# Elgar House

## Inspection report

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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 January 2015 – 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 Elgar House on 2 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. The practice discussed incidents, learned from them and improved their processes in order to prevent a recurrence.
- 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 and best practice.
- There was a cohesive, loyal practice team.
- Patients told us that staff treated them with compassion, kindness, dignity and respect and involved them in decisions about their care and treatment.
- Patient feedback on the level of care and treatment delivered by all staff was very positive.
- The practice had Armed Forces Veteran friendly accreditation.
- The practice promoted the Parkrun initiative for adults and children and was a certified Parkrun practice.
- Patient satisfaction results remained mixed with regard to telephone access. The practice had taken action as a result. For example, extra staff now manned the telephones at peak times.
- Continuous learning and improvement was actively encouraged at all levels of the organisation.

The areas where the provider **should** make improvements are:

- Continue to monitor and act on the results of patient satisfaction surveys in order to meet the needs of the patient population.
- Undertake a review of coding to ensure that patients receive care and treatment that meet their needs.
- Proactively encourage the uptake for cervical screening in order to ensure that appropriate care is provided.
- Consider ways to increase the identification of carers.

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

## Population group ratings

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

## Our inspection team

Our inspection team was led by a Care Quality Commission (CQC) lead inspector**.** The team included a GP specialist advisor and a second CQC inspector.

## Background to Elgar House

Elgar House is situated in Redditch, which is a town in north-east Worcestershire. An independent pharmacy is also based in the premises. Elgar House is registered with the Care Quality Commission (CQC) as a partnership provider to deliver the following Regulated Activities: diagnostic and screening procedures, family planning, maternity and midwifery services, surgical procedures and treatment of disease, disorder or injury. The surgery holds a General Medical Services (GMS) contract with NHS England. The GMS contract is a contract agreed nationally between general practices and NHS England for primary care services to local communities. At the time of our inspection, Elgar House was providing medical care to 14,721 patients.

The practice provides additional GP services commissioned by the NHS Redditch and Bromsgrove clinical commissioning group (CCG). For example, minor surgery. A CCG is an organisation that brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services.

There are two parking bays for disabled patients at the side of the practice. Other patients can use the public car park which is directly opposite the practice. Redditch bus station and railway station are within a few minutes' walk of the practice. The practice has facilities for disabled patients.

The practice is situated in an area with lower levels of deprivation. Information published by Public Health England rates the level of deprivation within the practice population group as five, on a scale of one to ten, where ten is the least deprived.

There are five GP partners (four male, one female) and five salaried GPs (one male, four female). Two salaried GPs were on maternity leave at the time of the inspection; their work was covered by locum GPs. They are supported by the practice manager, a deputy practice manager, two pharmacists, a specialist nurse practitioner, a nurse manager, two practice nurses, two healthcare assistants, and a reception and administrative team.

Elgar House is an approved training practice for trainee GPs. A trainee GP is a qualified doctor who is training to become a GP through a period of working and training in a practice. The practice cannot accept GP trainees until November 2019, because one trainer has recently retired and one is on maternity leave. The practice also offers placements to medical students from the University of Birmingham; one student is currently on placement at the practice.

Please see the evidence table for details of the opening hours and extended hours provision.

When the practice is closed, there is a recorded message giving details of the out of hours' service.

Information about the practice is available to download from their website: www.elgarhousesurgery.co.uk

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 and these were discussed at multi-disciplinary meetings, which were held every two to three months. Discussions were formally recorded and emailed to GPs. Learning from safeguarding incidents were available to staff.
- It was practice policy that only clinical staff acted as chaperones. They 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 (IPC). We saw that IPC audits were carried out annually.
- The practice had arrangements to ensure that facilities and equipment were safe and in good working order.
- Arrangements for managing clinical specimens kept people safe. We noted that the padlock on the clinical waste storage bin was not locked and that one of the metal clasps was broken, but the area was not accessible to patients or to the public and we were told that the issues were corrected the day after the inspection.

### 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. We were told that an additional member of reception staff had been recruited specifically to provide additional support answering telephones and cover during periods of absence, as well as carrying out reception duties. GPs provided holiday cover for each other whenever practical. Regular locums were employed to cover other periods of absence, including maternity leave.
- 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. We saw evidence of a co-ordinated approach between the practice and external agencies, such as district nurses and the health visitor to support the provision of safe care and treatment for patients.
- 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.

Good

# Are services safe?

- 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, up to date risk assessments in relation to safety issues. The risk assessments included Legionella.
- 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. The GP partners and the management team supported them when they did so.
- There were systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice. We saw that discussion of incidents was a standing agenda item at practice meetings.
- 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.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- Older patients who were frail or might be vulnerable received a full assessment of their physical, mental and social needs. The practice used an appropriate tool to identify patients aged 65 and over who were living with moderate or severe frailty. Those identified as being frail had a clinical review including a review of medication.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- Meetings to discuss patients with long term conditions were held every two months.
- 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 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 had 324 patients signed up to the online education programme for diabetes (Map My Diabetes), which was the highest number in the Redditch and Bromsgrove area. The next highest was 152 patients.
- Monthly audits were run to identify any patient with blood test results within the pre-diabetes range. These patients were invited either to self-refer to the National Prevention Programme or to contact the practice for further information.
- The practice actively screened all patients with a previous history of gestational diabetes (when a woman without diabetes develops high blood sugar levels during pregnancy) by inviting them to attend for an annual screen.
- The nurse who ran the diabetes clinic carried out diabetic reviews for housebound patients.
- The practice's performance on quality indicators for long term conditions was in line with local and national averages.

Families, children and young people:

- Childhood immunisation uptake rates were slightly lower than the target percentage of 90%. The practice was aware of this and actively encouraged uptake. Methods included producing letters about the importance of immunising children.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation.

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

- The practice's uptake for cervical screening was 63%, which was below the 80% coverage target for the national screening programme. The practice was aware that the uptake was below local and national averages and had taken steps to address this. Information about

cervical screening was prominently displayed in the reception area. We were told that many patients said that they preferred to have their screening done in their home country.
- The practice's uptake for breast and bowel cancer screening was in line with the national averages.
- 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. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

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

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

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services. There was a system for following up patients who failed to attend for administration of long term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- The practice offered annual health checks to patients with a learning disability.
- The practice's performance on quality indicators for mental health was in line with national averages, although exception reporting rates were higher than local and national averages. The practice told us that they would be reviewing coding practices.

**Monitoring care and treatment**

The practice had a programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. For example, the practice carried out regular clinical and non-clinical audits to monitor the standard of care and treatment.

- The practice was aware that exception rates were higher than local and national averages for some indicators. For example, chronic heart disease and chronic lung disease. We were told that this was due to coding issues and that this was being addressed.
- 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. For example, a nurse was studying for a master's degree in advanced clinical practice.
- 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.

Good

# Are services effective?

- 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 might 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 might 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.
- Staff encouraged and supported patients to be involved in monitoring and managing their own health, for example through social prescribing schemes. We were told that the Redditch and Bromsgrove clinical commissioning group funded a team of social prescribers for nine out of the 11 practices in Redditch, including Elgar House. Staff could refer patients to this service.
- The deputy practice manager (DPM) was the lead member of staff for the Parkrun scheme, after the practice received accreditation in June 2018. Details of the scheme, which involved weekly 5 kilometre runs in local parks, were displayed in the reception area. Members of the practice team were planning to take part in the Christmas parkrun in aid of a local hospice. The DPM told us that there were plans to promote the scheme more actively as more promotional material became available.
- 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?

**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 treat people.
- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- The practice's GP patient survey results were in line with local and national averages for questions relating to kindness, respect and compassion.
- We received 19 comment cards which had been completed by patients. The majority of the comments were very positive. Patients wrote that staff were caring and understanding. There were five mixed comments, which related to the difficulties experienced in booking routine appointments.

**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 had identified 193 carers, which represented 1% of their practice population.
- The practice's 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.

**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/did not take account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs.
- Telephone consultations were available which was helpful for patients who were unable to attend the practice during core working hours.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services. For example, patients with mobility scooters could use a side entrance, which was wider than the main entrance.
- 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.
- The practice had Armed Forces Veteran friendly accreditation, which was a scheme that was set up to improve medical care and treatment for ex-service personnel. Information about dedicated support services for military veterans was available on the practice's website and a GP had attended specific training relating to this cohort of patients.
- 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 GP and practice nurse also accommodated home visits for those who had difficulties getting to the practice.

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 wherever practical, and consultation times were flexible to meet each patient's specific needs.
- Home visits were carried out for diabetic patients who were housebound.
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.

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. For example, the practice provided extended opening hours and patients could also book appointments with a GP or nurse at the extended access hub on weekday evenings and on Saturday mornings (telephone appointments were available on Sunday mornings).

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 abode.

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

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.

Good

# Are services responsive to people's needs?

- We noted that the practice promoted support services for patients with memory problems or dementia in the Spring 2018 newsletter. There was also a section on the practice website specifically for this cohort of patients.

**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 online appointment system was easy to use, but that it could take a long time to get through to the practice by telephone.
- The practice's GP patient survey results were below local and national averages for questions relating to access to care and treatment. For example, 45% of respondents found it easy to get through to the practice by telephone compared to 75% across the Redditch and Bromsgrove clinical commissioning group and compared to the 70% national average. The practice was aware of the problem and had taken steps to address it, including employing an additional receptionist, training a pharmacist to run minor illness clinics, thereby freeing up GP appointments and introducing a care navigator system for allocating appointments to the most appropriate clinician. We were also told that the telephone system was being updated in order to provide a dedicated prescription line, which would ease demand on the main telephone line. Telephone options were being altered as well, so that it would be quicker to get through to reception staff in order to book an appointment.

**Listening and learning from concerns and complaints**

The practice took complaints and concerns seriously and responded/did not respond to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.
- 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, which were shared with staff. It acted as a result to improve the quality of care.

Good

# Are services well-led?

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

**Leadership capacity and capability**

The GP partners and management team 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 processes to develop leadership capacity and skills, including planning for the future leadership of the practice. For example, the practice manager was due to retire at the end of the year and their replacement had been appointed and had started work.

**Vision and strategy**

The practice had a clear vision and strategy to deliver high quality, sustainable care.

- There was a clear vision and set of values. The practice had a strategy 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 and valued by the GP partners and management team. We were told that the relationships between staff and teams were very positive and mutually supportive.
- It was clear that patients' needs were the focus of all staff.
- The GP partners and management team acted on behaviour and performance inconsistent with the vision and values.
- We saw evidence that the practice was open, honest and transparent in response 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.

**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
- The GP partners and management team had established policies, procedures and activities to ensure safety and assured themselves that they were operating as intended. Policies and procedures were regularly reviewed and staff were able to tell us how they could access them.
- The management team met every week and GPs could discuss clinical issues at protected coffee time every day.

**Managing risks, issues and performance**

There were processes for managing risks, issues and performance.

Good

# Are services well-led?

- 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. The GP partners and management team 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 a Business Continuity Plan 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 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 was keen to use information technology systems to monitor and improve the quality of care. For example, patients with chronic lung disease were being encouraged to use a software programme on their mobile devices to help them manage their 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 range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. There was a virtual patient participation group.
- The practice produced a newsletter every quarter which was available in reception and on the practice website. Patients could also sign up to receive the newsletter by email.
- A GP was the chair of the Local Medical Committee, which meant that the practice was kept abreast of current issues and initiatives.
- The practice was part of the local neighbourhood team of five practices.
- 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. For example, one of the clinical pharmacists had been supported by the practice to develop the skills necessary to hold minor illness clinics.
- 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.
- The practice was a training practice for future GPs and provided placements for medical students. We were told that three GPs started work at the practice as registrars, then became salaried GPs and went on to become partners, which evidences the culture at the practice and commitment to encouraging staff to develop their skill base.

**Please refer to the evidence tables for further information.**