments that had not been attended.

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. The practice gave examples of how it had improved patient's welfare through supporting patients with social needs.

• 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.

• The practice had developed two members of staff as health coaches. They worked with patients to establish goals and processes to avoid intensification of medication and improved clinical outcomes. Seventy per cent of patients who were overweight, had lost weight. Fifteen per cent of these patients had lost 5% or more of their body weight.

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 treated people.

• Staff understood patients' personal, cultural, social and religious needs.

• The practice gave patients timely support and information.

• The practices national GP patient survey results were consistently above or in line with national averages for questions relating to kindness, respect and compassion.

• The GPs provided their own mobile numbers to give rapid access to patients nearing the end of their life.

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 practices GP patient survey results were consistently above local and national averages for questions relating to involvement in decisions about care and treatment.

Privacy and dignity

The practice respected patients' privacy and dignity.

• When patients wanted to discuss sensitive issues or appeared distressed reception staff offered them a private room to discuss their needs.

• Staff recognised the importance of people's dignity and respect. They challenged behaviour that fell short of this.

Please refer to the evidence tables for further information.

Good

Are services responsive to people's needs?

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

Responding to and meeting people's needs

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

• The practice understood the needs of its population and tailored services in response to those needs.

• Telephone 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 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.

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.

• There were dedicated advanced nurse practitioners for care home patients who lived in care homes and acutely unwell housebound patients.

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. There was a main meeting to discuss all patients and dedicated meetings to discuss cohorts of patients; for example, patients with respiratory illness, patients experiencing poor mental health and patients in need of palliative care.

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 Saturday appointments.

• The practice provided an extensive range of online services for those registered to use the service. This included ongoing monitoring of test results.

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.

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 meeting with other healthcare professionals. Patients who failed to attend were proactively followed up by a phone call, letter or visit.

Good

Are services responsive to people's needs?

• The practice provided a credit card sized information documents advising patients of the names and contact details for local support groups.

Timely access to care and treatment

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs. However, telephone access was accepted as an issue by the practice and a new phone system was planned.

• 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. Staff and patients told us that same day urgent appointments were always accommodated; however, long waiting times had been experienced when booking a routine appointment.

• The practices GP patient survey results were generally in line with local and national averages for questions relating to access to care and treatment. However, the results for telephone access were below the local and national average.

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. It acted as a result to improve the quality of care.

Please refer to the evidence tables for further information.

Outstanding ☆

Are services well-led?

We rated the practice as outstanding 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.

• The practice had completed a merger with a second practice in April 2018. The second practice had approached Lion Health to propose the merger as part of their succession planning. Staff and patients we spoke with were positive about the successful management of the merger process and we saw that the administrative work involved had been comprehensively planned and successfully managed.

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.

• 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 care 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 had a strong focus on the needs of patients. Treatment and care was coordinated and tailored to individual patients to maximise opportunities to improve outcomes.

• 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 in the last year. Prior to their appraisals, staff completed a pre-appraisal questionnaire that included feedback from five people, nominated by the appraisee, to promote a more detailed and effective appraisal process. Staff were supported to meet the requirements of professional revalidation where necessary.

• 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 very positive relationships between staff and teams. Staff feedback on the management team consistently highlighted a strong support structure and an inclusive approach. For example, the advanced nurse practitioners had a GP led, weekly meeting that they formed the agenda for using case studies.

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 co-ordinated person-centred care.

Outstanding ☆

Are services well-led?

• There was an extensive programme of governance meetings that included all staff and extended to a wide range of healthcare professionals. The programme of multidisciplinary team meetings (MDT) included dedicated time set aside from the main MDT meeting to discuss and review the care and treatment for palliative patients, patients with poor mental health and patients with respiratory conditions. As an example of good practice, the local CCG shared learning from this practice model with other practices within the CCG and had been used as a demonstrator site for other CCGs. The framework of meetings was coordinated so that all staff could input and gain feedback. Staff we spoke with were universally positive about the internal communication.

• 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 and assured themselves that they were operating as intended.

• The practice proactively made use of technology to support governance arrangements. For example, the practice used a shared internal communication platform for recording, tracking and disseminating learning from significant events, near misses and complaints.

• There was a dedicated administration team to support the governance of patients with long-term conditions. There was data to evidence the positive impact the team had made on patient care.

Managing risks, issues and performance

There were clear 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. Practice leaders had oversight of safety alerts, incidents, and complaints.

• Clinical audit had a positive impact on quality of care and outcomes for patients and was used to promote safety within the practice. 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 considered and understood the impact on the quality of care of service changes or developments.

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 engaged with 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.

Outstanding ☆

Are services well-led?

• The practice invited patients to join practice staff in the planning and development of projects; for example, the patients had been involved with developing the approach to managing patients with long-term conditions and had been involved with discussion prior to the recent merger.

Continuous improvement and innovation

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

• There was a strong 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.

• Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.

• The practice's system for monitoring care and treatment not only drove improvement in patient outcomes within the practice population but had been adopted, in part, by the local CCG to drive improvements within other local practices.

Please refer to the evidence tables for further information.