

Care Quality Commission

Inspection Evidence Table

Church Lane - Khan (1-537760126)

Inspection date: 16 January 2019

Date of data download: 02 January 2019

Overall rating: Inadequate

Please note: Any Quality Outcomes Framework (QOF) data relates to 2017/18.

Safe

Rating: Requires Improvement

Safety systems and processes

The practice had some systems, practices and processes to keep people safe and safeguarded from abuse however we noted gaps in areas.

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
There were policies covering adult and child safeguarding.	Y
Policies took account of patients accessing any online services.	Y
Policies and procedures were monitored, reviewed and updated.	Y
Policies were accessible to all staff.	Y
Partners and staff were trained to appropriate levels for their role (for example, level three for GPs, including locum GPs).	Y
There was active and appropriate engagement in local safeguarding processes.	N*
There were systems to identify vulnerable patients on record.	Y
There was a risk register of specific patients.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none">Evidence demonstrated that safeguarding concerns and vulnerable patients were highlighted on	

Safeguarding	Y/N/Partial
<p>the patient record system. The practice had also reviewed their safeguarding registers to ensure that they were up to date and well organised. These were reviewed on an ongoing basis and discussed with other health and social care services as part of the practices approach to monitoring safeguarding. We also saw that all staff had received a DBS check following our last inspection.</p> <ul style="list-style-type: none"> *Conversations with staff highlighted that they were knowledgeable of safeguarding systems and processes but no evidence of completed training was available for the two GPs on the day of our inspection. This included child safeguarding training for the GP safeguarding lead. Following our inspection, we received evidence of completed safeguarding training for both GPs. This evidence demonstrated that their most recent safeguarding training was completed in February 2019 and that the GPs had been trained to the appropriate level. 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Partial
Staff vaccination was maintained in line with current Public Health England (PHE) guidance and if relevant to role.	Y
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
Staff had any necessary medical indemnity insurance.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> We observed that in some areas, the practices recruitment systems had improved since our last inspection in April 2018. For instance, in addition to the completion of DBS checks for all staff, there was evidence in place to demonstrate that the practice had strengthened their staff vaccination programme to reflect PHE guidance and records were provided to support this. However, the practice could not demonstrate that employment history had been checked and considered as part of their recruitment processes in all instances; specifically, we found that the practice could not provide evidence of completed employee references for the most recently recruited receptionist and the practice nurse. Therefore, the practice was unable to demonstrate that demonstrate they had assured themselves that prospective employees have the skills and knowledge to carry out their role specifically clinical roles. There was no evidence provided during our inspection to reflect medical indemnity insurance in place for the practice GPs and practice nurse. Following our inspection, the practice provided evidence of indemnity insurance for the practices GPs. 	

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: 24/3/18	Y
There was a record of equipment calibration. Date of last calibration: 14/8/18	Y
There were risk assessments for any storage of hazardous substances for example, liquid	Y

nitrogen, storage of chemicals.	
There was a fire procedure.	Y
There was a record of fire extinguisher checks. Date of last check: 13/11/18	Y
There was a log of fire drills. Date of last drill: 5/12/18	Y
There was a record of fire alarm checks. Date of last check: 3/1/19	Y*
There was a record of fire training for staff.	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: 5/9/18	Y
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Staff were aware of what to do in the event of a fire, a fire drill had been carried out in December 2018 and a log was kept supporting this. The practice nurse had also been appointed as a nominated fire lead. * Fire alarm testing records were provided shortly after our inspection. The fire alarm was being tested on a monthly basis and therefore did not reflect best practice national fire safety legislation guidelines, which recommends testing on a weekly basis. However, we saw that the practice had taken swift action and had updated their log to start testing on a weekly basis moving forward. 	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: April 2017	Y*
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: April 2017	Y*
Explanation of any answers and additional evidence: *Although we observed no health and safety issues on the day of our inspection, we noted that the last risk assessments were completed in April 2017 and it was not clear when these would be revisited.	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Y
Date of last infection prevention and control audit:	15/1/19
The practice had acted on any issues identified in infection prevention and control audits.	Y*
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence:	

*The practice was working on areas identified for improvement following their recent infection prevention control audit. Audit records outlined that cleaning of specific medical equipment was not always being recorded. Staff informed us that equipment was cleaned and they were beginning to keep records; we saw cleaning schedules and completed cleaning records in place during our inspection reflecting each area of the practice and medical equipment. Plans for action included hand hygiene training for staff, which was due to be delivered by the infection control lead along with face to face infection control training. As an interim measure staff had completed infection control training online.

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Partial
Comprehensive risk assessments were carried out for patients.	Y
Risk management plans for patients were developed in line with national guidance.	Y
Panic alarms were fitted and administrative staff understood how to respond to the alarm and the location of emergency equipment.	Y
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There was a process in the practice for urgent clinical review of such patients.	Y
There was equipment available to enable assessment of patients with presumed sepsis or other clinical emergency.	Y
There were systems to enable the assessment of patients with presumed sepsis in line with National Institute for Health and Care Excellence (NICE) guidance.	Y*
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> We observed an effective rota system in place for managing staff absences, we noted that protected time was factored in for duties such as recalling patients in for their health reviews. The practice had employed a practice nurse since our last inspection and conversations were positive with regards to staffing levels. We noted that the practice regularly used locum GPs, locum GPs were recruited through an agency and they worked at the practice every Tuesday and Friday. The practice demonstrated appropriate recruitment and induction systems for their locum GPs. Although staff described an effective induction system which was tailored to their role, the practice did not keep records to support this (with the exception of the locum GPs). *The practice had focussed on improving their sepsis awareness, we saw that this had been 	

discussed during a practice meeting in July 2018, staff had completed sepsis awareness training and sepsis guidelines were displayed in the reception area for staff to refer to when working at the reception desk. We noted that following training, an ambulance was called for a patient presenting with signs and symptoms and the outcome of the incident confirmed that staff had acted appropriately. This was also recorded as a significant event.

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y*
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referral letters contained specific information to allow appropriate and timely referrals.	Y
Referrals to specialist services were documented.	Y
There was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Y
Explanation of any answers and additional evidence: *During our inspection staff explained that they had inherited 450 patients from a nearby practice in September 2016 when the local practice had ceased providing a service. Some of the patient records had been fully transferred through to the practices system however roughly 300 records were still outstanding at the time of our inspection. Staff could see most of the patient record, some information such as full medical history however could not always be seen. This matter was outside of the practices control and we saw that the practice was regularly enquiring and chasing progress regarding the record transfer with the relevant organisations including the practices Clinical Commissioning Group.	

Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimisation.

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2017 to 30/09/2018) <small>NHS Business Service Authority - NHSBSA)</small>	1.09	0.90	0.94	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/10/2017 to 30/09/2018) (NHSBSA)	4.5%	7.6%	8.7%	Variation (positive)

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence:</p> <p>We noted that the practice had taken a number of measures to improve their medicines management and associated systems. For example:</p> <ul style="list-style-type: none"> We saw that the practice had implemented an effective system for monitoring prescription stationery. 	

Medicines management	Y/N/Partial
<ul style="list-style-type: none"> The practice had risk assessed their emergency medicines to ensure stock was appropriate to the services provided. Systems for checking emergency medicines had also been improved, records demonstrated that they were checked on a regularly basis. The practice had also replaced their defibrillator and we saw that it was regularly checked to ensure fit for use. 	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	6
Number of events that required action:	4
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Minutes of practice meetings and conversations with staff indicated that learning from significant events was shared formally during monthly practice meetings and staff also communicated informally on a daily basis if there was a need to discuss matters in-between meetings. 	

Examples of significant events recorded and actions by the practice.

Event	Specific action taken
Prescription stationery process not followed, resulting in prescriptions being allocated to the wrong room.	<ul style="list-style-type: none"> The practice reviewed their prescription monitoring and recording process further to avoid reoccurrence. Prescription co-ordinator responsibility was implemented so that secondary monitoring took place to ensure prescriptions were only allocated to each room based on the corresponding box.
Patient presenting with signs and symptoms of sepsis.	<ul style="list-style-type: none"> On identifying the matter, staff notified the GP immediately. The patient was seen straight away by the GP and an ambulance called. The matter was recorded as a significant event, learning was shared at a practice meeting and it was noted that feedback from the ambulance service indicated that the practice had acted appropriately. Staff reflected on how training had helped them to identify and act accordingly.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
<p>Explanation of any answers and additional evidence:</p> <p>We saw evidence of an effective system utilised in practice whereby safety alerts were received, shared and actions taken where required. Records were kept reflecting this process and we saw a policy in place to support this. During our last inspection the practice could not demonstrate that referrals and discussions had taken place for women of childbearing age following recommendations from a specific medicines alert. During this inspection we re-visited the alert as part of our review and saw that all patients affected were called in for a review. These patients had also been risk assessed and where required we saw that contraception was being discussed as part of the review and risk assessment process; in line with the alert guidelines. We saw that system alerts had been implemented to notify the practice each time a prescription was generated in relation to the alert criteria. We also saw that the practice regularly ran searches on this cohort of patients to ensure that they applied this process to any newly identified patients.</p>	

Effective

Rating: Inadequate

Effective needs assessment, care and treatment

Patients' needs were assessed, and care and treatment was delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways were in place to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Our observation of the practices patient record system demonstrated that clinicians were kept up to date with current evidence-based practice and had access to nationally and locally used guidelines. There was evidence of appropriate care planning in place and referral pathways were appropriately followed with clinical oversight to ensure patient needs were met.</p>	

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2017 to 30/09/2018) <small>(NHSBSA)</small>	1.52	0.81	0.81	No statistical variation

Older people

Population group rating: Inadequate

Findings

- At this inspection we saw evidence of appropriate tools which had been implemented and utilised in practice to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- 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.
- Health checks were offered to patients over 75 years of age.
- The practice was aware that they had inherited some historical coding issues with the uptake of patients transferred across in 2016. Although the practice provided an action plan which demonstrated a number of ongoing actions were underway to rectify their coding issues, we noted that the plan provided during our inspection did not provide assurance regarding timeframes for completion, the coding issues were inherited in 2016 and there were ongoing coding issues across practice registers at the point of this inspection.
- Following our inspection, the practice provided a comprehensive practice improvement plan which provided a monthly status on the progress of the actions taken across a variety of areas. We saw that ongoing work was being carried out to address the historical clinical coding and exception reporting issues and that this was regularly monitored.

People with long-term conditions

Population group rating: Inadequate

Findings

- 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 training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- Our review of the patient record system demonstrated that patients with suspected hypertension were offered ambulatory blood pressure monitoring and we saw examples to support that patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation

and hypertension.

- We saw examples where adults with newly diagnosed cardio-vascular disease were offered statins.
- However, we identified some coding problems during our inspection which highlighted that in some cases multiple codes were being used to identify patients with long term conditions; therefore the practice could not provide an accurate reflection of their disease registers as relevant patients were not always being captured under each register. For example, our review of the cardio vascular disease registers initially captured a low prevalence of 21 patients; this was based on a practice search from their patient record system. On further investigation we found an additional 62 patients that were not captured through the initial search, as the recommended clinical code was not always being used to capture them.
- We also noted that in some areas there were gaps in coding. The practice was aware of this as they had inherited some historical coding issues with the uptake of patients transferred from a nearby practice in 2016. Following our inspection, the practice provided a comprehensive practice improvement plan which provided a monthly status on the progress of the actions taken across a variety of areas. We saw that ongoing work was being carried out to address the historical clinical coding and exception reporting issues and that this was regularly monitored.

Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	87.0%	80.0%	78.8%	No statistical variation
Exception rate (number of exceptions).	21.3% (56)	12.4%	13.2%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2017 to 31/03/2018) (QOF)	72.3%	77.1%	77.7%	No statistical variation
Exception rate (number of exceptions).	23.2% (61)	10.4%	9.8%	N/A

	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2017 to 31/03/2018) (QOF)	86.0%	81.2%	80.1%	No statistical variation
Exception rate (number of exceptions).	18.3% (48)	11.6%	13.5%	N/A

Other long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2017 to 31/03/2018) (QOF)	72.5%	76.7%	76.0%	No statistical variation
Exception rate (number of exceptions).	10.2% (17)	6.2%	7.7%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	90.1%	91.3%	89.7%	No statistical variation
Exception rate (number of exceptions).	19.0% (19)	11.2%	11.5%	N/A

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2017 to 31/03/2018) (QOF)	82.5%	83.0%	82.6%	No statistical variation
Exception rate (number of exceptions).	10.4% (64)	4.5%	4.2%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2017 to 31/03/2018) (QOF)	91.7%	88.8%	90.0%	No statistical variation
Exception rate (number of exceptions).	23.4% (11)	8.1%	6.7%	N/A

Any additional evidence or comments

- Our review of the practices above average exception rates across various areas highlighted that in some cases the practice had followed an appropriate process in line with their policy whereby patients had not attended their appointments after three attempted contacts had been made by the practice. We noted that further allowance was made for vulnerable patients and patients with complex needs also so that they were not exception reported immediately after a third attempt. We also saw that in some cases, where treatment was judged to be inappropriate by the GP (such as where medicines could not be prescribed due to side-effects), patients were appropriately exception reported in line with the policy.

- However, we found that in a range of cases the practice had excluded patients because historically they had inappropriately been added to the disease register and therefore to exclude them from their QOF data collection the practice was exception reporting them. On further investigation we found that these cases were inherited from a nearby practice, from which the practice took on roughly 450 patients in September 2016. For example, our review of exception reporting for Rheumatoid Arthritis highlighted that the patients coded on the register did not have this condition, to manage this the practice had excluded them so that they were not falsely included in their QOF data collection. We also found evidence of this across other areas of exception reporting including for COPD, diabetes and depression.
- The practice was aware that they had inherited some historical coding issues with the uptake of patients transferred across in 2016. The practice provided an action plan to demonstrate the actions they had taken to rectify this issue. This included the recruitment of a pharmacy technician who was supporting the practice in cleansing their system, due to the number of cases that required cleansing this work was ongoing at the time of this inspection. The practice was also working with a community diabetes consultant to help manage their above average prevalence of diabetes.
- Although the practice provided an action plan which demonstrated a number of ongoing actions were underway to rectify their coding issues, we noted that the plan did not provide assurance regarding timeframes for completion, the coding issues were inherited in 2016 and there were ongoing coding issues at the point of this inspection. Furthermore, there was no evidence to demonstrate that the additional issues with the multiple codes identified on the day of our inspection had been identified by the practice and there was no evidence that these had been included in the action plan. Following our inspection, the practice provided a comprehensive practice improvement plan which provided a monthly status on the progress of the actions taken across a variety of areas. We saw that ongoing work was being carried out to address the historical clinical coding and exception reporting issues and that this was regularly monitored.

Families, children and young people

Population group rating: Inadequate

Findings

- The practice was aware that they had inherited some historical coding issues with the uptake of patients transferred across in 2016. Although the practice provided an action plan which demonstrated a number of ongoing actions were underway to rectify their coding issues, we noted that the plan did not provide assurance regarding timeframes for completion, the coding issues were inherited in 2016 and there were ongoing coding issues across practice registers at the point of this inspection.
- Following our inspection, the practice provided a comprehensive practice improvement plan which provided a monthly status on the progress of the actions taken across a variety of areas. We saw that ongoing work was being carried out to address the historical clinical coding and exception reporting issues and that this was regularly monitored.
- Childhood immunisation uptake rates were in line with the World Health Organisation (WHO) targets.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- The practice had arrangements for following up failed attendance of children's appointments

following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.

- Young people could access some services for sexual health and contraception at the practice. For procedures such as contraceptive implants however patients were referred to the Bordesley Green Access Hub also known as Omnia; of which the practice was part of a Hub for extended access.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib)((i.e. three doses of DTaP/IPV/Hib) (01/04/2017 to 31/03/2018) (NHS England)	31	34	91.2%	Met 90% minimum (no variation)
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2017 to 31/03/2018) (NHS England)	36	39	92.3%	Met 90% minimum (no variation)
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2017 to 31/03/2018) (NHS England)	36	39	92.3%	Met 90% minimum (no variation)
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2017 to 31/03/2018) (NHS England)	37	39	94.9%	Met 90% minimum (no variation)

Any additional evidence or comments

At the time of our last inspection in April 2018, child immunisation data specifically regarding immunisations for children under the age of two was slightly below the 90% target at 89%. We saw that this had improved to 91% at this inspection.

Working age people (including those recently retired and students)

Population group rating: Inadequate

Findings

- The practice was aware that they had inherited some historical coding issues with the uptake of patients transferred across in 2016. Although the practice provided an action plan which demonstrated a number of ongoing actions were underway to rectify their coding issues, we noted that the plan did not provide assurance regarding timeframes for completion, the coding

issues were inherited in 2016 and there were ongoing coding issues across practice registers at the point of this inspection. Following our inspection, the practice provided a comprehensive practice improvement plan which provided a monthly status on the progress of the actions taken across a variety of areas. We saw that ongoing work was being carried out to address the historical clinical coding and exception reporting issues and that this was regularly monitored.

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat medicines without the need to attend the surgery.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64) (01/04/2017 to 31/03/2018) (Public Health England)	59.5%	68.1%	71.7%	Variation (negative)
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	62.2%	64.0%	70.1%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2017 to 31/03/2018) (PHE)	40.7%	44.1%	54.6%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. (01/04/2017 to 31/03/2018) (PHE)	77.8%	73.8%	70.3%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2017 to 31/03/2018) (PHE)	26.7%	52.2%	51.9%	No statistical variation

Any additional evidence or comments

- Staff explained that they encouraged uptake for cancer screening opportunistically and discussed screening and encouraged uptake during consultations and patient interactions. We saw that there was also promotional material available in the practice.
- We noted that cervical screening uptake rates had increased from 55% to 59% since our previous inspection in April 2018. However, Public Health data for 2017/18 was below the CCG and national averages. On discussion with the practice staff advised that where possible, patients were offered

appointments at different times to support uptake and non-attenders were followed up. A female GP was trained to perform cervical screening at the practice and the practice had also recruited a female practice nurse since our previous inspection to help increase screening availability. Unpublished data from the practice's patient record system demonstrated that current uptake rates were at 77%.

- The practice shared an unpublished report provided from the local NHS trust which highlighted that the uptake for breast cancer screening was at 58% in the start of the financial year (April 2018) and the practice were working through calling and recalling 142 patients who had not attended their screening appointments.
- We noted that although no statistical variation was identified for the treatment new cancer cases, the practice achievement was below the CCG and national averages. We discussed this with staff during our inspection and saw examples of timely two week wait referrals, which included those resulting in treatment during our inspection. Our review of these cases on the patient record system presented no issues with regards to the referral process or the management of these cases.

People whose circumstances make them vulnerable

Population group rating: Inadequate

Findings

- 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.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice reviewed their vulnerable patients at local residential homes.
- The practice was aware that they had inherited some historical coding issues with the uptake of patients transferred across in 2016. Although the practice provided an action plan which demonstrated a number of ongoing actions were underway to rectify their coding issues, we noted that the plan did not provide assurance regarding timeframes for completion, the coding issues were inherited in 2016 and there were ongoing coding issues across practice registers at the point of this inspection. Following our inspection, the practice provided a comprehensive practice improvement plan which provided a monthly status on the progress of the actions taken across a variety of areas. We saw that ongoing work was being carried out to address the historical clinical coding and exception reporting issues and that this was regularly monitored.

People experiencing poor mental health (including people with dementia)

Population group rating: Inadequate

Findings

- At the time of our last inspection in April 2018 the practice was unable to provide evidence of Mental Capacity Act training for clinical staff. Evidence of completed training was provided at this

inspection.

- 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 was aware that they had inherited some historical coding issues with the uptake of patients transferred across in 2016. Although the practice provided an action plan which demonstrated a number of ongoing actions were underway to rectify their coding issues, we noted that the plan did not provide assurance regarding timeframes for completion, the coding issues were inherited in 2016 and there were ongoing coding issues across practice registers at the point of this inspection. Following our inspection, the practice provided a comprehensive practice improvement plan which provided a monthly status on the progress of the actions taken across a variety of areas. We saw that ongoing work was being carried out to address the historical clinical coding and exception reporting issues and that this was regularly monitored.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	97.1%	93.2%	89.5%	No statistical variation
Exception rate (number of exceptions).	8.1% (3)	9.5%	12.7%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	94.1%	93.2%	90.0%	No statistical variation
Exception rate (number of exceptions).	8.1% (3)	7.8%	10.5%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	92.9%	85.9%	83.0%	No statistical variation
Exception rate (number of exceptions).	17.6% (3)	6.0%	6.6%	N/A

Any additional evidence or comments

Our review of the practices above average exception rates across various areas highlighted that in a

range of cases the practice had excluded patients because historically they had inappropriately been added to the disease register and therefore to exclude them from their QOF data collection the practice was exception reporting them. We found evidence of this across various areas of exception reporting including for depression. The practice had recruited a pharmacy technician who was supporting the practice in cleansing their system. Although the practice provided an action plan which demonstrated a number of ongoing actions were underway to rectify their coding issues, we noted that the plan did not provide assurance regarding timeframes for completion, the coding issues were inherited in 2016 and there were ongoing coding issues at the point of this inspection. Following our inspection, the practice provided a comprehensive practice improvement plan which provided a monthly status on the progress of the actions taken across a variety of areas. We saw that ongoing work was being carried out to address the historical clinical coding and exception reporting issues and that this was regularly monitored.

Monitoring care and treatment

The practice had a programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	547.8	546.1	537.5
Overall QOF exception reporting (all domains)	10.9%	6.1%	5.8%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	Y

Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years

We saw examples of audits undertaken at the practice including an antibiotic prescribing audit focussing on patients diagnosed with a urinary tract infection (UTI), an audit on sore throat treatment, an audit on workflow letter and an audit on blister pack prescriptions. Each audit demonstrated improved outcomes to care and systems, results were also shared and discussed in practice.

The blister pack prescribing audit highlighted a cohort of vulnerable patients identified as receiving weekly blister pack prescriptions on pharmacy request. The audit involved a review of the patients notes to determine the appropriateness of prescribing. The audit highlighted that prescribing was appropriate in most cases and for one case, weekly prescriptions were stopped; we saw that the patient was involved in this decision also. To improve prescribing systems the practice set an action plan which included prompting prescribers to clearly document prescribing reasons and the medicines review process was strengthened to ensure prescribing occurrences formed part of this. We saw that this system was due to be reviewed in March 2019.

Effective staffing

The practice wasn't always able to demonstrate that staff had the skills, knowledge

and experience to carry out their roles.

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Y*
The learning and development needs of staff were assessed.	Y*
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Partial
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	N*
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Partial
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> *The practice could not provide induction evidence, including completion of the Care Certificate, for the Healthcare Assistant who had joined the practice in 2016. Following our inspection, the practice provided evidence of training for the healthcare assistant which incorporated the requirements of the Care Certificate. *At this inspection we saw that appraisals had since been completed for most of the practice team. The healthcare assistant had completed a pre-appraisal with the practice nurse who had recently joined the practice, we saw good evidence of supervision arrangements in place to support this. Whilst there was evidence that the appraisal programme had improved, we noted that the practice manager had not received an appraisal. Although staff described an effective induction system which was tailored to their role, the practice did not keep records to support this. The practice's recruitment policy confirmed that an induction plan and any essential training was provided on confirmation of employment. In addition to no evidence of safeguarding training for the GPs provided during our inspection, we also found that basic life support training had expired for one non-clinical staff member when we reviewed staff training as part of our inspection. Following our inspection, we received evidence and assurance of completed safeguarding training for the GPs. 	

Coordinating care and treatment

Staff worked together and with other organisations to deliver effective care and treatment.

Indicator	Y/N/Partial
-----------	-------------

The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2017 to 31/03/2018) (QOF)	Y
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.	Y
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	Y
Explanation of any answers and additional evidence: We saw evidence to support that regular multidisciplinary working took place with inclusion from other health and social care services. This included liaison and joint working with health visitors, midwives and a local diabetic consultant. We also saw evidence to support that formal safeguarding and palliative care meetings were taking place in the practice.	

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need 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.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Y

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	96.3%	96.1%	95.1%	No statistical variation
Exception rate (number of exceptions).	1.6% (15)	0.6%	0.8%	N/A

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
The practice monitored the process for seeking consent appropriately.	Y
Explanation of any answers and additional evidence: Discussions with clinical staff demonstrated that they understood best practice guidance for obtaining consent. Written consent was also obtained for immunisations and minor surgery procedures.	

Caring

Rating: Requires Improvement

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion. Feedback from patients was mostly positive about the way staff treated people.

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y

CQC comments cards	
Total comments cards received.	1
Number of CQC comments received which were positive about the service.	1
Number of comments cards received which were mixed about the service.	0
Number of CQC comments received which were negative about the service.	0

Source	Feedback
CQC Comment Cards	The comment card we received was very complimentary about the care provided by the clinical staff. Reception staff were described as friendly and the card noted that they would recommend the practice to others.
Interviews with patients	We were able to speak briefly with one patient on the day of our inspection who expressed that they were happy with the practice and had no complaints or concerns.
NHS Choices	The practice had received a 1.5 star rating based on 13 reviews. Most of the

	comments made within the past 12 months highlighted issues accessing appointments. We noted one negative comment which was responded to regarding reception and a positive comment noting the support from a GP was made in April 2018.
Practice suggestions Box	We saw that a compliment had been provided in the practices suggestions box, the compliment thanked the practice for their care delivered to a patient.

National GP Survey results

Note: The questions in the 2018 GP Survey indicators have changed. Ipsos MORI have advised that the new survey data must not be directly compared to the past survey data, because the survey methodology changed in 2018.

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
3625	416	111	27%	3%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2018 to 31/03/2018)	81.1%	87.7%	89.0%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2018 to 31/03/2018)	75.3%	85.9%	87.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2018 to 31/03/2018)	91.5%	95.4%	95.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2018 to 31/03/2018)	68.4%	81.0%	83.8%	No statistical variation

Any additional evidence or comments

Use this box to describe what action has been taken to improve any indicators that are lower than local or national averages.

- The practice provided results of an internal survey completed between April and December 2018. Results of the survey highlighted 123 responses described their experience as excellent, very good, good and fair with regards to the care provided by staff and staff communication. Seventeen responses described their experience as poor.
- We discussed the national GP patient survey results, which were published before the practices most recent survey; staff we spoke with explained that they were not aware of any issues regarding GP care and that feedback about care and treatment was usually positive.
- The practices survey results for recommending the practice to others highlighted that 70% of the respondents would recommend the practice.

Question	Y/N
The practice carries out its own patient survey/patient feedback exercises.	Y

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment.

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y

Source	Feedback
Interviews with patients.	The patient we spoke with on the day of our inspection told us they were happy with the practice and had no complaints or concerns.

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2018 to 31/03/2018)	82.2%	92.8%	93.5%	No statistical variation

Any additional evidence or comments

Use this box to describe what action has been taken to improve any indicators that are lower than local or national averages.

The practice provided results of an internal survey completed between April and December 2018. Results of the survey highlighted that most patients described their experience as excellent, very good, good and fair with regards to questions asked about staff listening during consultations, taking time to answer questions, giving medicines, lifestyle and treatment advice and with regards to the thoroughness of examinations.

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	Y
Information about support groups was available on the practice website.	Y

Carers	Narrative
Percentage and number of carers identified.	The practices carers register had increased from 12 carers to 50, this represented 1% of their registered patient list. The percentage at our previous inspection was 0.3%.
How the practice supported carers.	The practice was focussing on increasing their carers register to ensure carers were offered support to meet their needs. To help with this a member of the reception team was nominated as the carers lead. This involved monitoring the carers register and helping staff to opportunistically identify carers. Carers were provided with supportive resources where needed which included signposting information to support services, they were also offered flu vaccinations. The practice did not offer health checks to their carers however it was discussed as a future plan during our inspection.
How the practice supported recently bereaved patients.	The practice sent cards with condolences and supportive bereavement information to recently bereaved patients, they were also signposted to support services such as Cruse Bereavement Care.

Privacy and dignity

The practice respected patients' privacy and dignity.

	Y/N/Partial
Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.	Y
Consultation and treatment room doors were closed during consultations.	Y
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y

Responsive

Rating: Requires Improvement

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs in most areas.

	Y/N/Partial
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y*
The practice provided effective care coordination for patients who were more vulnerable or who had complex needs. They supported them to access services both within and outside the practice.	Y
Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.	Y
Explanation of any answers and additional evidence: The practice did not have a hearing loop installed and whilst staff advised that they had no patients requiring hearing support, we noted that the need for this had not been formally assessed as best practice.	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am – 8pm
Tuesday	8am – 6.30pm
Wednesday	8am – 6.30pm
Thursday	8am – 1pm
Friday	8am – 6.30pm
Appointments available:	
Monday	8.30am – 11am and 4pm – 8pm (extended hours opening)
Tuesday	8.30am – 11am and 4-6pm
Wednesday	8.30am – 11am and 4-6pm
Thursday	8.30am – 11am
Friday	8.30am – 11am and 4-6pm
<ul style="list-style-type: none"> There is a GP on call at the practice on Thursdays when the appointments finish after 11am. Patients can also access appointments through the Bordesley Green Access Hub also known as Omnia during the day when appointments were closed, on evenings from 6.30pm to 8pm and on weekends from 8.30am to 11.30am. 	

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
3625	416	111	27%	3%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that at their last general practice appointment, their needs were met (01/01/2018 to 31/03/2018)	89.3%	94.5%	94.8%	No statistical variation

Older people

Population group rating: Requires Improvement

Findings
<ul style="list-style-type: none"> Although all patients had a named GP at the practice, the practice regularly used locum GPs to help with the running of clinics every Tuesday and Friday. The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs and complex medical issues. However, satisfaction results with regards to access were below average, this affects all population groups. In recognition of the religious and cultural observances of some patients, the GP would respond quickly, often outside of normal working hours, to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.

People with long-term conditions

Population group rating: Requires Improvement

Findings
<ul style="list-style-type: none"> Satisfaction results with regards to access were below average, this affects all population groups. Patients with multiple conditions had their needs reviewed in one appointment. The practice liaised regularly with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues. Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.

Families, children and young people

Population group rating: Requires Improvement

Findings
<ul style="list-style-type: none"> 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. However, satisfaction results with regards to access were below average, this affects all population groups.
- Baby clinics took place at the practice every Wednesday afternoon and post-natal checks were carried out by the GP as part of this service.

Working age people (including those recently retired and students)

Population group rating: Requires Improvement

Findings

- 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.
- The practice was open until 8.15pm on a Monday and Friday. Pre-bookable appointments were also available to all patients at additional locations within the area, as the practice was a member of a GP federation. Appointments were available Saturday and Sunday 10am until 1pm.
- The practice was encouraging their patients to make use of online booking access, a report provided by the practice on the day of our inspection highlighted that approximately 6.5% of the practices patients had registered for online access. The practice was continually monitoring this and encouraging uptake, we noted that their new patient registration form had also been adapted to include online access registration.
- Patients could access evening and weekend appointments through the Bordesley Green Access Hub also known as Omnia; of which the practice was part of a Hub for extended access.
- However, satisfaction results with regards to access were below average, this affects all population groups.

People whose circumstances make them vulnerable

Population group rating: Requires Improvement

Findings

- 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.
- One of the GPs had been trained to deliver a substance misuse clinic for both registered and non-registered patients within the practice locality; this took place on a fortnightly basis.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability. However, satisfaction results with regards to access were below average, this affects all population groups.

People experiencing poor mental health (including people with dementia)

Population group rating Requires Improvement

Findings

- Priority appointments were allocated when necessary to those experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice was aware of support groups within the area and signposted their patients to these accordingly.
- Satisfaction results with regards to access were below average, this affects all population groups.

Timely access to the service

People were not always able to access care and treatment in a timely way.

National GP Survey results

	Y/N/Partial
Patients with urgent needs had their care prioritised.	Y
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Y
Appointments, care and treatment were only cancelled or delayed when necessary.	Y
Explanation of any answers and additional evidence: Home visit requests were reviewed by the GP who contacted the patient/carer to triage and attend if appropriate. There was a formal protocol in place to support this process.	

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2018 to 31/03/2018)	36.9%	n/a	70.3%	-
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2018 to 31/03/2018)	50.5%	62.5%	68.6%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2018 to 31/03/2018)	50.2%	63.0%	65.9%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2018 to 31/03/2018)	48.8%	69.9%	74.4%	Variation (negative)

Any additional evidence or comments

Use this box to describe what action the practice has taken to improve access

- Satisfaction results with regards to access were below average, on discussing the national GP patient survey results, staff noted that they were having to use various locum GPs for months at a time whilst one of the GPs was away from the practice. Staff described how due to being a small practice, patients often opted to see their preferred named GP however during this period this was difficult due to locum usage; staff explained that this may have contributed towards some of the below average satisfaction rates at the time.
- The practice provided results of a more recent internal survey completed between April and December 2018, to follow the national GP patient survey. Results of the survey highlighted that 143 respondents described their experience as excellent, very good, good and fair with regards to questions asked about ease of making appointments, after hours care, waiting times, referral processes and appointment availability. Seventeen respondents described a poor service with regards to their overall experience.
- Staff expressed that some of the actions taken since our previous inspection may have contributed towards improvements in areas, this included installing an additional phone line and recruiting a practice nurse to offer more appointments. The practice also joined a Hub in July 2019, where patients could access later and weekend appointments through the Bordesley Green Access Hub also known as Omnia. Furthermore, although locum GPs worked at the practice each week the overall use of various locums had reduced now that one of the GPs was back to normal working hours.

Source	Feedback
CQC Comment Cards	The one completed comment card we received noted that they would recommend the practice to others.
Interviews with patients	We spoke with one patient on the day of our inspection who expressed that they were happy with the practice and had no complaints or concerns.
NHS Choices	The practice had received a 1.5 star rating based on 13 reviews. Most of the comments made within the past 12 months highlighted issues accessing appointments.
Practice suggestions Box	We saw that two of the three comments from the practices suggestions box highlighted problems accessing appointments. The comments were anonymous and therefore the practice advised that whilst they were unable to respond, they would discuss these during their next practice meeting.

Listening and learning from concerns and complaints

Complaints were listened and responded to and used to improve the quality of care.

Complaints

Number of complaints received in the last year.	1
---	---

Number of complaints we examined.	1
Number of complaints we examined that were satisfactorily handled in a timely way.	1
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y

Example(s) of learning from complaints.

Complaint	Specific action taken
We observed the one complaint received by the practice as part of our inspection. We noted that this complaint was made regarding a locum GP whereby the patient was unhappy with their consultation.	The investigation noted that the locum GP followed the appropriate examination process and an apology was given to the patient.

Well-led

Rating: Inadequate

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y

Vision and strategy

The practice had a vision and strategy to provide high quality sustainable care however we noted that it wasn't fully effective in specific areas.

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Partial
There was a realistic strategy to achieve their priorities.	Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y

Progress against delivery of the strategy was monitored.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> Members of the management team explained that the practice was hoping to recruit a salaried GP as part of the practice's future strategy and succession planning. Additional actions included plans to move to a more modern, larger and purpose-built premise as space was sometimes restricted at their current location; managers advised that they were at the stage of finding a suitable location for the move. However, the practice did not demonstrate the effectiveness of their strategy across specific areas where risks and areas for improvement had been identified. For example, we noted that the GPs were not appropriately utilising their patient record system to ensure accuracy in record keeping; specifically, we found that a work-around process had been adapted to exclude patients inappropriately allocated to specific disease and long term conditions registers; instead of taking steps to ensure accuracy of registers. We also noted that although an action plan to support the cleansing of their system was in place, this did not include clear timeframes for monitoring of progress and completion and therefore the practice could not provide assurance of the progress made since the coding issues were inherited in 2016. We also identified that clinicians had been using multiple codes at the time of our inspection and that this impacted on the accuracy of their disease registers. Following our inspection, the practice provided a comprehensive practice improvement plan which provided a monthly status on the progress of the actions taken across a variety of areas. We saw that ongoing work was being carried out to address the historical clinical coding and exception reporting issues and that the practice was being supported by a pharmacy technician as part of this work. The practice regularly monitored this plan. In addition, the practice was working closely with their Clinical Commissioning Group and Local Medical Council to address challenges across data quality, the practice premises as well as practice partnership and sustainability plans. 	

Culture

The practice had a culture which drove high quality sustainable care.

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> At our last inspection in April 2018 conversations with some staff highlighted that they did not always feel supported in their role and did not always feel that their concerns were acted on. We saw minutes of a practice meeting which took place to discuss the findings from the last 	

inspection, minutes of the meeting demonstrated that staff were given the opportunity to discuss ways to improve the support arrangements in the practice. The meeting highlighted that staff had felt under pressure with the practices patient list increase, but that the recruitment of more staff and the implementation of a peer-support system had helped to ease pressure and boost morale.

- We found that morale had significantly improved based on discussions with staff at this inspection.
- The practice had also started to hold social events for staff to come together as a team if they wished to outside of work, a bowling evening and meal had been arranged for staff following our inspection as an initiative to boost well-being and encourage team building.

Examples of feedback from staff or other evidence about working at the practice

Source	Feedback
Conversations with staff	Staff expressed that the team was working well together and that things had improved, they described an open culture and were happy and supported in working at the practice. Some staff gave positive examples of how they had recently been supported by management. Overall, staff described a close supportive team, they were proud of the improvements achieved at the practice and proud of the relationships with patients.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management, however these were not fully effective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Practice specific policies were available on the practices shared computer system and in hard copy format. We saw a range of practice specific policies such as the practices safeguarding policies, significant event reporting and learning policy, the policy for managing high risk medicines and safety alerts.</p> <p>However, the practice could not demonstrate that they had fully improved their governance of the recruitment and induction processes since our last inspection. Furthermore, the practice did not demonstrate good governance with regards to their strategy and across specific coding issues where risks and areas for improvement had been identified.</p>	

Managing risks, issues and performance

There were some processes in place for managing risks, issues and performance however in some areas, these were not fully effective.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a systematic programme of clinical and internal audit.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Partial
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>We saw some examples of appropriate risk management during our inspection. For instance, we saw that risks associated with premises were formally assessed, we saw specific examples of how in areas, such as medicines, patient safety risks were assessed and acted on where required. However, we identified some coding problems on the patient record system during our inspection which highlighted that in some cases multiple codes were being used to identify patients with long term conditions; therefore the practice could not provide an accurate reflection of their disease registers as relevant patients were not always being captured under each register.</p>	

Appropriate and accurate information

The practice did not always act on appropriate and accurate information.

	Y/N/Partial
Staff used data to adjust and improve performance.	Partial
Performance information was used to hold staff and management to account.	Y
Our inspection indicated that information was accurate, valid, reliable and timely.	N
There were effective arrangements for identifying, managing and mitigating risks.	Partial
Staff whose responsibilities included making statutory notifications understood what this entails.	Y

Explanation of any answers and additional evidence:

- During our inspection staff explained that they had inherited a number of patients from a nearby practice in September 2016 and approximately 300 records were still not fully transferred through at the time of our inspection. Although staff could see most of the patient record (through GP to GP view) some information such as full medical history could not always be seen. This matter was outside of the practices control and we saw that the practice was regularly enquiring and chasing progress regarding the record transfer with the relevant organisations including the practices Clinical Commissioning Group.
- Our review of the practices above average exception rates across various areas highlighted that in a range of cases the practice had excluded patients because historically they had inappropriately been added to the disease register and therefore to exclude them from their QOF data collection the practice was exception reporting them. On further investigation we found that these cases were inherited from a nearby practice, from which the practice took on 450 patients in September 2016.
- The practice was aware that they had inherited some historical coding issues with the uptake of patients transferred across in 2016. The practice provided an action plan to demonstrate the ongoing actions they had taken to rectify this issue. This included the recruitment of a pharmacy technician who was supporting the practice in cleansing their system.
- Following our inspection, the practice provided a comprehensive practice improvement plan which provided a monthly status on the progress of the actions taken across a variety of areas. We saw that ongoing work was being carried out to address the historical clinical coding and exception reporting issues and that this was regularly monitored.

Engagement with patients, the public, staff and external partners

The practice involved staff and external partners to sustain high quality and sustainable care, and were attempting to improve public engagement.

	Y/N/Partial
Patient views were acted on to improve services and culture.	Partial
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y

Explanation of any answers and additional evidence:

- We saw that patients could provide suggestions and feedback through the practices suggestions box; this information was discussed at practice meetings so that improvements could be made where possible. There were plans to discuss the recent feedback regarding problems accessing appointments at the next practice meeting.
- Conversations with staff highlighted that the practice had struggled to implement a Patient Participation Group (PPG). A meeting had been called with a few interested patients recently however attendance was low and only one patient attended. We saw that the practice was trying to promote and develop a group through promoting this in the practice waiting room. Staff advised that they were exploring virtual PPG ideas also.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence: We noted that since our previous inspection in April 2018, the practice had been focussing on further training their non-clinical staff to improve skill-mix and to empower them to support one another confidently across different areas of the practice, in addition to any areas they led on. This had a positive impact on staffing and rota arrangements as it supported continuity of processes and systems in the event of sickness or annual leave.	

Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique we can be 95% confident that the practice's performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

The percentage of practices which show variation depends on the distribution of the data for each indicator, but is typically around 10-15% of practices. The practices which are not showing significant statistical variation are labelled as no statistical variation to other practices.

N.B. Not all indicators in the evidence table are part of the GP insight set and those that aren't will not have a variation band.

The following language is used for showing variation:

	Variation Band	Z-score threshold
1	Significant variation (positive)	$Z \leq -3$
2	Variation (positive)	$-3 < Z \leq -2$
3	No statistical variation	$-2 < Z < 2$
4	Variation (negative)	$2 \leq Z < 3$
5	Significant variation (negative)	$Z \geq 3$
6	No data	Null

Note: for the following indicators the variation bands are different:

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules based approach for scoring, due to the distribution of the data

It is important to note that z-scores are not a judgement in themselves, but will prompt further enquiry, as part of our ongoing monitoring of GP practices.

Guidance and Frequently Asked Questions on GP Insight can be found on the following link:
<https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease
- **PHE:** Public Health England
- **QOF:** Quality and Outcomes Framework
- **STAR-PU:** Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.