Lower Farm Health Centre

Inspection report

109 Buxton Road
Walsall
West Midlands
WS3 3RT
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www.ambarmedical-lowerfarm.nhs.uk

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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 July 2017 – Requires Improvement)

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 previously undertook a comprehensive inspection of Lower Farm Health Centre on 31 July 2017. The overall rating for the practice was Requires Improvement with the Caring and Responsive domains being rated as Requires Improvement. This was because the GP Survey results for the practice were lower than the local and national average, and the number of patients attending breast screening within six months of invitation was low.

We carried out an announced comprehensive inspection at Lower Farm Health Centre on 4 September 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 had systems to keep patients safe and safeguarding from the risk of abuse. The practice maintained registered of children and adults assessed as vulnerable and their care was discussed at the monthly practice meetings.
- 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 had a strategy for monitoring patients with long term conditions, which ensured all patients were offered an annual structured review.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- The practice had introduced a new telephone system, which enabled the volume of calls to be monitored as well as the number of calls waiting.
- The practice had introduced a triage system for patients requesting a home visit or urgent appointment.
- Patients told us they could usually get an appointment when they needed one.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.

The areas where the provider should make improvements are:

- Continue to identify and offer support to carers.

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	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 Practice Manager Adviser.

Background to Lower Farm Health Centre

Dr Hammad Lodhi is registered with the Care Quality Commission (CQC) as a single-handed provider operating two GP practices in Walsall, West Midlands. The practice is part of the NHS Walsall Clinical Commissioning Group. The practice holds a General Medical Services (GMS) contract with NHS England. A GMS contract is a contract between NHS England and general practices for delivering general medical services and is the commonest form of GP contract.

The practice operates from Lower Farm Health Centre, 109 Buxton Road, Walsall, West Midlands, WS3 3RT.

There are approximately 1,772 patients of various ages registered and cared for at the practice. Demographically the practice has a lower than average patient population aged under 18 years, with 15% falling into this category, compared with the CCG average of 24% and England average of 21%. Twenty-four per cent of the practice population is above 65 years which is considerably higher than the CCG average of 16% and the national average of 17%. The percentage of patients with a long-standing health condition is 57% which was in line with the local CCG average of 56% and national average of 54%.

The staffing consists of:

- One male principle GP (seven sessions) and one female long-term locum GP (two sessions).
- A part time practice pharmacist.
- A part time female nurse practitioner.
- A female part time health care assistant.
- A management team which included a practice manager, assistant practice manager, practice administrators and reception staff.

The practice is open every day from 8.30am until 6pm, except Thursday when it closes at 1pm. The telephone lines are open from 8.30am to 12.30pm, and 3.30pm until 5.30pm Monday to Wednesday and Friday and from 8.30am until 13:30pm on Thursday. When the telephones are not answered by practice staff during core hours (8am to 8.30am, 12.30pm to 3.30pm, 5.30pm to 6.30pm Monday to Wednesday and Friday, and 8am to 8.30am and 12.30pm to 6.30pm Thursday), WALDOC provides a call handling service. In the out of hours period between 6.30pm and 8.30am on weekdays and all weekends and bank holidays the service is provided through the NHS 111 service.

GP consultation times are between 9am and 12 noon Monday to Friday, and 3pm and 6pm Monday to Wednesday and Friday. Nurse practitioner appointments are available between 3.30pm and 5pm on Monday, 9am

to 5pm on Wednesday and 9.30am to 5pm on Friday. Health care assistant appointments are available between 9am and 12.30pm on Tuesday and 9am to 5pm on Wednesday and Friday.

The practice offers a range of services for example: management of long-term conditions, child development checks and childhood immunisations, contraceptive and sexual health advice. Further details can be found by accessing the practice's website at www.ambarmedical-lowerfarm.nhs.uk

Good

Are services safe?

We rated the practice as good for providing safe services.

Safety systems and processes

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

- The practice had appropriate systems to safeguard children and vulnerable adults from abuse. All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. 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. 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 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 taken action to support good antimicrobial stewardship in line with local and national guidance.
- The practice's level of prescribing for certain antibiotics was below the clinical commissioning group and national average.
- 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.
- The practice had introduced an alert system on the electronic records for patients who required blood monitoring prior to their prescription being authorised. Staff contacted patients to advise them if their blood test was overdue and to book them an appointment.
- The practice had signed up to the Clinical Practice Research Datalink (CPRD), which sent reports of patients that may be on certain medicines with contraindications who needed to be reviewed. For example, patients with heart failure who may be prescribed non-steroidal anti-inflammatory drugs. The GP and practice pharmacist reviewed these patients and made adjustments to their medicines as appropriate.

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. This helped it to understand risks and gave a clear, accurate and current picture of safety that led to safety improvements.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice.
- 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.
- 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 review of medication.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- Patients with diabetes were referred to the community diabetes co-ordinator for advice and education on diet and diabetes management.
- 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 they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD is an umbrella term used to describe progressive lung diseases), atrial fibrillation (a common abnormal heart rhythm) and hypertension (high blood pressure) through new patient checks and NHS health checks.
- From the unverified figures for 207/18 we saw that the practice's performance on quality indicators for long term conditions had improved from the previous year.

Families, children and young people:

- Childhood immunisation uptake rates were lower than the target percentage of 95% or above. The practice had very small numbers of children eligible for the childhood immunisations, and any non-attendees greatly affected the uptake percentage.
- A member of the clinical team reviewed the uptake of childhood immunisations on a monthly basis and identified non-attendees. The parents / guardians of these children were contacted and appointments made. Those children whose parents / guardians had declined the immunisations were clearly identified.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation. Any issues regarding childhood immunisations were also discussed with the locality health visitor or the school nurse.

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

- The practice's uptake for cervical screening was 79.6%, in line with the 80% coverage target for the national screening programme.
- The practice's uptake for breast and bowel cancer screening was in line with the national average. There were systems in place to follow up patients who did not attend screening appointments or return screening tools.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.

Good

Are services effective?

- 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 medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- The practice offered annual health checks to patients with a learning disability.
- The practices performance on quality indicators for mental health was above the local and national averages. From the unverified figures for 2017/18 we saw that the practice had maintained this performance.

Monitoring care and treatment

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. QOF is a system intended to improve the quality of general practice and reward good practice. The most recent published results for 2016/17 showed the provider's QOF results were comparable with the CCG and national averages. We looked at the end of year 2017/18 unverified data and saw that the results were higher than the previous year.

The practice had a programme of quality improvement activity and reviewed the effectiveness and appropriateness of the care provided. The practice had carried five audits in 2 years, all of which were two cycle audits. The audits we looked at in detail demonstrated quality improvements.

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, 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. They shared

information with, and liaised, with community services, social services and carers for housebound patients and with health visitors and community services for children who have relocated into the local area.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who 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. The practice signposted patients to local services for support with smoking cessation, weight reduction and exercise programmes.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.

Consent to care and treatment

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

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

Please refer to the evidence tables for further information.

Good

Are services caring?

We rated the practice as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from patients was positive about the way staff treated people.
- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- The practices GP patient survey results published in 2017 were below local and national averages for questions relating to kindness, respect and compassion. However, the 2018 GP survey results, although not directly comparable, demonstrated that patient satisfaction in relation to be listened to and having confidence in the healthcare professional they had seen had improved and was in line with the local and national average. The results for patient satisfaction in relation to being treated with care and concern had also improved.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment. They were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information that they are given.)

- Staff communicated with people in a way that they could understand, for example, communication aids, access to interpreters and large print and braille available on request.
- 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 practices GP patient survey results published in 2017 were below local and national averages for questions relating to involvement in decisions about care and treatment. However, the 2018 GP survey results, although not directly comparable, demonstrated that patient satisfaction in relation to their involvement in decisions about their care and treatment had improved as was in line with the local and national averages.

Privacy and dignity

The practice respected patients' privacy and dignity.

- When patients wanted to discuss sensitive issues or appeared distressed reception staff offered them a private room to discuss their needs.
- Staff recognised the importance of people's dignity and respect.

Please refer to the evidence tables for further information.

Good

Are services responsive to people's needs?

We rated the practice, and all of the population groups, as good for providing responsive services.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs.
- Telephone triage and consultations were available which supported patients who were unable to attend the practice during normal working hours and assisted those with the most urgent need to access appointments.
- 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:

- 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.
- In recognition of the religious and cultural observances of some patients, the GP would respond quickly, often outside of normal working hours, in order to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GP and practice nurse also accommodated home visits for those who had difficulties getting to the practice.
- The local community pharmacies provided a medicines delivery service for housebound patients.

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 offered dedicated clinics for comprehensive asthma reviews.
- 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 were offered a same day appointment when necessary.
- The practice held quarterly meetings with the health visitor to discuss any children at risk.

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, online services such as repeat prescription requests and appointments.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including homeless people, those with a learning disability, frail or socially isolated.
- The practice pro-actively identified patients who were vulnerable including those who transitioned from child to adult services. Children who had been 'looked after' or subject to a safeguarding order were transferred over to the vulnerable adult list. These lists were actively reviewed and patients who were considered vulnerable or at risk were discussed at the monthly practice meetings.
- The practice placed an alert on the electronic record to inform staff when a patient was identified as vulnerable and included on the register.

Good

Are services responsive to people's needs?

- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.
- Longer appointments where needed or requested were available, as well as home visits for those whose vulnerability prevented them from attending the practice.
- The practice worked with the palliative care team and community nursing teams to support patients near the end of their life.
- The practice shared care plans for vulnerable patients with the out of hours service.

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 worked closely with the community mental health nurse to provide care and support for patients with mental health needs.
- The practice offered same day appointments or telephone consultations for those patients who needed them.

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.
- The majority of the practice's GP patient survey results published in 2017 were below local and national averages for questions relating to access to care and treatment. The 2018 GP survey results, although not directly comparable, indicated that patients continue to express dissatisfaction with the practice in relation to access to care and treatment. Patient satisfaction in relation to the type of and times of general practice appointments as well as their experience of making an appointment was below the local and national averages.
- The practice had invested in a new telephone system which monitored call traffic and recorded all calls. The practice had reviewed the call traffic data to identify where demand was high and had adjusted staffing accordingly. The demand could also be monitored in real time and administrative staff were diverted from other duties if calls were waiting to be answered.
- The practice told us they reviewed telephone calls periodically to assess how reception staff managed requests for appointments. They told us feedback was given to staff individually when it was identified they could have handled the call differently.
- The practice had reviewed the GP survey results and developed an action plan to address the areas were patient satisfaction was below average. The practice planned to carry out an in-house survey to further explore patient views regarding appointments.

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.
- All complaints were discussed at the practice meetings.

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 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.

Managing risks, issues and performance

There were clear and effective around 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 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.

- The practice was in the process of further developing the patient participation group. Information regarding the group and minutes of meetings were on display in the waiting room. A suggestion box was available in the waiting room.
- Staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture.
- The service was transparent, collaborative and open with stakeholders about performance.
- The practice engaged with the local carers' association, who held meetings at the practice.

Continuous improvement and innovation

- There were 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.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.
- The practice had signed up to the Clinical Practice Research Datalink (CPRD), which sent reports of patients that may be on certain medicines with contraindications who needed to be reviewed. For example, patients with heart failure who may be prescribed non-steroidal anti-inflammatory drugs. The GP and practice pharmacist reviewed these patients and made adjustments to their medicines as appropriate

Please refer to the evidence tables for further information.