PRESTIGE MEDICAL GROUP

Mission statement, vision, values, and structure.

- Practice Mission Statement
- Practice Structure
- Practice Routines
- Evidence and examples of the quality of care provided for the six population groups

INTRODUCTION

Prestige Medical Group is committed to delivering exceptional healthcare by continuously striving for excellence across all aspects of patient care. This document provides an overview of how we meet and aim to exceed the standards set forth by the **Care Quality Commission** (CQC), structured around its Five Key Questions The 5 key questions we ask - Care Quality Commission and the 34 Quality Statements.

At Prestige Medical Group, our purpose is clear: **To deliver high-quality, sustainable healthcare through effective systems, continuous learning, and compassionate teamwork - removing health inequities and fostering kindness, inclusion, and a culture where everyone thrives.**

OUR VISION

We strive to eliminate health inequalities and ensure every person receives exceptional physical and mental healthcare - regardless of background or circumstance.

OUR VALUES

We live by the principles of:

ACCOUNTABILITY - Taking responsibility and acting with transparency

COMPASSION - Putting empathy and kindness into every action

RESPECT - Honouring individuality and creating inclusive environments

Together with: **KINDNESS, INCLUSION, TEAMWORK, CONTINUOUS LEARNING, AND EXCELLENCE**

These values shape how we serve, lead, and grow.

HOW WE STAY CQC - ALIGNED

We proudly meet the Care Quality Commission's Five Key Questions by ensuring care is:

SAFE

EFFECTIVE

CARING

RESPONSIVE

WELL LED

Across all 34 CQC Quality Statements, we champion equity, person-centred care, staff wellbeing, and continuous improvement—making our standards not just regulatory goals, but everyday practice.

PRACTICE MISSION STATEMENT

To deliver high-quality, sustainable healthcare through effective systems, continuous learning, and compassionate teamwork – removing health inequities and fostering kindness, inclusion, and a culture where everyone thrives.

PRACTICE STRUCTURE

To deliver our vision and values, we are structured to ensure accountable delivery.

BUSINESS MANAGER

Accountable to the Partners for the coordination of all leadership aspects of the organisation.

SAFE, EFFECTIVE, CARING, RESPONSIVE, WELL LED

Responsible for the timely achievement of all internal management tasks.

Responsible for external stakeholder engagement.

SENIOR ADMIN

Delegated accountability for aspects of administrative functions and patient contact aspects of the practice, in the absence of the PM to have active oversight of the daily administrative functions to ensure delivery of clinical appointments in the practice.

EFFECTIVE, CARING, RESPONSIVE

PRACTICE MANAGER

Delegated accountability for all aspects of the operational functions to allow the clinicians to attend to the patients.

ACP LEAD

Represents the ACP team and is responsible for working with the Management team to deliver seamless delivery of AHP services, dynamic oversight of Modern General Practice delivery, IPC.

SAFE, EFFECTIVE, CARING, WELL LED

NURSE LEAD

Represents the Nurse team and is responsible for, QOF achievement, IPC, clinical stock management, and working with the Management team to deliver the seamless delivery of Nursing services.

SAFE, EFFECTIVE, CARING, WELL LED

RECEPTION TEAM

Led by the Reception Lead, working as one department rotating all individuals to complete delegated tasks.

When not directly answering phones or interacting with patients face to face in reception - all individuals will be required to carry out other associated admin functions.

SAFE, EFFECTIVE, CARING, RESPONSIVE

RECEPTION LEAD

Responsible for the supervision and management of all reception staff ensuring all tasks, responsibilities and reception functions are carried out in accordance with agreed procedures, protocols and timescales.

EFFECTIVE, CARING, RESPONSIVE

PRACTICE ROUTINES

Delivery of the vision, values, and structure is enabled through individual accountability and a hierarchy of meetings.

ORGANISATIONAL

Partners Meeting (weekly)

Operations Meeting (weekly)

Staff Meetings

Departmental Meetings

Nurse/HCA Meeting (monthly)

ACP Meeting (monthly)

WORKSTREAM FOCUSSED

Modern General Practice

Long Term Condition Management

Disease area specific meetings e.g. respiratory, diabetes

Other meetings are convened according to current need and priorities.

SUPPORTIVE STRUCTURES

Clinical meeting (monthly)

ACP General Supervision

Pharmacy Clinical Supervision

Non-medical Prescribers

Long Term Condition Management

EVIDENCE AND EXAMPLES OF THE QUALITY OF CARE PROVIDED FOR THE SIX POPULATION GROUPS:

INTRODUCTION:

A vibrant and forward thinking practice, we strive to provide excellent medical care to our patient community. We take personal ownership of each of our patient population groups in order to provide them with high quality health care that meets their clinical needs. Working to educate, support and encourage our patients to consider making appropriate changes that will positively affect their overall health in order to improve their health status, living longer, better lives.

OLDER PEOPLE

Dr Alice Mervin is the PCN and Practice lead for this population group supported by the PCN Community and Care Home team consisting of:

- Community Matron (Care Homes)
- ARRS GP (Care Homes)
- Frailty Nurse
- Care Home HCA
- Nursing associates x 2.

Dr Mervin was involved in the design and implementation of the care home delivery plan and continues to provide oversight and clinical support to the team while they deliver monthly ward round with GPs and advanced care planning for people living in the community.

The service routinely reviews patients and processes to identify gaps in LTC reviews to feed back to NAs and/or individual practice. Frailty and dementia reviews and carried out along with the collating of information, appropriate DNACPR preparation and placement as well as care plan documentation.

The Care Home Nursing team conduct work up for LTC reviews for housebound patients (community or care home) and carry out physical checks which enable individual practice's nurses to complete reviews by telephone, reducing workload whilst maintaining quality and continuity of care.

The Care Home workload is coordinated by PCN team.

EVIDENCE

- A 4 weekly multi-disciplinary Palliative care meeting is held at the practice. This meeting is attended by the District Nursing Team, Hospice representative and the palliative care team.
- We have empowered an Administrator giving her delegated responsibility and ownership. She ensures that calling notice is sent in advance to allow each service to indicate patients to discuss and highlight areas of concern.
- The aim is to ensure a collaborative approach to patient care for patients approaching the end of life.

PEOPLE WITH LONG TERM CONDITIONS

Care is focused on the principles of the NHS Ten Year Plan, delivering a new model of care, fit for the future, it will be central to how we deliver on our health mission. The Modern General Practice (MGP) model has been fully embraced by the practice with '*the right care, at the right time, with the right person*' central to our appointment triage system.

QOF – robust recall systems evidenced by an annual good QOF achievement. Responsibility for clinical domains shown in the table. This process ensures accountability and gives teams ownership and a sense of pride for clinical achievement within these areas.

CLINICAL AREA	CLINICAL LEAD	NURSE LEAD	ADMIN LEAD
RESPIRATORY (asthma & COPD)	**Fiona Colton** (ANP)	**Joanne Motley**	**Sarah Peirce**
CARDIOVASCULAR (atrial fibrillation, CHD, cholesterol, CKD, heart failure, peripheral arterial disease, stroke & TIA)	**Dr Lucy Astle**	**Joanne Motley**	**Ciara Thain**
DIABETES (non-diabetic hyperglycaemia)	**Dr Martin Astle**	**Kelly Huges**	**Rachel Forster**
CANCER	**Dr Sana Andleeb**		**Ciara Thain**
MENTAL HEALTH	**Dr Alice Mervin**		
DEMENTIA	**Dr Alice Mervin**		**Ciara Thain**
PALLIATIVE CARE	**Dr Alice Mervin**		**Ciara Thain**
LEARNING DISABILITY	**Dr Alice Mervin**	**Vicki Lee** (ANP)	
VACCINATION & IMMUNISATION		**Joanne Motley**	

PEOPLE WITH LONG TERM CONDITIONS

The process description below illustrates the recall and review system for diabetes Patient with diabetes review due:

1. Invitation sent following the practice system (link to document i.e. policy around inviting and exempting)
2. Patient attends first appointment with HCA or Nurse (long term condition work-up). A nurse digital review is booked for follow-up of results.
3. GP actions blood results (checks a digital review has been booked)
4. Nurse within digital review, reviews work-up appointment, and blood results.
5. Diary date is moved on if no further action needed, or patient is invited to make a face-to-face follow-up appointment.

Standard pathways protocols for reviews and use of Ardens smart templates where applicable. The multi-morbidity template is particularly useful, as it supports a making-every-contact-count (MECC) approach and asks, "*what matters to you?*"

Investment in technology e.g. in-house 24-hour blood pressure service, Broomwell ECG service.

The practice has recently incorporated some automation of blood results, using GP Automate. This system has MHRA approval and follows standard algorithms for processing of normal blood results and some abnormal results e.g. lipids and HbA1c. Information about use of GP Automate is published on the practice website.

Standardised, evidence-based information about reviews e.g. information about statins exists as a standard letter on the website and a paper version sent to patients. At present all patients are receiving paper letters, but there is an aim to move to digital versions for patients who have access.

For Housebound and care home patients – LTC reviews by the PCN nursing team linking with the practice team or our own nursing team. GPs review their own care home list before reviews are completing, for example in the situation where a patient is receiving palliative care, they are most likely to be exempted from reviews. Decisions are made on a case-by-case basis.

PEOPLE WITH LONG TERM CONDITIONS

The practice has adopted the Lancashire and South Cumbria, long-term condition LES, which focuses on improving equity of care and ensuring long-term condition reviews are holistic. The key areas of focus are diabetes and respiratory. A patient with COPD will be asked about any housing concerns and referred for support if needed. This approach integrates with practice work to reduce health inequalities.

The practice is an energetic participant in the Long-Term Condition Local Enhanced Service, currently focusing on local priority groups for diabetes and COPD as well as patients with SMI and Population Health/Health Inequalities groups.

The Practice has process and protocols to ensure Patients have a yearly recall set. As part of an ongoing process of continuous improvement and to complement and enhance the system is in the process of moving to an ARDENS templated system.

Reports are run monthly, and letters sent advising yearly review is due.

An initial appointment is with the HCA and all relevant checks are carried out and a follow up appointment booked with the Practice Nurse.

A task is created to send results letter which ensures that the patient has all information for the follow up appointment.

Patient attends the Practice Nurse appointment to discuss results etc. and recall set for the following year with administrative checks to confirm the process is carried out.

EVIDENCE

- Practice Managers hierarchy recall
- Recall policy
- Example of pathways: lipids, hypertension
- Standard document for reviews – on all noticeboards

PEOPLE WHOSE CIRCUMSTANCES MAKE THEM VULNERABLE

The practice maintains a LD register which is maintained by the Lead ANP (Sister Vicki Lee) and has a specific policy regarding patient dignity, included within the policy is a list of examples of those groups that may make up the vulnerable.

We have a learning disability team within the practice. This consists of Dr A Mervin, ACP Vicki Lee and supported by a named administrator (Ciara Thain). Queries from patients about annual reviews, needing extra time or support for appointments or general information are sent to this group, which also have their own internal email. (Learning disability team).

This group attended an online seminar delivered by the Learning Disability Health Facilitation Team from LSCft and engaged with the learning disability coordinators at the hospital to better support our patients with moderate to severe learning disabilities who may need secondary care support with outpatient appointments and urgent cancer referrals.

The recording and picking up of missing patients for the LD register is conducted using an inclusion tool form which is a scoring system which will give weight to various answers which will increase the likelihood of a person having a learning disability.
Additionally, the Practice conducts an annual validation process with external agencies.

Dr Alice Mervin is the Adult safeguarding lead and Dr David Cliff is the child safeguarding lead. Dr Cliff was a hospital paediatrician for 10 years prior to becoming a GP and has extensive knowledge and experience. Safeguarding/vulnerable patients are a standing item at the monthly clinical meeting where all related items are discussed for GP awareness.

Dr Lucy Astle is the Health Inequality Clinical Lead for Burnley East PCN. In this capacity she has worked with practices to improve the care for people experiencing health inequalities, following the NHS CORE20Plus approach. This work has informed the Lancashire and South Cumbria Long Term Condition LES, which is about creating a sustainable approach to providing holistic health assessment to people in need.

PEOPLE WHOSE CIRCUMSTANCES MAKE THEM VULNERABLE

Health inequality work has also focused on inclusion health groups such as individuals experiencing homelessness, asylum seekers and refugees, individuals in contact with probation services, and individuals with alcohol and drug problems. The practice has established close links with voluntary, community, faith, and social enterprise (VCFSE) organisations in Burnley, and the practice is recognised for its kind and flexible approach, for examples facilitating same day registration for patients, providing supporting letters, offering flexible appointments, and consistent use of translation services.

Dr Astle has worked with the PCN team to establish an outreach service where drop-in clinics are providing in the community and can be accessed for health advice, long-term condition reviews.

Through liaison with Inspire, the practice offers a ‘shared care approach’ for those patients who are stable on opioid substitution treatment. Dr Liz Curtis works closely with a trained and knowledgeable worker in substance misuse. Meeting patients with the worker annually for a review of their care plan and a full risk assessment.

EVIDENCE

- Patient Dignity Policy

FAMILIES, CHILDREN, AND YOUNG PEOPLE

Ante-natal clinics are held weekly by the midwife who works with the doctors and the Hospital to provide both ante-natal and post-natal care. Post natal check appointments with a GP are available on request.

The practice proactively contacts the parents of all newborn babies to invite them to a combined 8 week check and first immunisation appointment with a appropriately trained GP. Further immunisation appointments are delivered by the Nursing team. In recent years, the practice has participated in additional weekend MMR sessions to address poor local immunisation rates.

Young children and new mothers are considered and prioritised by the team for the same day access service or the on-call GP.

WORKING AGE PEOPLE (Including recently retired and students)

The practice recognises that the working community can often find it difficult to find appointments, particularly if they are suddenly ill. To best address this, we have introduced the **Modern General Practice Total Triage model.** This offers a triaged telephone and face to face service for acute onset illness and acts as an advice and guidance service for patients with illness questions and concerns.

PEOPLE EXPERIENCING POOR MENTAL HEALTH
(Including people with dementia)

The practice is dementia friendly with all staff have previously participating in the training and a refresher process was commenced in December of 2022.

Dr Alice Mervin is the Practice lead on mental health and coordinates the care as delivered by the PCN Mental Health worker based in the practice.

Guided by QOF and the Local Enhanced Service for Dementia we offer a programme of annual reviews for people living with dementia and, where appropriate, their carers. These are carried out at home by the PCN team for those who are housebound or living in residential of nursing homes and by our in-house nursing team for those who can attend. We aspire to a "*one-stop shop*" approach for annual reviews for this group to minimise any distress caused by repeated appointments.

Where a range of health and social needs are recognised, we refer onward to the integrated neighbourhood team for a coordinated approach.

APPOINTMENTS

The Practice Leads and the Modern General Practice working party regularly review access and demand to ensure our appointment provision best matches patient need. These reviews include input by the Patient Participation Group.

We ensure staffing levels and a skills mix that promotes and delivers safe care and treatment.

APPOINTMENT BOOKING PROCESS

Total Triage is a modern approach to managing patient access to general practice services. In this model, every patient request (whether by phone, online, or in-person) is first assessed (triaged) before being directed to the most appropriate healthcare professional or service.

The Total Triage model incorporates several key features that enhance the delivery of general practice services. It adopts a digital-first approach, encouraging patients to submit consultation requests online, which allows for timely and structured information gathering. All patient contacts are then assessed by clinicians through a process of clinical triage (Red, Amber, Green), ensuring that each case is directed to the most appropriate healthcare professional.

RED - preferable that the patient is seen within 24 hours.
Patient is contacted by the reception team directly and an appointment arranged on the day, where possible.

AMBER - preferable the patient is seen within 4-7 days.
Patient is contacted using the most appropriate means* and offered an appointment.

GREEN - preferable the patient is seen within 7-14 days.
Patient is contacted using the most appropriate means* and offered an appointment.

*(online booking link, text message, telephone call)

This system enables equitable prioritised access, where urgent cases are identified quickly and managed accordingly, while routine issues are scheduled more efficiently.

The model also leverages the expertise of multi-disciplinary teams, meaning patients may be seen by a health practitioner based on their specific needs. It also allows continuity of care to be a factor considered during the appointment offering process.

Finally, care is delivered through a combination of remote and in-person consultations, with the mode of contact chosen according to clinical necessity and patient preference.

Where patients, for whatever reason, have challenges to complete the online form our staff are on hand to either guide them through the process (over the phone or in person at the practice). Where requested Staff will complete the form for the patient so that no individual is excluded.

CARE NAVIGATION

Our receptionists are all trained to direct patients to the most appropriate service or individual. They will request pertinent information when patients ring to book an appointment or make a request. This is to ensure they receive the most appropriate guidance relative to their identified needs.

As an organisation we are cognisant of the concerns of patients being asked questions by non-clinical staff. To ensure that the questions are appropriate we have a rolling program of continuous training for the reception staff. This is overseen and quality controlled by the Lead ACP.

As part of the care navigation the reception staff will direct patients with coughs and colds and other minor illnesses without consulting a medical professional.
They will signpost to useful advice about self-management of common conditions and provide links and direct patients to our website to use the links or to other NHS resources.

NURSING TEAM APPOINTMENTS

Our nurses and health care assistants see patients for routine reviews and investigations. For patients with a Long-term condition, they are sent a choice of appointments for them to select and book electronically.

Other routine or emergent requirements for nurse appointments are booked in person or via the telephone. These appointments can be booked up to 14 days in advance, and further ahead at the discretion of the team linked to patient need.

Unutilised LTC appointments are changed to routine nursing appointments 48 hours ahead of availability to maximise uptake and use.

TRAINING

The recruitment process ensures that staff have the skills, knowledge and experience to deliver safe and effective care, support and treatment. We use the NHS jobs resource, which ensures adherence to anti-discrimination recruitment processes. It also ensures candidates are aware of the positional requirements, which are checked during the hiring procedure.

TRAINING

All new employees participate in an induction programme, within the first week of starting work. This ensures the delivery of effective training in our safety systems, processes and practices from the outset. Thereafter employees are required to complete the NHS's statutory and mandatory training. Attendance at statutory and mandatory training forms part of an employees terms and conditions.

This training includes core health and safety awareness and training:

- Awareness of the local health and safety policy
- Awareness of the control of substances hazardous to health *(COSHH)*
- When and how to report injuries, diseases and dangerous occurrences *(RIDDOR)*
- Fire safety awareness training
- Manual handling training
- Basic risk assessment training
- Annual updates in essential areas of fire safety and manual handling

Individual clinical professions are also required to carry out specific training to ensure the safe and efficient delivery of services.

All staff receive regular training in Basic Life Support (BLS) and safeguarding to ensure prompt, appropriate responses to emergencies and to protect vulnerable patients. We uphold strict data security protocols to maintain patient confidentiality and comply with information governance standards. Focused training is delivered as part of the new joiner's induction period and then supported annually through internal training opportunities.

We have a proactive Learning Disability Awareness to provide accessible, person-centred care that reduces health inequalities, while conflict resolution training equips staff to manage challenging situations with professionalism and compassion. Equality, diversity, and inclusion are embedded across our practice, ensuring that every patient is treated with dignity, respect, and fairness.

COMPETENCY LEVELS AND SUPERVISION

Our internal recruitment processes assure that staff can demonstrate the appropriate level of competency for patients to provide care and treatment. Staff employed on a temporary or locum basis are required to provide appropriate certification.

Developmental and staff learning needs are addressed during the appraisal process and ensure that we have a culture of continuous improvement and staff development.

As part of the induction process new joiners have a period of shadowing and supervision commensurate to the individuals experience and assessed needs.

GOVERNANCE

CLINICAL AND ADMINISTRATIVE

The Practice has a robust governance system enabled by a hierarchical structure, individual accountability supported by a range of meetings where information is shared. This then populates into subsequent forums.

The monthly **Practice clinical meeting** is the primary enabler for this process. Within the agenda there are several standing items e.g. new cancer, sepsis review.

There is a **Burnley East INT MDT** held monthly. This MDT is an opportunity for any clinician to discuss patients for advice and general clinical awareness. External partners contribute to the meeting and participate where they have the information they wish to communicate or discuss with the clinicians. The meeting is attended by Practice representatives and attended by Social Services, health and voluntary sector agencies including carer support services to ensure a two-way flow of pertinent information to each organisation.

A **palliative care meeting** is held monthly in the practice and includes representatives from the Practice, District Nursing Team, ELHT clinicians and administrators.

Weekly Team lead meetings discuss the operational aspects of the interrelationship working across the practice.

Modern General Practice and **Chronic disease management** meetings are held at regular intervals so that each element of the service delivery is reviewed and refreshed.

SIGNIFICANT EVENT ANALYSIS

The Practice is fully committed to the routine and regular analysis of significant events. Significant incidents are investigated within the specific department in the first instance. Team leads collect and collate as much information on the event as possible from personal testimonies, written records and other healthcare documentation.

The team carries out a detailed discussion of the event, looking for insightful analysis and identifying learning needs and agreement on any action to be taken. This is then brought to the weekly meeting by the team lead or to the monthly clinical meeting dependant on content and urgency, having understood the root cause.

The analysis of a significant event is guided by answering four questions:

1. What happened?
2. Why did it happen?
3. What has been learned?
4. What has been changed or actioned?

Once these have been addressed, the incident is then discussed from a whole practice perspective to see what interdependencies there may be. Next, they are reviewed, ensuring full awareness of all issues (Clinical/non-clinical), learning identified and captured. This learning is then disseminated appropriately, and the agreed action implemented by staff designated.

A comprehensive, anonymised, written record of every SEA is captured within the meeting and placed in the SI file. They are reviewed again looking for trends/practice weaknesses. Outcomes from this meeting are communicated to the Practice with specific actions delegated to individuals. The action is held open until reported complete to ensure assurance.

LOCALITY WORKING

PMG is an active participant in Burnley East PCN and PCN professionals employed under the ARRS scheme deliver services to our patients. These include social prescribers, first contact physiotherapists, pharmacists, pharmacy technicians, paramedic, nursing associates and care coordinators.

Additionally, a Community Matron and Frailty Nurse are employed under the EHCH and local over 75 service. These professionals are employed by the local GP Federation under a service level agreement (except for social prescribers employed by the Council of Voluntary Services and physios employed by a private provider). The Federation are responsible for their recruitment, training and supervision. Direct line management is provided by the PCN. These allied staff record directly into the patients' medical records under a data sharing agreement. This allows them to operate as part of the practice team with appropriate oversight of their work by the GPs.

Dr Alice Mervin is the locality lead for Care Homes and the over 75’s.

Dr Lucy Astle is the locality lead for Health Inequalities.

PMG QUALITY STATEMENTS

SAFE KEY QUESTION

Safety is a priority for everyone, and leaders embed a culture of openness and collaboration. People are always safe and protected from bullying, harassment, avoidable harm, neglect, abuse and discrimination. Their liberty is protected where this is in their best interests and in line with legislation.

1. Learning culture: We have a proactive and positive culture of safety based on openness and honesty, in which concerns about safety are investigated and reported thoroughly, and lessons are learned to continually identify and embed good practices.

2. Safe systems, pathways and transitions: We work with people and our partners to establish and maintain safe systems of care, in which safety is managed, monitored and assured. We ensure continuity of care, including when people move between different services.

3. Safeguarding: We work with people to understand what being safe means to them as well as with our partners on the best way to achieve this. We concentrate on improving people's lives while protecting their right to live in safety, free from bullying, harassment, abuse, discrimination, avoidable harm and neglect. We make sure we share concerns quickly and appropriately.

4. Involving people to manage risks: We work with people to understand and manage risks by thinking holistically so that care meets their needs in a way that is safe and supportive and enables them to do the things that matter to them.

5. Safe environments: We detect and control potential risks in the care environment. We make sure that equipment, facilities and technology support the delivery of safe care.

6. Safe and effective staffing: We make sure there are enough qualified, skilled and experienced people, who receive effective support, supervision and development. They work together effectively to provide safe care that meets people's individual needs.

7. Infection prevention and control: We assess and manage the risk of infection. We detect and control the risk of it spreading and share any concerns with appropriate agencies promptly.

8. Medicines optimisation: We make sure that medicines and treatments are safe and meet people's needs, capacities and preferences by enabling them to be involved in planning, including when changes happen.

EFFECTIVE KEY QUESTION

People and communities have the best possible outcomes because their needs are assessed. Their care and support and treatment reflects these needs and any protected equality characteristics. Services work in harmony, with people at the centre of their care. Leaders instil a culture of improvement, where understanding current outcomes and exploring best practice is part of everyday work.

1. Assessing needs: We maximise the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

2. Delivering evidence-based care and treatment: We plan and deliver people's care and treatment with them, including what is important and matters to them. We do this in line with legislation and current evidence-based good practice and standards.

3. How staff and teams work together: We work effectively across teams and services to support people. We make sure they only need to tell their story once by sharing their assessment of needs when they move between different services.

4. Supporting people to live healthier lives: We support people to manage their health and wellbeing so they can maximise their independence, choice and control. We support them to live healthier lives and where possible, reduce their future needs for care and support.

5. Monitoring and improving outcomes: We routinely monitor people's care and treatment to continuously improve it. We ensure that outcomes are positive and consistent, and that they meet both clinical expectations and the expectations of people themselves.

6. Consent to care and treatment: We tell people about their rights around consent and respect these when we deliver person-centred care and treatment.

CARING KEY QUESTION

People are always treated with kindness, empathy and compassion. They understand that they matter and that their experience of how they are treated and supported matters. Their privacy and dignity is respected. Every effort is made to take their wishes into account and respect their choices, to achieve the best possible outcomes for them. This includes supporting people to live as independently as possible.

1. Kindness, compassion and dignity: We always treat people with kindness, empathy and compassion and we respect their privacy and dignity. We treat colleagues from other organisations with kindness and respect.

2. Treating people as individuals: We treat people as individuals and make sure their care, support and treatment meets their needs and preferences. We take account of their strengths, abilities, aspirations, culture and unique backgrounds and protected characteristics.

3. Independence, choice and control: We promote people's independence, so they know their rights and have choice and control over their own care, treatment and wellbeing.

4. Responding to people's immediate needs: We listen to and understand people's needs, views and wishes. We respond to these in that moment and will act to minimise any discomfort, concern or distress.

5. Workforce wellbeing and enablement: We care about the wellbeing of our staff, and we support and enable them to deliver person-centred care.

RESPONSIVE KEY QUESTION

People and communities are always at the centre of how care is planned and delivered. The health and care needs of people and communities are understood, and they are actively involved in planning care that meets these needs. Care, support and treatment are easily accessible, including physical access. People can access care in ways that meet their personal circumstances and protected equality characteristics.

1. Person centred care: We make sure people are at the centre of their care and treatment choices and we decide, in partnership with them, how to respond to any relevant changes in their needs.

2. Care provision, integration, and continuity: We understand the diverse health and care needs of people and our local communities, so care is joined-up, flexible and supports choice and continuity.

3. Providing information: We provide appropriate, accurate and up-to-date information in formats that we tailor to individual needs.

4. Listening to and involving people: We make it easy for people to share feedback and ideas or raise complaints about their care, treatment and support. We involve them in decisions about their care and tell them what's changed as a result.

5. Equity in access: We make sure that everyone can access the care, support and treatment they need when they need it.

6. Equity in experiences and outcomes: We actively seek out and listen to information about people who are most likely to experience inequality in experience or outcomes. We tailor the care, support and treatment in response to this.

7. Planning for the future: We support people to plan for important life changes, so they can have enough time to make informed decisions about their future, including at the end of life.

WELL-LED KEY QUESTION

There is an inclusive and positive culture of continuous learning and improvement. This is based on meeting the needs of people who use services and wider communities, and all leaders and staff share this. Leaders proactively support staff and collaborate with partners to deliver care that is safe, integrated, person-centred and sustainable, and to reduce inequalities.

1. Shared direction and culture: We have a shared vision, strategy and culture. This is based on transparency, equity, equality and human rights, diversity and inclusion, engagement, and understanding challenges and the needs of people and our communities in order to meet these.

2. Capable, compassionate and inclusive leaders: We have inclusive leaders at all levels who understand the context in which we deliver care, treatment and support and embody the culture and values of their workforce and organisation. They have the skills, knowledge, experience and credibility to lead effectively. They do so with integrity, openness and honesty.

3. Freedom to speak up: We foster a positive culture where people feel that they can speak up and that their voice will be heard.

4. Workforce equality, diversity and inclusion: We value diversity in our workforce. We work towards an inclusive and fair culture by improving equality and equity for people who work for us.

5. Governance, management and sustainability: We have clear responsibilities, roles, systems of accountability and good governance. We use these to manage and deliver good quality, sustainable care, treatment and support. We act on the best information about risk, performance and outcomes, and we share this securely with others when appropriate.

6. Partnerships and communities: We understand our duty to collaborate and work in partnership, so our services work seamlessly for people. We share information and learning with partners and collaborate for improvement.

7. Learning, improvement and innovation: We focus on continuous learning, innovation and improvement across our organisation and the local system. We encourage creative ways of delivering equality of experience, outcome and quality of life for people. We actively contribute to safe, effective practice and research.

8. Environmental sustainability, sustainable development: We understand any negative impact of our activities on the environment and we strive to make a positive contribution in reducing it and support people to do the same.

CLINICAL ROLES AND RESPONSIBILITIES

DISEASE	LEAD
ADHD	LC
Anticoag	MA
Atrial Fibrillation	MA
Cancer	SA
Cervical Screening / Cytology	GW
Child Health / Baby Clinic	DC
CVD - Heart Disease	LA
Dementia	AM
Depression	AM
Diabetes	MA
Essential Hypertension	LA
Frailty	AM
Gynae	GW / LA
Heart Failure	LA
Housebound / Care Home Patients	AM
HRD	MA
IPC	LD
Inspire / Blue Scripts	LC

CLINICAL ROLES AND RESPONSIBILITIES

DISEASE	LEAD
Learning Difficulties	AM / VL
Mental Health	AM
Menopause	LA / SF
Minor Ops	LC
NMP	MA
PPG	AM
Respiratory - Asthma & COPD	FC
Safeguarding Adults	AM
Safeguarding Children	DC
Stroke & PVD	LA
Training	DC

WORKSTREAMS	LEAD
Demand Management	LC
Chronic Disease	MA / LA
Methods of Consultation	DC / AM

RESOURCES

- **The 5 Key Questions We Ask** - *Care Quality Commission*
- **The 34 Quality Statements** - *Care Quality Commission*
- **10 Year Health Plan for England: fit for the future** - *NHS*
- **Ardens**
- **Britain's Largest ECG Interpretation Service For NHS Primary Care** - *Broomwell Healthwatch*
- **GP Automate**
- **Core20PLUS5 (adults) – an approach to reducing healthcare inequalities** - *NHS*
- **Best Practice Sessions** - *NHS Lancashire and South Cumbria Integrated Care Board*
- **Control of Substances Hazardous to Health** - *Health and Safety Executive*
- **RIDDOR** - *Health and Safety Executive*