

Oak Tree Partnership

Inspection report

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

Ratings

Overall rating for this location

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

Good 

Are services well-led?

Good 

Overall summary

This practice is rated as Good overall. (Previous rating December 2015 – Good)

The key questions at this inspection are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Good

We carried out an announced comprehensive inspection at Oak Tree Partnership (Oak Tree Health Centre) on 12 June 2018. This inspection was part of our inspection programme.

At this inspection we found:

- The practice had a system 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. However, within one day of the inspection the practice made further improvements to their incident reporting processes.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence-based guidelines.

- The practice regularly reviewed the composition of the clinical team to meet the needs of patients. For example, a paramedic practitioner and a practice nurse trained to deal with minor illnesses had recently been appointed.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.
- Patients offered mixed feedback about the practice appointment system. Particularly when accessing the practice by telephone. The practice was aware of this and was installing an updated telephone system. However, patients reported that they were able to access care when they needed it.
- The practice performance in meeting indicators of care for patients with long term conditions had improved in 2017/18.

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

- Review the implementation and sustainability of the revised processes introduced on the day of inspection.
- Follow up patients due cervical cytology screening who have not attended after being invited for this screening under the national recall system.

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 comprised a lead Care Quality Commission (CQC) inspector, a CQC GP specialist advisor and a second CQC inspector.

Background to Oak Tree Partnership

The Oak Tree partnership is located in a purpose built health centre which they have occupied since 2002. The practice is in an area of modern housing and there are a larger number of patients aged between 0 and 14 and 25 to 49 years than the average for Oxfordshire and England. There are approximately 800 patients aged over 65 registered with the practice which is significantly lower than the national average. A total of approximately 10,300 patients are registered and the practice has experienced a steady growth in registered patients in the last eight years to a point where the practice renegotiated their catchment area with NHS England. The new catchment area was agreed to manage future growth of the practice at sustainable levels. Data shows there to be minimal income deprivation among the registered population.

Six GPs work at the practice equating to just over 4.5 whole time GPs. Four are partners and two are employed GPs. Five of the GPs are female and one male. There are three practice nurses. There are also two health care assistants and a part time paramedic practitioner. The practice holds a General Medical Services (GMS) contract and is registered with the Care Quality Commission to

provide the regulated activities of: Treatment of disease, disorder and injury, Diagnostic and screening procedures, Maternity and midwifery, Family planning and Surgical procedures.

The practice is open between 8am and 6.30pm Monday to Friday. It operates a system called GP access where patients receive a call from a GP to either assess the requirement for a face to face appointment or complete the appointment over the phone. All appointments are offered on the day the patient calls and can be given at any time from 8.20am until the practice closes.

The practice has opted out of providing out of hours services to their patients. Out of hours services are provided by Oxfordshire GP out of hours service. The service is accessed via NHS 111. There are arrangements in place for services to be provided when the surgery is closed and these are displayed at the practice and on the patient website.

All services are provided from:

Oak Tree Health Centre, Tyne Avenue, Didcot, Oxfordshire, OX11 7GD

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.
- 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. However, the

guidance to staff had not been updated recently. It did not include reference to possible signs of sepsis. Clinicians knew how to identify and manage patients with severe infections including sepsis.

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

Information to deliver safe care and treatment

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

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

Appropriate and safe use of medicines

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

- The systems for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment, minimised risks.
- Staff prescribed and administered or supplied medicines to patients and gave advice on medicines in line with current national guidance. The practice had reviewed its antibiotic prescribing and taken action to support good antimicrobial stewardship in line with local and national guidance.
- There were effective protocols for verifying the identity of patients during remote consultations.
- 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. Whilst the practice provided evidence of

Are services safe?

recording and reviewing significant events the system was not embedded in a policy and procedure. We discussed this with the practice. They commenced formalising the system within a policy immediately. We received a copy of the policy and the method used to update staff within one day of the inspection.

- Staff understood their duty to raise concerns and report incidents and near misses. They did so verbally to one member of staff who held responsibility to record all incidents. Leaders and managers supported them when they did so. The updated policy included a standardised reporting form for staff to complete when reporting a significant event.

- 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. Non-clinical staff also told us they did not receive feedback on all significant events, only those that were relevant to their role.
- 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.

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. The practice had recently appointed a paramedic practitioner. Part of their role involved visiting older frail patients to keep their condition monitored and maintain their independence.
- 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's performance on quality indicators for long term conditions was in line with local and national averages from data yet to be validated and published for 2017/18. The practice had identified that their performance was below average in 2016/17 and had worked on improving performance throughout the last year.

Families, children and young people:

- Childhood immunisation uptake rates were above the target percentage of 90% in all four immunisations provided for children aged two years old.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation.

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

- The practice's uptake for cervical screening was 75% (clinical commissioning group (CCG) and national average 72%). However this was below the 80% coverage target for the national screening programme. The practice was aware of the below national standard uptake and offered encouragement to attend screening and opportunistic screening when possible.
- The practice's uptake for breast and bowel cancer screening was above the national average.
- The practice had systems to inform eligible patients to have the meningitis vaccine. For example before attending university for the first time they advised the patient to seek vaccination when they registered with their University medical practice.
- 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.

Are services effective?

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice offered annual health checks to patients diagnosed with a learning disability. Of the 22 patients on the register 18 (82%) had received their health check in the last year.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice had commenced work on a programme to review and/or make contact with patients who had not been in contact with the practice for a long time to check whether these patients required any additional support.

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

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services. There was a system for following up patients who failed to attend for administration of long term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- The practice had completed a care plan or reviewed the care plan for 87% of patients diagnosed with dementia in 2016/17 (Similar performance noted from data yet to be validated for 2017/18). This was in line with the CCG average of 85% and national average of 84%.
- The practice had undertaken a review of the care plans for 88% of patients diagnosed with a long term mental health problem. This was similar to the CCG average of 91% and national average of 90%.

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 QOF results for 2016/17 (last published results) were below local and national averages at 89%. The Oxfordshire Clinical Commissioning Group (CCG) average was 97% and national average 96%. The practice provided us with data that had yet to be validated for 2017/18 which showed a 4% improvement to 93%.
- In 2017/18 the practice had also worked on reducing the number of patients they removed from the QOF indicators. This is called exception reporting (Patients can be exception-reported from individual indicators for various reasons, for example if they do not attend appointments or where the treatment is judged to be inappropriate by the GP, such as medication cannot be prescribed due to side-effects or if they decline treatment or investigations). However, we noted that the exception rates for diabetes indicators remained above average at 17%. The GP advisor reviewed a sample of these exceptions and found the practice had followed the appropriate process of reminding the patient three times to attend before they removed them from the indicator.
- The practice used information about care and treatment to make improvements.
- The practice was actively involved in quality improvement activity. Where appropriate, clinicians took part in local and national improvement initiatives.

Effective staffing

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

- Staff had appropriate knowledge for their role, for example, to carry out reviews for people with long term conditions, older people and people requiring contraceptive reviews.
- Staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.

Are services effective?

- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with ongoing support. There was an induction programme for new staff. This included one to one meetings, appraisals, coaching and mentoring, clinical supervision and revalidation.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

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

- We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.
- The practice shared clear and accurate information with relevant professionals when discussing care delivery for people with long term conditions and when coordinating healthcare for care home residents. They shared information with, and liaised, with community services, social services and carers for housebound patients and with health visitors and community services for children who have relocated into the local area. We spoke with three health visitors who all confirmed that information sharing between the practice and health visiting team was constructive and detailed.
- 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 encouraged and supported patients to be involved in monitoring and managing their own health, for example through referral to weight management and exercise classes.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately.

Please refer to the evidence tables for further information.

Are services caring?

We rated the practice as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from patients was positive about the way staff treat people.
- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- The practice's GP patient survey results were mostly in line with national averages for questions relating to kindness, respect and compassion. Where results were below average the practice was aware and had considered ways of achieving improvement. For example, longer appointments were offered to patients with complex needs to give more time to consult with these patients.

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.) There was a detailed policy in place to support staff in adhering to the Accessible Information Standard.

- Staff communicated with people in a way that they could understand, for example, communication aids were available. Easy read leaflets and information could be made available when it was identified that a patient required these formats.
- 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's GP patient survey results were mostly 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.

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 facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services. We saw that the practice held records of patients with disabilities. For example, those who had a sensory impairment were identified in order for staff to offer these patients additional support.
- The practice provided effective care coordination for patients who are more vulnerable or who have complex needs. They supported them to access services both within and outside the practice.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice was responsive to the needs of older patients. Longer appointments were available for those with complex needs and home visits were also available for those unable to attend the practice. The practice encouraged older patients who required support to bring a relative or friend to their appointment.
- The GPs and paramedic practitioner also accommodated home visits for those who had difficulties getting to the practice due to limited local public transport availability.
- Telephone calls from carers of older patients are identified as a priority on the GPs call lists.

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. 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.
- The practice had appointed a paramedic practitioner and a practice nurse trained to deal with minor illnesses to expand the minor illness service.

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, by working with the local GP federation extended opening hours every weekday evening and Saturday appointments were offered at nearby locations.
- The practice increased the availability of healthcare assistants to extend the hours when blood tests could be taken.
- Physiotherapy services were available locally at a nearby practice.
- The local GP federation had a funded plan to make blood test appointments available on Saturday mornings, to meet the needs of this population group.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.

Are services responsive to people's needs?

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 held regular meetings with the local consultant psychiatrist to discuss patients with complex needs and who needed extra support in managing their mental health problems.

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.
- The practice operated an appointment system called 'GP access' all patients calling for an appointment were called back by the GPs or nurses and either given immediate treatment advice or an appointment on the day they called. GPs were also able to arrange an appointment at a later date following the initial telephone consultation with the patient.
- Waiting times, delays and cancellations were minimal and managed appropriately.

- Patients with the most urgent needs had their care and treatment prioritised.
- Patients gave mixed feedback about the appointment system. A practice survey showed that over 60% found the system easy to use. Other patients reported difficulty getting through to the practice by phone. The practice was in the process of installing a new telephone system that would increase access and advise patients of their position in the call queue.

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.

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. This was demonstrated in the last year when a new lead GP partner took over from the previous lead when they retired.

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 a detailed supporting business plan 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 in Oxfordshire. 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 the duty of candour. However, the processes in place did not always identify the need for formal responses to patients who had been affected by risk. For example, verbal contact with patients was not always followed up by a formal

response. We discussed this with the practice and within one day of inspection the practice leaders completed a review of the requirements of the duty of candour. A new policy was introduced that included classification of risk and incidents.

- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

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. When weaknesses in procedures were identified they were rectified quickly and communicated to staff.

Managing risks, issues and performance

There were 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.

Are services well-led?

- 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 incidents that could affect continued delivery of services from the practice. There was a business continuity plan in place.
- The practice considered and understood the impact on the quality of care of service changes or developments.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The practice used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses. The practice was responsive when weaknesses were identified by others. For example, within one day of inspection the practice reviewed the process for recording significant events. The practice also responded to the lower than average performance in 2016/17 for supporting patients with long term conditions. This was demonstrated by a 4% improvement in 2017/18.
- 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, 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 (PPG). However, both the group and the practice planned to strengthen the role of the PPG by giving more autonomy to the group.
- 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.
- Senior staff and clinical staff knew about improvement methods and had the skills to use them.
- The practice made use of internal 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.