Whittaker Lane Medical Centre

Inspection report

Daisy Bank
Whittaker Lane, Prestwich
Manchester
Greater Manchester
M25 1EX
Tel: 0161 773 1580
www.wlmc.co.uk

Date of inspection visit:
Date of publication: 21/12/2018

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 June 2016 – 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 Whitaker Lane Medical Centre on 26 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.
- 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.
- 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 appropriate knowledge for their role. The practice understood the learning needs of staff and provided protected learning time and training to meet them.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Feedback from patients was positive about the way they were treated and staff understood patients' personal, cultural, social and religious needs.
- Patients found the appointment system easy to use and reported that they could access care when they needed it.
- The practice staff were well informed about local support services and voluntary groups. They actively directed patients to use these services so they could manage their health care issues in a more holistic way.
- Leaders had the capacity and skills to deliver high-quality, sustainable care.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.

The areas where the provider should make improvements are:

- The practice should keep a summary log of safety alerts for monitoring and following-up on actions taken in response to the alerts.
- The level of detail recorded about significant events and staff meetings should be consistent so that staff have information about discussions held, actions taken and lessons learned.

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 Care Quality Commission (CQC) inspector and included a GP specialist adviser.

Background to Whittaker Lane Medical Centre

Whittaker Lane Medical Centre provides personal medical services to 6886 patients within the NHS Bury Clinical Commissioning Group (CCG) area. Services are provided from: Daisy Bank, Whittaker Lane, Prestwich, Manchester M25 1EX

The practice website is: www.wlmc.co.uk

Information taken from Public Health England placed the area in which the practice is located as number four 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 eight GPs working at the practice (five male and three female). There is one senior partner, two partners, a salaried GP, three registrars and along term locum. The GPs are supported by a full-time practice nurse and a health care assistant. There is an administration team which comprises of a practice manager, a senior receptionist, two administration / secretaries, a finance manager and a team of administration staff.

The practice regulated activities are:

Family planning

Treatment of disease, disorder or injury

Maternity and midwifery services

Diagnostic and screening procedures

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 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.
- There were 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 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. For example, all staff were trained in basic life support.
- 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 were 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.
- Prescriptions were stored securely and records kept of when they were removed from printers at night. A record was not kept of the handwritten prescriptions kept by GPs.

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

Good

Are services safe?

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 acted to improve safety in the practice.
- The practice acted on and learned from external and internal safety events as well as patient and medicine safety alerts. There was no summary log of safety alerts for monitoring. Although a standard form for recording significant events was available, this was not used by all staff.

Please refer to the evidence tables for further information.

Good

Are services effective?

We rated the practice and all of the population groups as good for providing effective 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.
- A range of appointments were available to reflect patients' needs including telephone and face-to-face consultations. Longer appointments were available if necessary.
- A register of patients' carers was kept and they were offered regular health checks.
- All staff were trained in adult and child safeguarding guidelines.
-

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.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs. All patients over 75 years old had a named GP.
- The building was accessible for patients with mobility problems, although a lift was not provided. A consultation room was available on the ground floor for patients who were unable to manage the stairs.
- Influenza and pneumococcal vaccinations clinics were available along with shingles vaccinations.
- Patients aged over 75 were invited for a health check. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan. The practice had close links with Age UK and the Carers Centre in Bury.
- The practice followed up on older patients discharged from hospital, and there was a process for alerting clinicians when significant diagnosis was made. In these circumstances, the patient's care plan was reviewed and updated.
- A named GP visited patients registered with the practice but living in a nursing / residential care home for continuity of care.
- There was a system for actively tracking patients approaching the end of their life. GPs and clinical staff worked with healthcare professionals to provide a team approach to managing patients' care.

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.
- 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 could demonstrate how it identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension)
- Patients with long term conditions which may leave them at increased risk of hospital admission were closely monitored and provided with information about how to manage their health at home.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma. Patients who were discharged from hospital had their medication checked by a practice pharmacist.

Good

Are services effective?

- The practice's performance on quality indicators for long term conditions was above local CCG and national averages. For example, the percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) was 140/80 mmHg or less was 94%. This compared to the CCG average of 80% and the national average of 78%.

Families, children and young people:

- Childhood immunisation uptake rates were above the target percentage of 90% or above. Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccinations given 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.
- A full range of family planning services were available on site including oral contraception, implants and coils.
- The practice had an active process for doing cervical smears, and identifying non-responders and encouraging attendance.
- Appointments were available for immunisations to fit around school times.
- 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 ran a baby clinic to provide support for mothers and a 6-week baby check.
- A GP with a special interest in gynaecology ran a weekly clinic for women.
- The practice ensured that there was the choice of male and female GPs.

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

- The practice's uptake for cervical screening was 82% which was above the 80% coverage target for the national screening programme.
- The practice's uptake for breast and bowel cancer screening was in line with the local CCG and national average.
- Patients who did not engage in cervical smear, breast or bowel screening were targeted by the practice.
- 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.
- Practice nurse and health care assistant appointments were available from 8am to 6pm

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.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- Reception staff were alerted through the IT system to patients who failed to collect prescriptions or when patients did not attend appointments.
- GPs worked with and referred to local services such as the drug and alcohol services and mental health services.
- There was a process for identifying patients who were at increased risk from a hospital diagnosis.
- The practice had signed up to the local homeless pledge and was aware of the sleep scheme being managed by the local authority.
- The practice used language translation and signing facilities.

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.

Good

Are services effective?

- Patients at risk of dementia were offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- The practices performance on quality indicators for mental health was above the local CCG and national averages. For example, the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in the record in the preceding 12 months was 100%. This was compared to the CCG average of 94% and the national average of 90%.
- The practice had a process for reducing antipsychotic medicines in patients with dementia and learning disabilities. This work was led by the practice pharmacist who was the national lead for STOMP. STOMP stands for stopping over medication of people with a learning disability, autism or both with psychotropic medicines.
- Information leaflets were available at the practice and services were promoted on the practice website and Facebook page.

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 patients with long term conditions, older patients and patients 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.
- Staff training was provided through clinical meetings, online training and formal face to face training events.
- The practice understood the learning needs of staff and provided protected learning time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff at all levels told us they were encouraged and given opportunities to develop in their role.
- The practice provided staff with ongoing support. There was an induction programme for new staff. This included one to one meetings, appraisals, mentoring, clinical supervision and 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 considered the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

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

Good

Are services effective?

- 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.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.
- Staff encouraged and supported patients to be involved in monitoring and managing their own health, for example through social prescribing schemes. The practice actively promoted social prescribing which aimed to improve patients' quality of life, health and wellbeing by recognising that health was affected by a range of social, economic and environmental factors. They promoted patients attending local services such as the Creative Living Centre, Bury Exercise and Therapy Scheme (BEATS) and the Living Well service.
- The practice had released time for the frontline staff to have active conversations with patients, and staff had completed the 'care navigator' training.

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 patients.
- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- The practice GP patient survey results were in line with local CCG 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.
- The practice proactively identified carers and supported them.

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.
- The practice staff were well informed about local support services and voluntary groups. They actively directed patients to use these services so they could manage their health care issues in a more holistic way.
- 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.
- Flexible appointments were available to accommodate patients' needs. These included face-to-face and telephone appointments. The IT system alerted receptionist staff if a longer appointment or home visit was needed.
- Safeguarding policies and training was in pace for all staff.
-

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.
- A GP and practice nurse carried out home visits for those who had difficulties getting to the practice due to limited local public transport availability, mental health or social reasons.
- Flu vaccinations were given during home visits.

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. For example, clinics were held for patients with asthma and Chronic Obstructive Pulmonary Disease (COPD).
- Patients with long term conditions such as dementia and COPD had a care plan in place.
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues and palliative care.
- The practice had recently introduced a new service for patients who needed a longer appointment. Patients were sent a simple form to complete before their appointment asking them to think about what mattered to them and to list three things that made them feel happy or supported them. The purpose of this was to support the patient in the best possible way and to ensure they received a holistic package of care.
- Patients had access to routine GP and nurse appointments in the evening and weekend via the extended working hours.

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.
- All staff were trained in child safeguarding procedures.
- There was a safeguarding policy in place so staffs knew what to do if they had a concern about a patient's welfare.
- The practice could set up an immunisation programme in the event of a public health concern.

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

Good

Are services responsive to people's needs?

continuity of care. For example, extended opening hours in the evenings and weekend appointments. These were provided by the GP Federation although the practice nurse often provided Saturday morning surgeries
- Routine GP appointments were available from 8am to 6 pm, and on a Tuesday until 8 pm.
- NHS checks were actively promoted.
- WIFI was available in the whole practice.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed address.
- Annual reviews were carried out for patients with a learning disability. This appointment was provided either at the surgery or in the patient's own home.
- Patients' carers were offered an NHS health check

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 and mental illness.
- The administration staff had completed Dementia Friendly training
- The practice held GP led dedicated mental health and dementia clinics. Patients who failed to attend were proactively followed up by a phone call from a GP.
- Annual reviews were carried out to ensure patients' care plans accurately reflected their care needs.
- GPs liaised with mental health teams to ensure patients received the care they needed. The practice had close links with the Creative Living Centre, Dementia Advisory Service and Making Space.

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.
- Patients reported that the appointment system was easy to use.
- The practices GP patient survey results were in line with local CCG and national averages for questions relating to access to care and treatment.

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

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 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.

- 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.

- 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.
- There were processes for providing all staff with the development they need. This included mentoring 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 were positive relationships between staff and teams.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.

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.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control. For example, the practice nurse was responsible for infection control and a GPs had individual lead responsibility for managing safeguarding issues, complaints and quality assurance.
- 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 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. Multi-disciplinary meetings also took place to ensure staff had information from external sources about patients care needs. While a record was kept of the meeting held, some records lacked detail to give a clear summary of the discussions held.

Good

Are services well-led?

- 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 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' and staffs' views and concerns were encouraged, heard and acted on to shape services and culture.
- 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.