Threeways

Inspection report

Pennylets Green
Stoke Poges
Buckinghamshire
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Date of inspection visit: 22/06/2018
Date of publication: 20/07/2018

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Overall summary

This practice is rated as Good overall.

The previous inspection was in August 2016 and the practice was rated 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 at Threeways in Stoke Poges, Buckinghamshire on 22 June 2018. We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the practice was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

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.
- The practice had increased activity to proactively identify and support people with caring responsibilities. This included work with Carers Bucks (an independent charity to support unpaid, family carers in Buckinghamshire) to increase identification of carers who were registered at the practice.
- Patients found the appointment system easy to use and reported that they were able to access care when they needed it.
- There was a focus on continuous learning and improvement at all levels of the organisation. The practice was fully aware of the developments within South Buckinghamshire and the local health economy.

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 adviser and a second CQC Inspector.

Background to Threeways

Threeways is a GP practice located in Stoke Poges and provides general medical services to approximately 6,350 registered patients in Stoke Poges in Buckinghamshire and the surrounding area.

Clinical services are provided from:

- Threeways Surgery, Pennylets Green, Stoke Poges, Buckinghamshire SL2 4AZ

The practice website is:

- www.threewayssurgery.co.uk

The practice has core opening hours from 8am to 6.30pm Monday to Friday to enable patients to contact the practice. Extended hours appointments (GP and nurse) were available between 7.30am and 8am every Tuesday, Thursday and alternate Wednesday/Friday mornings. Further extended hours appointments were available until 7pm every Tuesday and Wednesday.

The practice also provides primary care GP services for three local care and nursing homes (35 patients) within the local area and two specialist residential homes for people with learning disabilities (approximately 28 patients).

The practice comprises of three GP partners (two females, one male) and two Salaried GPs. The all-female nursing team consists of a minor illness nurse prescriber, a practice nurse and a health care assistant with a mix of skills and experience.

A practice manager and a team of reception and administrative staff undertake the day to day management and running of the practice.

Out of hours care is accessed by contacting NHS 111.

The practice is registered by the Care Quality Commission to carry out the following regulated activities: Maternity and midwifery services, Family planning, Treatment of disease, disorder or injury, Surgical procedures and Diagnostic and screening procedures.

Good

Are services safe?

We rated the practice as good for providing safe services.

Safety systems and processes

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

- The practice had appropriate systems to safeguard children and vulnerable adults from abuse. All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Learning from safeguarding incidents 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.
- From the review of recruitment files and supporting processes we saw 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. This included annual audits which resulted action logs.
- 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 appropriate 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, retirements, busy periods and epidemics. There were plans for the provision of services to be clustered with other local practices, this would increase the skill mix to meet patients' needs and provide flexibility and resilience for staff absence.
- 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. Staff used toolkits and other recognised guidance to identify patients with severe infections including sepsis. We also saw the practice reviewed all sepsis admissions using the significant event process. Sepsis is a rare but serious complication of an infection.
- 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 practice was prescribing hypnotics, antibacterial prescription items and antibiotic items including Cephalosporins and Quinolones in line with local and national averages.
- 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. We saw patient literature in

Good

Are services safe?

the waiting areas which clearly explained safe and appropriate antibiotic usage. Furthermore, we saw the minor illness nurse prescriber used a tool from Public Health England which supported and encouraged the prudent use of antibiotics.

- 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.
- 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 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 medication.
- The practice had worked with the local clinical commissioning group (CCG) and completed a six-month programme of medicine reviews at one of the local care homes (26 patients) which accessed GP services from the practice. We saw the practice and CCG jointly reviewed and audited the efficiency of the reviews. Data indicated the review had led to a series of interventions that have reduced the risk of causing a hospital admission, reduced the likelihood of causing a fall and stopped or reduced usage of medicines that patients no longer needed to take.
- 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 GPs and nurses 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. For example, one of the nurses was completing additional diabetes training to support patients who have not been able to control their diabetes with tablet medicines.
- Clinicians followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma. This work was coordinated by the minor illness nurse who had a special interest and additional qualifications in respiratory disease.
- 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's performance on quality indicators for long term conditions was in line with local CCG averages and national averages. Although comparable, the practice were aware of areas that could be improved for example, the practice was reviewing diabetes performance with a view to improve patient outcomes.

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.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term

medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance. The practice website also contained information about 'keeping well during pregnancy'.

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

- The practice's uptake for cervical screening was 81%, which was above the 80% coverage target for the national screening programme.
- The practice's uptake for breast and bowel cancer screening was above the local CCG average and national average.
- 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. We saw data for 2017/18 which indicated 227 health checks had been completed including an uptake rate of over 50%. We saw 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 those with a learning disability.
- There was a named Learning Disabilities nurse to provide effective continuity of care to all 34 patients on the Learning Disabilities register. All 34 patients (100%) had been invited for an annual health check. We saw 33 of the 34 (98%) had attended a health check, and the remaining patient had been contacted on the telephone on further occasions inviting them to attend a health check.
- 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 practices performance on quality indicators for mental health including dementia was above local CCG averages and national averages.

Monitoring care and treatment

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

- The practice used the information collected for the Quality and Outcome Framework (QOF), local performance scheme (known as Primary Care Development Scheme) and performance against national screening programmes to monitor outcomes for patients. The QOF incentive scheme rewards practices for the provision of 'quality care' and helps to fund further improvements in the delivery of clinical care.
- 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. Several members of the reception team were completing training to become care navigators.
- 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.
- There was a practice ethos which encouraged all staff to develop their skills, to enable this the practice understood the individual learning needs of each member of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained.
- 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.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records and examples of care plans 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.
- 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. The practice had implemented the 'Gold Standard Framework' for patients who were nearing the end of their life. The Gold Standard Framework ensures patients are involved in decisions about their care and treatment for as long as possible. Furthermore, the Framework promotes better coordination and collaboration between healthcare professionals.

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.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- Members of the reception team had almost completed their training to become Care Navigators. We spoke with three members of staff who were completing this training, they were all positive and looking forward to this extended role and their opportunity to support people make positive choices to promote good health and emotional wellbeing.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, antibiotic resistance and 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.

Good

Are services effective?

- The practice had recently reviewed legislation and national guidance for consent and the collection of next of kin details. As a result, the practice was collecting up to date next of kin and emergency contact details and updating systems to reflect patient preference and preferred coordination.

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.

- Verbal and written feedback from patients was positive about the way staff treated people.
- Feedback from external stakeholders (three care and nursing homes and two homes where people with a learning disability lived) which accessed GP services from the practice was overwhelmingly positive.
- Staff understood patients' personal, cultural, social needs.
- The practice gave patients timely support and information.
- The practice was consistently inline and in many areas higher in the GP national survey than other practices in the clinical commissioning group (CCG) and national averages for questions related 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.) All practice staff we spoke with explained how information was an important part of the patient journey. We saw information about how the practice can further support patients and carers to attain accessible information was available on the practice website.

- Staff communicated with people in a way that they could understand, for example, communication aids such as a hearing loop 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 increased activity to proactively identify and support people with caring responsibilities.
- The practice was consistently inline and in many areas higher in the GP national survey than other practices in the CCG and national averages for questions related 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.
- The practice had considered the privacy and dignity for breast feeding mothers with the provision of a designated private room.
- 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 patient needs and preferences.

- The practice understood the needs of its population and community of Stoke Poges and tailored services in response to those needs. This included the growing and aging population, the increase in long term conditions prevalence and the subsequent increased demand on primary care services.
- Telephone were available which supported patients who were unable to attend the practice during normal 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.
- 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:

- The practice provided GP services to three local care and nursing homes for older people (35 patients). We spoke with the representatives from the homes; they advised the practice was highly responsive to the needs of the patients and staff who worked at the homes.
- The practice was reviewing and allocating all patients over 70 with 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 arranged 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, and consultation times were flexible to meet each patient's specific needs.
- The practice held regular meetings with the local community 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.
- Following feedback, the practice provided protected 'after school' GP and nurse appointments specifically for patients aged between 12 and 16.
- 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, a variety of extended opening hours.
- The practice had appointed a minor illness nurse prescriber in response to the increasing number of acute care consultations.

People whose circumstances make them vulnerable:

- There was a named nurse allocated to all patients with a learning disability.
- The practice provided GP services to two local homes where people with a learning disability lived. There was a designated nurse point of contact for the centre (supporting approximately 28 patients). Contact details of the designated staff member were shared with the relevant staff at the homes, enabling continuity of care and quick access to the right staff at the practice. There

Good

Are services responsive to people's needs?

were regular visits to the homes and also the provision of appointments on an ad-hoc basis. We spoke with the representatives from the homes; they advised the practice was highly responsive.

- The practice held a register of patients living in vulnerable circumstances and offered these patients longer appointments, if required.

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.
- The practice proactively identified those patients who were showing signs of dementia and referred them to secondary care when appropriate.

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 including the online appointment function was easy to use.
- On the day of our inspection we saw GP and nurse appointments were available.
- Results for the national GP patient survey were collated between January 2017 and March 2017 showed that patient's satisfaction with how they could access care and treatment was comparable and in some areas higher when compared to local CCG and national averages.

Listening and learning from concerns and complaints

The practice took complaints, concerns and feedback seriously and responded to them appropriately to improve the quality of care. This included reviewing and where necessary responding to feedback about the practice made on websites and social media.

- 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 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 comprehensively understood national and local challenges and were addressing them. For example, a clear understanding about the General Practice Forward View (GP Forward View), with a view to improve patient care and access, and invest in new ways of providing primary care.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills.

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. The Senior GP partner was the strategy and business lead within the practice.
- 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 and ethos of high-quality sustainable care.

- Staff stated and provided written feedback that 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.
- We saw feedback from a medical student who had recently completed a placement (under the supervision of a GP) at the practice. This feedback highlighted the welcome, the positive culture within the practice, the teamwork and the mentorship of the GPs.
- The practice actively promoted equality and diversity. 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. Over the last two years, the leadership team, specifically the practice manager had embedded and strengthened existing governance arrangements. 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, prescribing and infection prevention and control.
- The practice had established policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

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

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. Practice leaders had oversight of safety alerts, incidents, and complaints.
- Quality improvement exercises had a positive impact on the care and outcomes for patients. There was 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 and had 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 and actions 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. For example, the practice recently submitted information to the Care Quality Commission about a change in the GP partnership and a notification of an incident reported to the police.
- There were clear arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. Data protection training occurred internally for most staff and staff had undertaken additional reading in line with the implementation of the General Data Protection Regulation (GDPR) in May 2018. Recent actions following the introduction of the new regulation was the appointment of a Data Protection Officer and collaborative working arrangement with other local GP practices regarding data security.

Engagement with patients, the public, staff and external partners

The practice involved patients, 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 patient participation group.
- The service was transparent, collaborative and open with stakeholders about performance. For example, the practice engaged with the local clinical commissioning group (CCG) and completed a six-month programme of medicine reviews at one of the local care homes which accessed GP services from the practice.

Continuous improvement and innovation

There was evidence of systems and processes for learning and continuous improvement.

- There was a focus on continuous learning and improvement. For example, the practice had plans to continue and expand their work in supporting patients with caring responsibilities. Furthermore, members of the reception team had almost completed their care navigator training. We heard of ambitious plans to continue to develop this role which aligned to the practice vision.
- In line with the General Practice Forward View (GP Forward View), the practice was finalising plans with other local practices to provide cluster community hub which would provide appointments between 8am and 8pm each weekday.
- Staff knew about improvement methods and had the skills to use them.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.

Please refer to the evidence tables for further information.