St Stephens Surgery

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 inspection November 2014 – Good)

The key questions 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 inspection at St Stephens Surgery on 8 May 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.

•Staff involved and treated patients with compassion, kindness, dignity and respect.

•Patients found the appointment system easy to use.

•There was a strong focus on continuous learning and improvement at all levels of the organisation.

•There was a strong emphasis on the safety and well-being of all staff.

However we found one area where the provider should make improvements:

- Review and identify methods to improve areas of lower performance in the National GP Patient Survey, in particular in respect of patients' experience of making an appointment.

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 CQC lead inspector. The team included a GP specialist adviser.

Background to St Stephens Surgery

St Stephens is located in Redditch and provides primary medical services to patients living in Redditch. The practice has six GP Partners and seven salaried GPs. The partnership has two sites with two different patient lists. Occasionally staff work across both sites. The other site is called Maple View Medical Practice. (Maple View Medical Practice will be inspected separately because it is registered with the Care Quality Commission as a separate location.) The GPs are supported by practice nurses, a diabetes specialist nurse, healthcare assistants, a phlebotomist and a physician's associate. The administration team consists of the practice manager, assistant practice manager, secretary and reception staff.

The practice offers minor surgery such as ear irrigation and joint injections.

There are 10,373 patients registered with the practice. The practice is open from 8.00am to 6.30pm Monday to Friday. Patients can access the service for appointments from 8.30am and on line booking is also available. The practice offers extended hours on a Wednesday evening until 7.30pm.

St Stephens has a Personal Medical Services contract. The PMS contract is the contract between general practices and NHS England for delivering primary care services to local communities.

The practice is an approved GP training practice. This means that qualified doctors who want to work in general practice spend 12 months working at the practice as registrars as part of their three years specialist training to become a GP.The practice also teaches medical students from Birmingham University and Warwick University.

The Out of Hours provider for St Stephens Surgery is Care 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. During the inspection we saw an example of when the practice had appropriately referred a family to social services because of concerns raised. All staff received up-to-date safeguarding and safety training appropriate to their role. Staff knew how to identify and report concerns. Reports and learning from safeguarding incidents were available to staff. Staff who acted as chaperones were trained for their role and had received a 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, harassment, 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. During the inspection we reviewed the latest infection control audit from 6 March 2018. We saw that the practice followed up on action plans. For example they had replaced bins in the treatment rooms and purchased new soap dispensers.

•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 valued training and development and had comprehensive competency based frameworks for non-clinical and clinical staff.

•The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures. All members of staff had received basic life support training.

•Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections including sepsis.

•When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

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

•The care records we saw showed that information needed to deliver safe care and treatment was available to staff. There was a documented approach to managing test results.

•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, 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.

•The practice had recently reviewed their prescribing of a particular antibiotic to ensure it was in line with current guidelines. An electronic search was carried out which identified 30 patients. It was identified that six of these

Good

Are services safe?

patients were on the correct antibiotic but had not been prescribed it for the correct duration. They should have been prescribed for 14 days instead of seven days. The GPs were going to discuss this at their next clinical meeting to identify areas for improvement.

•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 for example health and safety, fire safety and legionella. Legionella is a term for particular bacteria which can contaminate water systems in buildings.

•The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture of safety that led to safety improvements.

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. In the last year we saw the practice had recorded 12 significant events.

•The practice acted on and learned from external safety events as well as patient and medicine safety alerts. We reviewed the last three safety alerts received and they had been dealt with appropriately by the practice. The practice pharmacist helped to ensure that alerts were acted upon.

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.

(Please note: Any Quality Outcomes (QOF) data relates to 2016/17. QOF is a system intended to improve the quality of general practice and reward good practice.)

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 used appropriate tools to assess the level of pain in patients.

•Staff advised patients what to do if their condition got worse and where to seek further help and support. Staff we spoke gave examples of when they had to pull the panic alarm to seek help from the GPs when patient's conditions had deteriorated.

Older people:

•The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.

•Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.

•All older patients had a named GP.

•The practice offered same day appointments to older patients

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. The clinics for long-term conditions such as asthma, chronic obstructive pulmonary disease (COPD) and hypertension were run by nurses.

•For patients with diabetes, blood tests and notes were triaged by a GP. The practice had a specialist diabetes nurse who ran regular clinics. This meant that patients with type two diabetes rarely needed referrals to secondary care. The specialist diabetes nurse had a comprehensive pack with information on living with type two diabetes which was given out to patients.

•Staff who were responsible for reviews of patients with long term conditions had received specific training.

•GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.

•The practice had arrangements for adults with newly diagnosed cardiovascular disease including the offer of high-intensity 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 carried out minor surgery such as joint injections.

Families, children and young people:

•Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were in line with the target percentage of 90%.

•Baby checks and post-natal checks were carried out at the practice.

•The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation.

•The practice offered a comprehensive sexual health service for younger patients including contraception and sexually transmitted infection screening.

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

•The practice's uptake for cervical screening was 76%, which was in line with the 80% coverage target for the national screening programme. The practice regularly sent out reminders to patients to remind them to book their screening test.

•The practice's uptake for breast and bowel cancer screening was in line with the national average.

Good

Are services effective?

•Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. In the last year the practice had carried out 213 NHS checks and 455 new patient checks. 2678 patients were eligible for an NHS health check and 323 were invited. 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. Palliative care patients were discussed at clinical meetings.

•The practice held a register of patients living in vulnerable circumstances including those with a learning disability. The practice had 38 patients on the learning disabilities register. In the last year they had carried out 30 learning disability checks.

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.

•90% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This is higher than the national average of 84%. Seven patients declined.

•92% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This is higher than the national average of 90%.

•The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example 94% of patients experiencing poor mental health had received discussion and advice about alcohol consumption. This is higher than the national average of 91%.

•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.

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. For example the practice had carried out an audit to review patients on digoxin who did not have heart failure or irregular pulse. The search picked up four patients. These patients have now been coded correctly. The audit has been repeated and showed all patients were correctly on this medicine.

Where appropriate, clinicians took part in local and national improvement initiatives. For example the practice carried out an audit to ensure oestrogen only Hormone Replacement Therapy was prescribed appropriately. This audit concluded that in the last 12 months 12 more patients were taking oestrogen only HRT and they all had progestogen protection (medicine to protect against sexually transmitted infections). The diary date was correct for all patients except two patients who had no diary date at all. The practice continued to refer to NICE guidelines to ensure safe prescribing.

•QOF results were higher than average. In the last year the practice scored 98% which was 2% above the national average.

•The overall exception rate was 6% which was 4% below the national 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.

Good

Are services effective?

•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 was very proactive in learning and development. Most GPs who trained with the practice went on to become partners at the practice.

•The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation.

•One of the GPs at the practice was the lead for clinical supervision and one partner was the deputy lead this ensured clinical staff got time to reflect on their practice. One salaried GP who had been with the practice for three years still met with their clinical supervisor on a monthly basis. Clinical staff fed back how helpful this had been for them.

•The physician's associate worked closely with the duty doctor each day and mainly reviewed emergency patients.

•The induction process for healthcare assistants included the requirements of the Care Certificate. The practice ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing.

•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 deciding care delivery for people with long term conditions and when coordinating healthcare for care home residents. They shared information with, and liaised, with community services, social services and carers for housebound patients and with health visitors and community services for children who had relocated into the local area.

•Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.

•The practice had an efficient system for ensuring blood tests were followed up on. All blood samples taken were coded. The phlebotomist would then check on a weekly basis to ensure all blood results were documented in the patient's notes. If there was a problem with a result, they would contact the patient and arrange or them to have a repeat test.

•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. The practice had quarterly palliative care meetings which a member of the district nursing team and Macmillan nursing team also attended. The practice also discussed patients who had died at the end of each significant event meeting.

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.

•Staff encouraged and supported patients to be involved in monitoring and managing their own health, for example through social prescribing schemes. The practice had agreed to be a new pilot site for social prescribing and at the time of our inspection shared some examples. For

example one patient was assessed and referred to a weight management exercise programme. The aim of social prescribing was to reduce isolation and help patients with anxiety and stress.

•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. We saw examples of consent forms for procedures such as ear irrigation and insertion of contraceptive coils both of which were very thorough.

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.

• National survey results in questions related to kindness and compassion were in line with CCG and national averages.

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 posters in the waiting room for carers and carer's cards were available.

•National survey results in questions related to involvement in decisions about care and treatment were in line with CCG and national averages.

Privacy and dignity

The practice respected patients' privacy and dignity.

•Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer 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.

•Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.

•The GPs used an application on their phones to enable them to access specialist advice quickly when required for a number of different specialities.

•The facilities and premises were appropriate for the services delivered.

•The practice made reasonable adjustments when patients found it hard to access services.

•The practice provided effective care coordination for patients who were more vulnerable or who had complex needs. They supported them to access services both within and outside the practice.

•Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

•The practice carried out joint injections to patients and patients at neighbouring practices. In the last year the practice had given 412 joint injections. 38 of these were given to patients registered at different practices.

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 due to limited local public transport availability.

•In the last year 1344 patients over the age of 65 received their flu vaccination. 2004 patients over the age of 65 were eligible for their flu vaccination. 432 patients had declined the vaccination.

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.

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, extended opening hours. The nurses ran clinics up to 7.30pm on Mondays and Tuesdays.

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?

•All staff at the practice had received dementia friendly training.

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.

•National survey results were in line with the CCG and national averages, with the exception of patient experiences in being able to make an appointment.

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. For example a patient had raised a complaint as they had rang the reception team to ask for results of their x-ray. The patient was advised to make an appointment with the GP. This was discussed at the practice meeting and it was agreed that doctors would write if the result was normal in the results field and receptionists would be able to share this with the patient.

Please refer to the Evidence Tables for further information.

Good

Are services well-led?

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

Leadership capacity and capability

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

•Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them. Each of the GPs had individual lead roles.

•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. For example most GP registrars who trained at the practice stayed with the practice as salaried GPs and sometimes became partners at the practice.

Vision and strategy

The practice had a clear vision to provide the highest standards of medical care within the resources available to the practice.

•There was a clear vision and set of values. The practice had a strategy and supporting business plans to achieve priorities. The practice developed its vision, values and strategy jointly with patients, staff and external partners.

•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 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 needed. This included appraisal and career development conversations. We noted that all staff received annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.

•Staff were encouraged to attend study days. At the time of the inspection staff shared examples of immunisation and diabetes study days which had been particularly helpful in enabling staff to keep up to date.

•Clinical staff were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work.

•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.

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 interactive and co-ordinated person-centred care.

•Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control.

Good

Are services well-led?

•Practice leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

•There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.

•The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Practice leaders had oversight of national and local 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 implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

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 was encouraged, heard and acted on to shape services and culture. There was an active patient participation group (PPG).

•The PPG had worked closely with the practice and their ideas were valued. For example the PPG wrote an article in their newsletter about a day in the life of a GP. This highlighted the work GPs were doing on a daily basis when they were in between clinics.

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

Continuous improvement and innovation

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

•There was a focus on continuous learning and improvement.

•Staff knew about improvement methods and had the skills to use them. For example the practice had developed a competency based framework for key members of the team. The practice shared these with neighbouring practices.

•The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.

•Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.

Good

Are services well-led?

•The practice recruited a physicians associate to work alongside the duty doctor each day. The GPs informed us how well this worked and patients we spoke with with were happy with this service.

Please refer to the Evidence Tables for further information.