Swan Lane Medical Centre

Inspection report

Swan Lane
Bolton
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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 rating October 2015 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 comprehensive inspection at Swan Lane Medical Centre on 24 October 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 care when they needed it.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.

We saw one area of outstanding practice:

- Proactive care and treatment is provided for patient's resident in care homes. GPs provided weekly rounds to each unit within a large complex in addition to regular reactive care provided by the practice. We were provided with numerous examples of the impact of this work on patient's wellbeing because of the proactive involvement of clinicians and the patient plan manager at the practice. Data provided by the practice also showed a reduction in the number of patients having to go to A&E or call outs from paramedics to the nursing home.

The areas where the provider should make improvements are:

- There should be a formal system in place to monitor uncollected prescriptions.
- All significant events should be formally documented centrally and clinical meetings minuted.

Professor Steve Field CBE FRCP FFPH FRCGPChief Inspector of General Practice

Population group ratings

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

Our inspection team

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

Background to Swan Lane Medical Centre

Swan Lane Medical Centre is the registered provider and provides primary care services to its registered list of approximately 8500 patients. The practice delivers commissioned services under a Personal Medical Service (PMS) contract and is a member of Bolton Clinical Commissioning Group (CCG).

The PMS contract is the contract between general practices and NHS England for delivering primary care services to local communities. The practice offers direct enhanced services that include meningitis provision, the childhood vaccination and immunisation scheme, facilitating timely diagnosis and support for people with dementia, influenza and pneumococcal immunisations, learning disabilities, minor surgery and rotavirus and shingles immunisation.

Regulated activities (Family planning, Diagnostic and screening procedures, Treatment of disease, disorder or injury, Surgical procedures and Maternity and midwifery services) are delivered to the patient population from the following address:

Swan LaneBoltonLancashireBL3 6TL

The practice has a website that contains comprehensive information about what they do to support their patient population and the in-house and online services offered:

At the time of our inspection there were three full time GPs partners (two males, one female), two part time advanced nurse practitioners (female), two practice nurses (female) an assistant practitioner (female) a health care assistant (male) and a patient plan manager. Clinical staff are supported by a new practice manager and assistant practice manager and twelve other staff in the reception and administration team. There is also a health trainer, health improvement practitioner, pharmacist, pharmacy technician and a mental health practitioner working in the practice, theses posts are funded and managed by Bolton Clinical Commissioning Group.

The age profile of the practice population is broadly in line with the CCG averages. The practice ethnicity profile showed 53% of patients were of Asian background another 19% were from a diverse range of ethnic backgrounds and 28% were White British. Approximately 60% of patients did not speak English as a first language. The practice also provided care to approximately 133 patients living in a nearby residential and nursing home. Information taken from Public Health England placed the area in which the practice is located is the second most deprived (from a possible range of between 1 and 10). In general, people living in more deprived areas tend to have greater need for health services.

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. 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 on-going basis.
- There was an effective system to manage infection prevention and control. An infection control audit had been carried out, but it was not clearly documented when actions had been completed.
- 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 staff including 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 acted 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.
- The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture of safety that led to safety improvements.

Lessons learned and improvements made

Good

Are services safe?

The practice learned and improvements were made 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 systems for reviewing and investigating when things went wrong. The practice learned and shared lessons identified themes and acted to improve safety in the practice.
- The practice acted on and learned from external safety events as well as patient and medicine safety alerts.

Please refer to the Evidence Tables for further information.

Good

Are services effective?

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

(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. However, we reviewed the QOF data for 2017/18 published 26 October 2018 and noted the practice continued to be comparable with other practices in all areas.)

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 on-going 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 utilised a range of evidence based tools and templates to carry out holistic reviews of care and provided personalised care plans where appropriate.
- 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.
- The practice was comparable with other prescribers of antibiotics in line with guidance when compared with the England average.
- The practice was actively looking at ways to improve cancer screening and improve on early diagnosis rates. As a result, one GP has become a cancer lead and is linking in with two organisations to develop additional knowledge to enable better outcomes and screening.

Older people:

- Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. The practice used an appropriate tool to identify patients aged 65 and over who were living with moderate or severe frailty. Those identified as being frail had a clinical review including a review of medication.
- Patients aged over 75 were invited for a health check and personalised care plans were in place for vulnerable patients over 75. Alongside the physical and mental health check, the opportunities for social interaction activities were discussed and referrals made where appropriate.
- The practice employed a patient plan manager whose role included following up on older patients discharged from hospital ensuring care plans and prescriptions (working with a CCG pharmacist) were updated to reflect any extra or changed needs. They also actively referred older patients to the Bolton 'Stay well service' for support in the community where required.
- Multi-disciplinary palliative care meetings took place to co-ordinate and review care and monthly meetings were held for older patients with complex needs.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- The practice provided care to approximately 133 older people living in a local nursing and residential home and included specialist dementia units. The practice split the care into units with a GP taking responsibility for the care across two units to enable them to provide continuity of care. Once a new resident was registered with the practice the appropriate GP would visit within a week and develop a care plan. The patient plan manager monitored and reviewed care plans, ensuring they were up dated following for example hospital discharge, accident and emergency attendance and ensured reviews were carried out six monthly (Data provided by the practice showed 100% of medication and care plans reviews had been completed). The practice provided weekly ward rounds within the home as well as visits as and when required. The practice told us it was important to provide joined up care to patients living in residential care to maximise patient's wellbeing but also working with care staff to prevent unplanned hospital admissions.
- We were provided with numerous example of positive outcomes for patients as a result of the focused care provided by Swan Lane Medical Centre, for example reviewing medication previously prescribed to dementia patients and making changes which resulted in patients being more alert and engaged or making changes to medications where patients were experiencing side effects. Data provided by the practice also showed a reduction in the number of patients having to go to A&E or call outs from paramedics to the nursing home.

Good

Are services effective?

- Feedback from the care home managers was positive stating that GPs always took time to complete comprehensive assessments for new residents and made arrangements wherever possible to meet with relatives. They also praised the GPs for the care they provided particularly to patients with dementia.
- There was a nursing home pharmacy technician employed by the CCG who supported the practice in ensuring medicines prescribed were appropriate.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice had arrangements for adults with newly diagnosed cardiovascular disease including the offer of high-intensity statins for secondary prevention, people with suspected hypertension were offered ambulatory blood pressure monitoring and patients with atrial fibrillation were assessed for stroke risk and treated as appropriate.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension
- The practice team included pharmacists employed by the CCG who carried out medication reviews for patients with long term conditions and reviewed patient's medication for example if they had attended accident and emergency or following discharge from hospital.

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

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

- The practice's uptake for cervical screening was 67%, which was below the 80% coverage target for the national screening programme, however this was in line with the England average uptake of 72%. The practice had an initiative in place to promote screening uptake and we noted from 2017/18 QoF data uptake had increased.
- The practices' uptake for breast cancer screening 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 including NHS checks for patients aged 40-74 or 35 years of age for patients from Black and Minority ethnic groups. 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, asylum seekers and refugees, 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.

Good

Are services effective?

- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in the record was comparable with the local and national average.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- The practice offered annual health checks to patients with a learning disability.

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 and regularly attended training and events.

- The practice used information about care and treatment to make improvements.
- The practice was actively involved in quality improvement activity.

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 on-going support. This included an induction process, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support 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 deciding 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 team worked closely with staff within the nursing/residential home in which they provided care and the new Telemedicine service. (technology which is connected directly to nurses or doctors in a clinical hub, providing Care Home staff immediate access to medical advice as an alternative to contacting GPs in the first instance).

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

- The practice identified patients who may need 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.

Good

Are services effective?

- Staff encouraged and supported patients to be involved in monitoring and managing their own health, for example through social prescribing schemes. Such as Bolton Council for voluntary service social prescribing scheme.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.
- A health trainer and health improvement practitioner funded by the NHS Bolton Clinical Commissioning Group (CCG), worked at the practice and carried out health checks and gave advice and information about how to maintain a healthy lifestyle.

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 and we saw numerous examples of where staff showed this when supporting patients. We saw staff had a good awareness of patient's individual needs and were committed to providing person centred care.

Feedback from patients was positive about the way staff treat people.

- Staff understood patients' personal, cultural, social and religious needs.
- The practice was award gold as part of the Pride in Practice scheme.
- The practice gave patients timely support and information.
- The practices GP patient survey results were in line with local and national averages for questions relating to kindness, respect and compassion.

Involvement in decisions about care and treatment

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

- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.
- A high percentage of patients did not speak English as a first language. Several staff spoke other languages or could access translators via a telephone translation service to ensure patients who did not speak English understood procedures. Longer appointments were allocated where a translator was required. GPs and nurses also explained health screening to patients who did not speak English as a first language, and provided written information in a range of different languages to encourage uptake of screening programmes.
- The practice proactively identified carers and supported them.
- The practices GP patient survey results were in line with local and national averages for questions relating to involvement in decisions about care and treatment.

Privacy and dignity

The practice respected patients' privacy and dignity.

- 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 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 consultations with a GP were available which supported patients who were unable to attend the practice including evenings and weekends.
- 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.

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 GPs and nurses also accommodated home visits for those who had difficulties getting to the practice due to limited local public transport availability.

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 clinical team reviewed all unplanned hospital admissions and attendance at Accident and Emergency to follow up patients where required.

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 5 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. The practice could also book patients appointments with a GP or nurse at the local 7-day extended access service which had clinics at the weekend and in the evening.
- The practice offered extended hours on a Saturday morning.
- Opportunistic flu vaccinations were offered to patients at different times of day to accommodate carers, workers and school children.

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.
- Staff participated in regular dementia awareness training and staff were proactive in offering screening for patients where there may be concerns.
- Patients could access same day urgent appointments.
- A mental health practitioner, also funded by the NHS Bolton CCG, worked at the practice. Their role was to support patients with their mental health needs and

Good

Are services responsive to people's needs?

direct them to local support services. If a patient was identified as being at risk of harm, then staff would direct them to this practitioner for support in addition to speaking with their GP.

Timely access to care and treatment

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

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- Patients reported that the appointment system was easy to use and appointments were available on a Saturday morning.
- The practices GP patient survey results were in line with local and national averages for questions relating to access to care and treatment.
- New patients moving into a residential or nursing were seen by a GP within a week and detailed care plans developed.

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 from analysis of trends. It acted as a result to improve the quality of care.
- The practice carried out an annual review of complaints to identify any patterns or trends and these were shared during team meetings.

Please refer to the Evidence Tables for further information.

Good

Are services well-led?

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

Leadership capacity and capability

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 utilised opportunities such as the retirement of the practice manager to review the role and appoint a new management team to reflect the changing needs of the practice. The partners were also aware of the need for additional clinical staff as a result of an increasing number of patients and were working with the team to look at the best way to address the gap.

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 priorities across the region. The practice planned its services to meet the needs of the practice population.
- The practice monitored progress against delivery of the strategy.

Culture

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

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- The practice focused on the needs of patients and clearly understood the challenges faced by many vulnerable groups in accessing primary care and being responsive to older people in care preventing unplanned hospital admissions.
- 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 had received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- The practice encouraged and support staff to gain additional skills and qualifications, for example NVQs for reception and administration staff and supporting nursing colleagues to become prescribers and advanced nurse practitioners.
- 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 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. The practice was in the process of re-structuring the PPG to be more accessible and more representative of the patient population.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

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

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