Dr Law & Partners

Inspection report

The Surgery
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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 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 Dr Law & Partners on 31 October 2018 as part of our inspection programme.

At this inspection we found:

- The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence-based guidelines.
- The practice understood the needs of its population and tailored services in response to those needs. There was evidence of a number of projects and services the practice had been involved with to ensure patients' needs were met.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- The appointment system had changed to a Care Navigation system in which reception staff had been in receipt of appropriate training.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.

There were areas of outstanding practice:

- The practice had developed a number of bespoke protocols and 'intelligent' templates on the electronic record system which included automated prompt messages for care plans, referral forms and links to information support packs/guidance and local services, so that GPs were able to ensure patients received standardised, up to date and timely care and treatment at the point of need.
- The practice identified the need for additional primary care input into local care homes to improve outcomes for older people with urinary tract infections. As part of this project, the practice provided training to care home managers and staff on their 'urinary tract infection pathway' which strengthened systems and ensured older people received effective care and treatment. This was being considered as potentially being rolled out CCG wide.

Professor Steve Field CBE FRCP FFPH FRCGPChief Inspector of General Practice

Please refer to the detailed report and the evidence tables for further information.

Population group ratings

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

Our inspection team

Our inspection team was led by a Care Quality Commission (CQC) lead inspector. The team included a GP specialist adviser and a practice manager adviser.

Background to Dr Law & Partners

Dr Law and Partners' practice provides primary medical services to patients living in Burton-on-Trent, Staffordshire. The practice is a two-storey purpose-built town practice. The practice has its own patient car park with easy access for patients with disabilities. The practice building is owned jointly by some of the partners. The practice hosts attached staff including district nurses, health visitors and midwives all of whom provide clinics within the practice.

There is a team of six GP partners, three salaried GPs (one currently on maternity leave) and a GP Registrar. Other clinical staff include a senior practice nurse, five practice nurses and a health care assistant. The clinical team are supported by a practice manager, assistant practice manager, receptionists and administrative staff including IT leads, note summariser and an apprentice. The practice provides care and treatment for approximately 11,056 patients. There are female and male GPs at the practice to provide patients with a choice of who to see.

The practice provides an anticoagulation clinic for patients who are on blood thinning medicine and need to have their blood monitored on a regular basis. The practice is a training practice for GP Registrars (a fully qualified doctor who is training to become a GP).

Opening hours are 8am until 6pm Monday to Friday. From the hours of 8am and 8.30am, a telephone message advises patients to call the surgery's mobile number in the event of an emergency. The practice is closed every Thursday lunchtime between 12.30pm and 1.30pm for staff training, and one half day each month from 2pm. The practice has opted out of providing an out of hours care provision. Out of hours care is provided by Staffordshire Doctors Urgent Care Limited. Between the hours of 6pm and 8am, patients are advised to call NHS 111.

Further information about the practice can be found at: www.wetmoreroadsurgery.co.uk

Good

Are services safe?

W e rated the practice as good for providing safe services.

Safety systems and processes

The practice had clear systems to keep people safe and safeguarded from abuse.

- The practice had appropriate systems to safeguard children and vulnerable adults from abuse. All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Learning from safeguarding incidents were available to staff. Staff who acted as chaperones were trained for their role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- Staff took steps, including working with other agencies, to protect patients from abuse, neglect, discrimination and breaches of their dignity and respect.
- The practice carried out appropriate staff checks at the time of recruitment and on an ongoing basis.
- There was an effective system to manage infection prevention and control.
- The practice had arrangements to ensure that facilities and equipment were safe and in good working order.
- Arrangements for managing waste and clinical specimens kept people safe.

Risks to patients

There were adequate systems to assess, monitor and manage risks to patient safety.

- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness, busy periods and epidemics.
- There was an effective induction system for temporary staff tailored to their role.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections including sepsis.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

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

- The care records we saw showed that information needed to deliver safe care and treatment was available to staff.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made timely referrals in line with protocols.

Appropriate and safe use of medicines

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

- 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 taken action 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.

- Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice.

Good

Are services safe?

- The practice acted on and learned from external safety events as well as patient and medicine safety alerts.

Please refer to the evidence tables for further information.

Good

Are services effective?

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

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.
- Ambulatory blood pressure machines were available for assessed patients who required monitoring.
- Atrial fibrillation (AF) monitoring equipment was used to improve detection. (AF is a heart condition that causes an irregular and often abnormally fast heart rate).
- Staff advised patients what to do if their condition got worse and where to seek further help and support.
- The practice had developed bespoke protocols and 'intelligent' templates on their electronic record system which included automated prompt messages for care plans, referral forms and links to information support packs/guidance and local services, so that GPs were able to ensure patients received standardised, up to date and timely care and treatment at the point of need.

Older people:

- Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. The practice used an appropriate tool to identify patients aged 65 and over who were living with moderate or severe frailty. Those identified as being frail had a clinical review including a review of their medicines.
- 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.
- The practice monitored if elderly patients missed an appointment. If there was a concern in this area they contacted the patient to find the reason for this and offered support as required. This was done on an individual basis.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Local care homes all had named GP's as leads to ensure wherever possible, continuity of care was provided for the most vulnerable of patients.
- The practice recently set up a urinary tract infection (UTI) pathway for the care homes to assist them in providing a standardised and safe method of treatment.
- The practice worked closely with district nurses and the community matron to ensure housebound patients who needed support received it effectively.
- The practice worked with third sector support organisations such as Age UK.
- The practice ensured older patients who were housebound received the flu vaccination at home.

People with long-term conditions:

- The practice had designed bespoke practice specific templates to ensure they captured all of the appropriate information for patients and ensure they receive the correct treatment and advice.
- The practice provided an in-house anti-coagulation monitoring service to assist patients in not having to travel to the hospital as well as in-house ECG's and Spirometry. Staff had a buddy system in place for ECG's to ensure they were thoroughly checked and reviewed.
- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- Practice nurses used signposting to direct patients to support groups and other treatment options and had developed a 'Wellbeing' pack which focused on healthy diet and increasing exercise.
- 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.

Good

Are services effective?

- The practice was working with Virgin Care on a new chronic obstructive pulmonary disease (a collective name for a number of lung diseases) pilot for patients whose management would be intensified with greater support. If successful, this may be rolled out to a greater number of patients and practices.
- The practice was able to demonstrate how it identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension).
- The practice's performance on quality indicators for long term conditions was in line with local and national averages.
- The practice met annually with the Adult Ability Team (a neurological community-based interdisciplinary team, comprising of the following specialists; Parkinson's nurses, multiple sclerosis nurses, occupational therapists, physiotherapists) to ensure a coordinated and high-quality service for people with progressive neurological conditions, from diagnosis and throughout the entire pathway.
- The practice withdrew from high risk medicines monitoring shared care arrangements and all other Amber 2 drugs, due to safety concerns around certain aspects of the monitoring system as the practice was not happy with safety procedures for some patients. The practice felt the system now in place provided patients with a clear support system for specialised medicines within secondary care.

Families, children and young people:

- Childhood immunisation uptake rates were above the target percentage of 90%.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation.
- Child safeguarding meetings took place amongst a multi-disciplinary team on a regular quarterly basis lead by the practice safeguarding lead.
- The practice told us they made sure children were seen the same day for urgent appointments.
- The practice provided a family planning services.

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

- The practice's uptake for cervical screening was 74% which was below the 80% coverage target for the national screening programme. The practice had targeted areas for improvement on their notice boards including cervical screening. They aimed to improve these results by health promotion, notice board leaflets and opportunistic discussions during consultations.
- The practice's uptake for breast cancer screening was below the CCG and England average, bowel cancer screening uptake was above the CCG and England average. The staff demonstrated their awareness of these results. They had sourced information in different languages and promoted screening on their notice boards, in leaflets and opportunistic discussions during consultations.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.

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

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services. There was a system for following up patients who failed to attend for administration of long term medicines.
- 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?

- The practice hosted and utilised the Toolbox clinic which provided low level support and signposting for patients experiencing poor mental health.
- The practice worked with a local drug and alcohol rehabilitation centre to support residents when they required a GP service.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia.
- The practice was a dementia friendly practice. They provided a dementia pack to those patients who needed them and supported carers of dementia patients. The practice nurses attended the Dementia friends training and one of the nurses was a Dementia Champion for the practice having attended training in January 2018.
- Where dementia was suspected there was an appropriate referral for diagnosis.
- The practice offered annual health checks to patients with a learning disability.

Monitoring care and treatment

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

- Quality Outcome Framework (QOF) results were in line with the CQC and slightly above the England average.
- 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 contraceptive reviews.
- Staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.
- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with ongoing support. There was an induction programme for new staff. This included one to one meetings, appraisals, coaching and 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 have relocated into the local area.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

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

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.

Good

Are services effective?

- Staff encouraged and supported patients to be involved in monitoring and managing their own health, for example through social prescribing schemes.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.

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?

W e 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 treat people.
- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- The practices GP patient survey results were in line with local and national averages for questions relating to kindness, respect and compassion.

Involvement in decisions about care and treatment

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

- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.
- The practice proactively identified carers and supported them. The practice had appointed two carer champions who work to ensure the practice provide appropriate support and advice.
- The practices GP patient survey results were in line with local and national averages for questions relating to involvement in decisions about care and treatment.

Privacy and dignity

The practice respected patients' privacy and dignity.

- 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 facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services.
- The practice provided effective care coordination for patients who are more vulnerable or who have complex needs. They supported them to access services both within and outside the practice.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs.
- The practice noted if an older patient missed an appointment and if there was a concern in this area contacted the patient to find the reason and offer support as required. This was done on an individual basis.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.
- The practice held an in-house anti-coagulation monitoring service to assist patients in not having to travel to the hospital.
- The practice provided in-house electrocardiogram (ECG) which is a simple test that can be used to check the heart's rhythm and electrical activity. The practice had a buddy system for ECG's to ensure they were thoroughly checked and reviewed.
- The practice completed in house Spirometry. (Spirometry is a simple test used to help diagnose and monitor certain lung conditions).
- The practice provided home blood pressure monitors for patients who needed them.

Families, children and young people:

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.

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

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- Text reminders and on-line booking were available to patients.
- Extended hours appointments were available via the East Staffordshire Extended Hours service between 6.30pm and 8pm Monday to Friday from September 2018.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.
- Homeless patients were not required to produce forms of identity to register at the practice.

Good

Are services responsive to people's needs?

- There was a named nurse for patients with a learning disability who had experience in working with people with a learning disability. The named nurse completed annual reviews and any nurse led appointments required throughout the year.

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

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- Staff had received dementia friendly training and provided a dementia pack to those patients who need them and supported carers. One of the practice nurses was a Dementia Champion for the practice having attended training in January 2018.
- The practice had worked with Age UK over the last year in arranging clinics with them where they attended surgeries and discussed their services.

Timely access to care and treatment

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

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- Patients reported that the appointment system was easy to use.
- The practices GP patient survey results were in line with local and England 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 also from analysis of trends. It acted as a result to improve the quality of care.

Please refer to the evidence tables for further information.

Good

Are services well-led?

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

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

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 we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.
- There were processes for providing all staff with the development they need, and managers prioritised investment in staff including apprenticeships.
- The practice promoted learning and development for staff including care home staff within their locality. The practice provided urinary tract infection training across the care homes to ensure patients regardless of whether they were registered at the practice received effective care which followed the appropriate care pathway.

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
- Practice leaders had established policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.
- The practice had processes to manage current and future performance. Practice leaders had oversight of safety alerts, incidents, and complaints. Each incident was assigned and reviewed. For example, more recently the nursing team submitted a ten-point action plan as described by the Chief Nursing Officer NHS England in July 2017 to recognise and develop roles that general practice nurses have which transform care and help

develop the plan to make the NHS fit for the future. This plan included discussion for a nurse associate role, training in immunisation for another practice nurse and succession planning.
- A range of quality improvement measures including 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 initiated projects to address key areas where issues were identified from performance data and implemented action plans. They had experienced common themes contributing to areas of lower performance including an increase in patient list size. Quality improvement areas included addressing lower uptake for cervical screening, bowel and breast cancer screening.

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.
- The practice used performance information which was reported and monitored, and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high-quality sustainable services.

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. There was an active patient participation group.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There was evidence of 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. Practice nurse individuals as well as the practice had achieved several awards from NHS Health Education England, including, Practice Nurse Mentor/ Educator of the Year 2016, New Practice Nurse of the Year 2016, General Practice Nurse Student of the Year 2017.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements. A range of procedural audits, clinical audits and other quality improvement projects had been developed.
- The practice was working with Virgin Care on a new COPD pilot for patients whose management would be intensified with greater support. If successful, this may be rolled out to a greater number of patients and practices.

Good

Are services well-led?

- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.
- There was evidence the practice developed, drove and initiated projects both in the practice and externally to impact change in services to meet needs of the local population.

Please refer to the evidence tables for further information.