

The Dunstan Partnership

Inspection report

Brightmet Health Centre,
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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 December 2014 – Good)

The key questions at this inspection are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Good

We carried out an announced comprehensive inspection at The Dunstan Partnership on 13 November 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.
- Staff took steps, including working with other agencies, to protect patients from abuse, neglect, discrimination and breaches of their dignity and respect.
- 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 had the skills, knowledge and experience to carry out their roles. The practice understood the learning needs of staff and provided training to meet them.

- Staff involved and treated patients with compassion, kindness, dignity and respect.
- The practice gave patients timely support and information. The practice's GP patient survey results were above and in line with local and national averages for questions relating to kindness, respect and compassion.
- The practice understood the needs of its population and tailored services in response to those needs.
- The practice had been awarded the Pride in Practice award which included training in health care for lesbian, gay, bisexual and transgender patients.
- Leaders had the capacity and skills to deliver high-quality, sustainable care.
- There were clear responsibilities, roles and systems of accountability to support good governance and management.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.

We saw one area of outstanding practice:

The practice had found that patients with long term conditions often contacted out of hours services during the evening and at weekends more frequently. A GP now makes a courtesy call to the patient on a Friday afternoon to see if they had any specific needs that required attention before the weekend. This had reduced the need for those patients to contact the out of hours service.

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

Population group ratings

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

Our inspection team

Our inspection team was led by a Care Quality Commission lead inspector and included a GP specialist adviser.

Background to The Dunstan Partnership

The Dunstan Partnership provides personal medical services to 10,498 patients within the NHS Bolton Clinical Commissioning Group (CCG) area.

Services are provided from: Brightmet Health Centre, Brightmet Fold Lane, Brightmet, Bolton BL2 6NT.

The practice website is:

Information taken from Public Health England placed the area in which the practice is located as number two on the deprivation scale of one to ten. (The lower the number the higher the deprivation). In general, people living in more deprived areas tend to have greater need for health services.

The out of hours provider is Bury and Rochdale Doctors on Call (BARDOC).

There are seven GPs working at the practice (three male and four female). They work between five and eight sessions per week. The GPs are supported by a team of

nursing staff which includes two advanced nurse practitioners (one is the nurse manager) and four practice nurses. There is also a health care assistant, a pharmacy technician and a mental health practitioner.

There is a team of administration / reception staff headed up by the practice manager. The team comprises of a practice manager, a deputy practice manager, two administration coordinators, a medical secretary and a team of administration staff. The practice also has two health improvement practitioners and a midwife. These staff are not directly employed by the practice.

The practice regulated activities are:

Surgical procedures

Treatment of disease, disorder or injury

Maternity and midwifery services

Diagnostic and screening procedures

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 policies, procedures and 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 was 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.
- There was a business continuity plan which provided staff with information and guidance about what to do in the event of an emergency.

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.

- The systems for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment, minimised risks.
- Staff prescribed and 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 safety using information from a range of sources.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Are services safe?

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

Please refer to the evidence tables for further information.

Are services effective?

We rated the practice and all of the population groups as good 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.

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

Older people:

- Older patients who were frail or may be vulnerable received a full assessment of their physical, mental and social needs. The practice used an appropriate tool to identify patients aged 65 and over who were living with moderate or severe frailty. Those identified as being frail had a clinical review including a review of medication.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- All patient over 75 have a named GP
- The building was accessible for patients with mobility problems.
- The practice had recently purchased an adjustable hydraulic examination couch for those patients with mobility problems.
- Influenza, pneumococcal and shingles vaccine were encouraged and offered.
- The practice contacted all patients aged 75 years or over who had attended A&E or had a non-elective admission in order to review their needs and update their care plan where necessary.

- Nursing and residential home patients received a face to face comprehensive assessment by a GP or advanced nurse practitioner. Level 3 medication reviews were carried out by the pharmacist on admission to the nursing home and following hospital discharge.

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, for example, integrated neighbourhood team to deliver a coordinated package of care.
- The practice provided a "one stop clinic" service for all patients with a chronic disease or long-term condition for their annual review.
- 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 demonstrated how it identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- The practice's performance on quality indicators for long term conditions was in line with local and national averages.
- Same day appointments were available to all patients.
- Patients with palliative care needs had a named GP who contacted the patients regularly and worked with the district nursing and Macmillan team to co-ordinate care.

Families, children and young people:

- Childhood immunisation uptake rates were above the target percentage of 90% or above.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation.

Are services effective?

- The practice offered contraceptive advice and onward referral for those choosing long active reversible contraception e.g. coils and implants.
- The practice provided baby checks alongside post-natal check for parents' convenience.
- Two GPs had a lead role in managing safeguarding incidents and regular meetings were held with the outreach midwife and the health visitor.
- Flexible appointments were available to parents who were unable to attend the scheduled immunisation clinic.
- Same day GP and advanced nurse practitioner appointments were available to children.

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

- The practice's uptake for cervical screening was 76% which was below the 80% coverage target for the national screening programme. However, this was in line with the Clinical Commissioning Group average of 73% and the national average of 72%.
- The practice's uptake for breast cancer screening was in line with the local and national average. The practice's uptake for bowel cancer screening was above the local and national average.
- The practice actively encouraged patients to attend for their breast, bowel, abdominal aortic aneurysm and cervical screening, with recurrent reminder letters being sent out to patients.
- The Practice promoted chlamydia screening for patients aged 18 to 25 years.
- 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 years. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- During the practice's Saturday flu clinic, the practice arranged for members of the healthcare team to be present to carry out opportunistic health checks.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which considered 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.
- A GP and a nominated staff member co-ordinated the care of patients with a learning disability and ensured they all received an annual health check.
- Information and letters were written in an easy read format, which made it easier for patients to understand. Health checks were carried out at the patient's own home or in the surgery.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice had a few patients with refugee or asylum status. An alert was placed on their records to ensure longer appointments were offered.
- The practice used translation services for patients whose first language was not English.
- The practice registered patients who were homeless and had a registration process which enabled the patient to use the practice address for medical correspondence.
- The practice referred patients to the local drug and alcohol service when necessary.

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. These patients were offered same day appointments and access to the practice mental health practitioner for a same day appointment if required.
- There was a mental health coordinator. Their role was to remind patients of their appointments and offer additional support and information about mental health services as required.

Are services effective?

- 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. Staff were trained in dementia care and the Mental Capacity Act.
- The GP lead for dementia co-ordinated dementia annual health reviews either in the patient's own home or in the surgery and formulates a care plan.
- The practice's performance on quality indicators for mental health was in line with local and national averages.
- The practice had a mental health lead GP and a register of patients with mental health problems.
- A mental health practitioner worked at the practice two afternoons each week. They provided patients with longer appointments if needed.
- The practice encouraged and supported young people with mental health problems to access an online mental health support service.
- 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, for example, the health care assistant had completed the Care Certificate.
- The practice provided staff with ongoing support. There was an induction programme for new staff. This included one to one meetings, coaching and mentoring.
- Clinical staff received clinical supervision and revalidation.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.
- Staff were given a handbook which provided information about the practice policies and procedures so they were clear about their responsibilities and knew what was expected of them.

Monitoring care and treatment

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

- The 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.

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 contraception.
- The nursing team attended regular CCG practice nurse training events which include the treatment of chronic diseases.
- 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.

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 considered the needs of different patients, including those who may be vulnerable because of their circumstances. There was a dedicated GP palliative care lead who managed

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appointments and met with district nurses to ensure patients received the care they needed. The GP also attended the quarterly Gold Standard Framework meetings with the local palliative care team.

Helping patients to live healthier lives

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.
- 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 patients' health, for example, stop smoking campaigns and tackling obesity. Patients were supported by the health improvement practitioners who worked at the practice.

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 decisions.
- 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.

- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- The practice's GP patient survey results were in line with local and national averages for questions relating to kindness, respect and compassion. For example, 94% of respondents to the GP patient survey stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern. This was compared to the CCG average was 89% and the national average was 87%.
- The practice's GP patient survey results were above national averages for questions relating to access to care and treatment. For example, 100% of respondents to the GP patient survey stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to.

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's GP patient survey results were above local and national averages for questions relating to involvement in decisions about care and treatment. For example, 100% of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their 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 patients' 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, 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.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services. For example, telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.
- 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.
- The GPs met daily to discuss patient management plans and care for patients in all categories.
- The practice had a GP safeguarding lead and a deputy GP safeguarding lead who managed safeguarding referrals for all patient population groups.

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 provided a daily early visiting service by the advanced nurse practitioner, for patients who required a home visit for conditions which could become worse or require hospital admission if left until after the GPs have finished their surgery. This enabled the patient to receive timely intervention via the home visit and allowed the GP to continue to spend more time consulting with patients at the surgery.
- Flexible appointments were offered to patients which also suited a patient's carer.
- The practice encouraged the use of online services for making appointments and ordering prescriptions which also meant their medication could be delivered to their home.

- The practice provided an enhanced service to two local nursing homes. The advanced nurse practitioner provided annual reviews to nursing and residential home patients with long term conditions.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being met appropriately. Patients with 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 integrated neighbourhood team co-ordinator to review patients' social care needs.
- A monthly multi-disciplinary team meeting took place to discuss and manage the needs of patients with complex medical issues.
- The practice had taken steps to safely reduce the use of opioids in all patients including patients with long term conditions.
- The practice encouraged the use of online services for making appointments and ordering prescriptions. The practice provided one to one IT services for those patients who struggled to access online services.
- The practice had found that patients with long term conditions often contacted out of hours services during the evening and at weekends more frequently. A GP now makes a courtesy call to the patient on a Friday afternoon to see if they had any specific needs that required attention before the weekend. This had reduced the need for those patients to contact the out of hours service.

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.
- Children who attended A&E were reviewed by their GP with a follow-up appointment provided as necessary.
- The safeguarding lead GP met regular with the outreach midwife and the health visitor.

Are services responsive to people's needs?

- The practice staff were trained in gender identity issues and dealt with these appropriately and in accordance with guidelines.
- The practice encouraged and supported young people to access an on line mental health support service.
- The practice had been awarded the Pride in Practice award which included training in health care for lesbian, gay, bisexual and transgender patients.

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

- The needs of these patients 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.
- Public Wi-Fi was available in the practice.
- Early morning appointments were available with the health care assistant, practice nurse and GPs and late evening telephone consultations were from 6.30 pm.
- The practice was planning to offer on line consultations to patients, which may be helpful for those who work.
- The practice provided a one to one IT service for those patients who struggle to access online services. Patients are taken into a private room and taken through the process and taught how to use it.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- Patients in vulnerable circumstances could register with the practice, including those with no fixed abode.
- The practice provided safeguarding reports for child protection meetings.
- The practice provided a safe environment for victims of domestic abuse to be able to consult with the domestic violence team in the practice. Staff were trained in this area of care.
- The learning disability lead receptionist contacted patient or carers the day before their appointment to remind them to attend. Patients were followed up if they did not attend.
- Annual health checks were offered to patients' carers.

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

- Staff had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- Patients with dementia had a lead GP who co-ordinated the production of their care plans.
- All incoming mental health correspondence was sent to a GP for review
- Reception and front-line staff who noticed when a patient was becoming forgetful or acting out of character knew to report this to a GP.
- Patients who do not attend their annual mental health review were followed up.
- Longer appointments were provided to these patients as necessary.

Timely access to care and treatment

Patients could 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 and dealt with by a duty doctor.
- Same day appointments were available.
- Patients were never asked to ring back more than twice for an appointment.
- Patients reported that the appointment system was easy to use.
- Routine and pre-bookable GP and practice nurse appointments were available from 7.15 am. Daily telephone consultations were available along with evening telephone consultations from 6.30 pm.
- The practice offered extended hours routine appointments in the evenings and at week-end at one of the Bolton Hubs.
- The practice provided patients with information about mobile phone apps that could be downloaded for health care advice and information.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded/did not respond 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.

Are services responsive to people's needs?

- 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.

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 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.
- 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 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 told us they could raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and

career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.

- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. Staff were trained in equality and diversity and said 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.

- 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.

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. Practice leaders had oversight of safety alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was evidence of action to change practice to improve quality.
- The practice had plans 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.

Are services well-led?

- 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, staff and external partners to support high-quality sustainable services.

- A range of patients' and staff views and concerns were encouraged, heard and acted on to shape services and culture. There was an active patient participation group.

- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

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

- Arrangements were being made with the NHS Bolton Clinical Commissioning Group for a musculoskeletal practitioner to work at the practice.
- 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.
- The practice manager supported and engaged with all the practices in Bolton and the CCG and hosted regular learning, training and sharing good practice meetings.

Please refer to the evidence tables for further information.