The Acorn Group Practice - Jackson

Inspection report

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Date of inspection visit: 17 July 2018
Date of publication: 26/09/2018

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. (Previous rating October 2014 – Good)

The key questions at this inspection are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? - Good

We carried out an announced comprehensive inspection at The Acorn Group Practice - Jackson on 17 July 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 and reported that they were able to access care when they needed it.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.

We saw one area of outstanding practice:

- The practice had worked in conjunction with its PPG to improve the support offered to young carers. This involved liaising with the local carers' charity and school nurse to increase the number of young carers recorded on the practice's system, developing a young carers information pack, and presenting to the local PPG network and Regional CCG representatives in order to share learning.

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

- Introduce a system for recording which clinical room stocks of prescription sheets are assigned to, and introduce and monitor a system for reviewing uncollected prescriptions.
- Provide training to non-clinical staff on identifying the signs of sepsis.
- Review the arrangements in place to address the areas of premises non-compliance highlighted in the infection prevention and control audit, to ensure that these adequately mitigate the risks identified.
- Whilst the practice was very pro-active in identifying and supporting young carers, they should ensure that the processes they have in place to identify adult carers are effective in identifying all patients who may require support.

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

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

Population group ratings

Older people	Good
People with long-term conditions	Good
Families, children and young people	Outstanding
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.

Background to The Acorn Group Practice - Jackson

The Acorn Group Practice provides primary medical services in Twickenham to approximately 8600 patients and is one of 29 practices in Richmond Clinical Commissioning Group (CCG).

The practice population is in the least deprived decile in England. The proportion of children registered at the practice who live in income deprived households is 7%, which is lower than the CCG average of 10%; for older people the practice value is 11%, which is lower than the CCG average of 12%. The age profile of patients registered at the practice is broadly the same as the CCG averages; however, the practice population has a slightly below average proportion of patients aged under 18 years (34% compared with a CCG average of 40%); the majority of patients at the practice are aged between 15 and 44 years. Of patients registered with the practice, the largest group by ethnicity are white (85.9%), followed by Asian (7.5%), mixed (3.6%), black (1.6%) and other non-white ethnic groups (1.5%).

The practice is situated over three floors of a purpose-built medical centre. The building comprises of a reception and waiting area, nurse and GP consultation rooms on the ground floor, further consultation rooms on the first floor, and administrative space on the second floor. All floors are accessible by both stairs and a lift. Patient and staff toilets area available, including an accessible toilet with baby changing facilities on the ground floor.

The practice team at the surgery is made up of three full time GPs who are partners (one female, two male), three part time salaried GPs (all female), a part time practice nurse, a part time healthcare assistant and a part time pharmacist. The practice team also consists of a practice manager, assistant practice manager, nine receptionists, a secretary and a finance assistant.

The practice operates under a General Medical Services (GMS) contract, and is signed up to a number of local and national enhanced services (enhanced services require an enhanced level of service provision above what is normally required under the core GP contract).

The practice is open between 8:30am and 6pm Monday to Friday. Appointments are from 8:30am to 5:30pm. An extended hours surgery is offered between 6:30pm and 7:45pm on Tuesdays. In total 34.5 GP sessions are available per week. Patients can also access appointments via the CCG seven-day opening Hub, which offers appointments from 8am until 8pm every day.

When the practice is closed patients are directed to contact the local out of hours service.

The practice is registered as a sole provider with the Care Quality Commission to provide the regulated activities of diagnostic and screening services; maternity and midwifery services; treatment of disease, disorder or injury; surgical procedures; and family planning.

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.
- 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); however, the practice's most recent IPC audit had identified some fixtures and fittings within the building which did not comply with IPC guidance. The practice had made the decision that the cleaning arrangements they had in place were adequate to mitigate these risks until such time that the fixtures in question were replaced; however, they had not conducted a risk assessment to assure themselves that these arrangements were adequate.
- The practice had arrangements to ensure that facilities and equipment were safe and in good working order.
- Arrangements for managing waste and clinical specimens kept people safe.

Risks to patients

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

- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness, busy periods and epidemics.
- There was an effective induction system for temporary staff tailored to their role.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections including sepsis; however, reception staff had not received any training on identifying sepsis. We saw evidence that a training module on sepsis was available via the practice's online training system and the practice told us that they would ensure that all staff completed this training module.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

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

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

Appropriate and safe use of medicines

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

- The systems for managing and storing medicines, including vaccines and emergency medicines minimised risks.
- Staff prescribed and administered or supplied medicines to patients and gave advice on medicines in line with current national guidance. The practice had reviewed its antibiotic prescribing and taken action to support good antimicrobial stewardship in line with local and national guidance.
- Patients' health was monitored in relation to the use of medicines and followed up on appropriately. Patients were involved in regular reviews of their medicines.

Track record on safety

The practice had a good track record on safety.

Good

Are services safe?

- 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 .

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.
- The practice provided on-site blood testing for patients who were prescribed some high risk medicines; this prevented patients from having to travel to hospital for tests.
- 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 their medicine.
- 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.
- 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's performance on quality indicators for long term conditions was in line with local and national averages.

Families, children and young people:

- The most recent verified data on childhood immunisation uptake rates (2016/17) showed that the practice had achieved below the 90% target in three of the areas reported on; however, during the inspection we reviewed submitted data relating to the 2017/18 reporting year, which showed that the practice had achieved the 90% target for immunisations administered to children under two years and children aged five.
- The practice had arrangements for following up failed attendance of children's appointments in secondary care or for immunisation. We saw evidence that the practice nurse kept a record of all babies born to patients of the practice to enable her to track that these children received immunisations at the correct time, and, where necessary, to contact parents to encourage them to have their child immunised. Any instances of appointments for immunisation being missed, or parents informing the practice that they did not wish to have their child immunised, were escalated.
- The practice had actively built a relationship with a local school nurse, who had begun to attend the practice's multi-disciplinary meeting as a result. The school nurse had access to systems and information which the practice could not access, and was therefore able to make the practice aware of young people who may be at risk or may require an enhanced level of support.

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

Good

Are services effective?

- The most recent verified data (2016/17) showed practice's uptake for cervical screening was 72%, which was below the 80% coverage target for the national screening programme, but in line with local and national averages. During the inspection the practice showed us the data they had submitted for the 2017/18 reporting year which showed an 81% uptake rate.
- The practice's uptake for breast and bowel cancer screening was in line with local and national averages.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including homeless people, 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 medicine.
- 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 had audited their care of patients with dementia in order to ensure that they were following best practice guidance.
- 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 or above local and national averages.

Monitoring care and treatment

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

- The practice's achievement against targets for the Quality Outcomes Framework were in line with or above local and national averages. Overall, the most recent published results showed the practice had achieved 558 points out of a total of 559, compared to a local average of 543 and a national average of 539.
- The practice's overall exception rate was 4.9% compared to a local average of 4.2% and national average of 5.7%. We reviewed a sample of patient records for patients who had been excepted and were satisfied that the practice was using the appropriate criteria.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

- Staff had appropriate knowledge for their role; for example, to carry out reviews for people with long term conditions, older people and people requiring contraceptive reviews.
- Staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.
- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with ongoing support. There was an induction programme for new staff. This included one to one meetings, appraisals, coaching and mentoring, clinical supervision and revalidation.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

Good

Are services effective?

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 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 ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

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

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

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.

Please refer to the evidence tables for further information.

Good

Are services caring?

We rated the practice as good for being caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

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

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment. Staff communicated with people in a way that they could understand.

- 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, particularly young carers.
- 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. 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 except for the " Families, children and young people" population group which was rated outstanding.

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 GP consultations 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 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.

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.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.
- The practice had signed-up to a locally commissioned service designed to provide holistic cancer care reviews for patients who have been diagnosed and treated for cancer. This involved identifying patients who had been diagnosed with cancer in the preceding 6 to 24 months, and inviting them to attend for a review, in order that these patients could be supported in dealing with the physical, psychological and practical impact of the diagnosis once active treatment had finished. The practice had identified 17 patients who had received a cancer diagnosis in the past 24 months; 10 of these patients had been seen regularly by the practice during and after their treatment and the remaining seven were invited to, and attended, specifically for a review.

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.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.
- The practice had established a link with a school nurse who worked in several of the local schools. The practice explained that this had been particularly helpful, as the school nurse had access to information systems which the practice could not access, and therefore, was able to share information about young people who could benefit from additional monitoring or support. The practice was able to provide examples of specific children and families who were identified and supported as a result of this collaborative working; they also explained that as a result of working with the school nurse, they had identified that there was a wide-spread issue locally of teenagers suffering from anxiety and potentially self-harming, and as a result staff were more alert to identifying signs of this during consultations.

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. Extended opening hours and telephone consultations were available for patients who were unable to visit the practice during normal opening times.

People whose circumstances make them vulnerable:

Good

Are services responsive to people's needs?

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. One of the GPs at the practice was working on a project to develop a CCG-wide strategy to improve the care provided to homeless patients.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.
- The practice, in conjunction with their PPG, had identified that there was a need to provide tailored support to young people with caring responsibilities. In order to address this issue, representatives from the practice's PPG had led on a project aimed at increasing the identification of young people registered at the practice who had caring responsibilities, and offering them appropriate support. The scope of the project had been designed by the PPG, with specific areas and tasks assigned to members of the practice staff, both administrative and clinical.

At the start of the project the practice did not have any young carers recorded on their system; in order to increase the identification of young carers, the practice had liaised with the local carers' charity, and established that the charity had seven young carers registered who had disclosed that they were patients of the practice. The practice drafted a letter, to be sent by the charity, to these patients, encouraging them to notify the practice that they were carers, in order that they could be offered additional support. The carers' charity also highlighted that they only hold information about which GP practice young carers are registered with for around 35% of young carers registered with them; therefore the practice proposed to work with the charity to develop a new registration form which asks young people to disclose which GP practice they are registered with when they register with the charity. In addition to this, the practice also used links with a local school nurse to help identify young people who may require support

Alongside the work in identifying young carers, the practice also developed a young carers' information pack and a presentation (written by medical students on placement at the practice). On the evening of the inspection day, PPG representatives from the practice were scheduled to give a presentation about the project to the local PPG Network and Regional CCG group, in order to share learning and encourage and support other practices to run similar projects.

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.
- There was a designated GP who had a special interest in mental health, who led on this area. This GP was involved in a CCG-wide project to improve the transition of patients between adolescent and adult mental health services.

Timely access to care and treatment

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

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- Patients reported that the appointment system was easy to use.
- The practice's GP patient survey results were in line with local and national averages for questions relating to access to care and treatment.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. The practice learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care.

Please refer to the evidence tables for further information.

Good

Are services well-led?

We 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.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

Vision and strategy

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

- There was a clear vision and set of values. The practice had a realistic strategy and supporting business plans to achieve priorities.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social care priorities across the region. The practice planned its services to meet the needs of the practice population.
- The practice monitored progress against delivery of the strategy.

Culture

The practice had a culture of high-quality sustainable care.

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- The practice focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they needed. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control
- Practice leaders had established policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

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

- There was an effective process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice had processes to manage current and future performance. Practice leaders had oversight of safety alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.
- The practice had plans in place and had trained staff for major incidents.
- The practice considered and understood the impact on the quality of care of service changes or developments.

Good

Are services well-led?

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The practice used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

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

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

Continuous improvement and innovation

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

- There was a focus on continuous learning and improvement.
- Staff knew about improvement methods and had the skills to use them.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.

Please refer to the evidence tables for further information.