Care Quality Commission

Inspection Evidence Table

OHP-Lordswood House Medical Practice (1-3918096187)

Inspection date: 11 February 2019

Date of data download: 28 January 2019

Overall rating: Good

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

Safe Rating: Good

Safety systems and processes

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

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.	Y
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

Safeguarding	Y/N/Partial

Explanation of any answers and additional evidence:

Staff we spoke with explained that safeguarding leads attend regular safeguarding meetings with school nurses and health visitors to maintain safe management of this patient group.

The practice further extended their systems for keeping patients safe and safeguarded from potential abuse. For example, staff took a proactive approach to raising the profile of safeguarding and created a streamlined process across their three sites to enable efficient management of safeguarding. An experienced safeguarding administrator was appointed to act as central point of contact as well as coordinate meetings with other professionals.

The practice maximised opportunities to learn from internal and external safety events to improve patient safety. For example, at the time of our inspection, staff were in the process of completing training in identification and referral (IRIS). IRIS is a General Practice based domestic violence and abuse (DVA) training and support referral programme). This had been identified as an area where they might improve, as a result of a previous, effectively managed case, so further training had been arranged to ensure that their systems were even more effective.

In line with the Counter Terrorism and Security Act 2015 recommendations, staff had completed PREVENT awareness training (a course aimed at raising awareness of the risks of radicalisation and extremism in various forms and settings).

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current Public Health England (PHE) guidance and if relevant to role.	Partial
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

Explanation of any answers and additional evidence:

The provider supported the practice in relation to recruitment for example, advertising on the Our Health Partnership (OHP) website and newsletters. The central team produced standardised job descriptions for the practices.

The provider had developed a bespoke system for recruiting locum staff. For example, staff explained that OHP had an internal locum pool. This was managed through an external locum agency where both clinical and non-clinical staff who worked at an OHP member practice could join the scheme and offer their availability to support and work in other OHP practices. Following feedback from the practice regarding maintaining continuity of care, the provider adapted the system to attract salaried GPs. Members of the management team explained this support resulted in the practice successfully recruiting salaried GPs.

The practice was unable to demonstrate all healthcare staff received immunisations that were appropriate to their role. Members of the management team explained immunisations were part of the induction process and we saw proof of immunisation status for healthcare staff recruited in the last 12 months. Following our inspection, the medical group provided proof of immunisation status for all health care staff.

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: Lordswood House Medical Centre (LHMC): Date: 28/11/2018 Quinton Family Practice (QFP): Date: 23/11/2018 Quinborne Medical Practice (QMP): Date 21/11/2018	Y
There was a record of equipment calibration. Date of last calibration: LHMC: Date: 30/11/2018 QFP: Date: 29/10/2018 QMP: Date: 04/12/2018	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y
There was a fire procedure.	Y
There was a record of fire extinguisher checks. Date of last check: LHMC: Date: 11/05/2018 QFP: Date: 20/02/2018 QMP: Date 04/01/2019	Y
There was a log of fire drills. Date of last drill: LHMC: Date: 23/01/2019 QFP: Date: 22/01/2019 QMP: Date: 30/01/2019	Y
There was a record of fire alarm checks. Date of last check: LHMC: Date: 04/02/2019 QFP: Date: 01/02/2019 QMP: Date: 29/01/2019	Y
There was a record of fire training for staff. Date of last training: All staff completed training in the last 12 months.	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: 28/08/2018 carried out at all three sites.	Y
Actions from fire risk assessment were identified and completed.	Y

Explanation of any answers and additional evidence:

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 20/11/2018 carried out at all three sites.	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 26/11/2018 carried out at all three sites.	Y
Explanation of any answers and additional evidence: Legionella risk assessments had been carried out on 15/03/2017 at all three sites and there were arrangements in place for reassessment to be carried out in March 2019.	

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:	Y
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:

Infection prevention and control (IPC) audits were carried out at the main site Lordswood House Medical Centre (LHMC) and the two branch sites at Quinton Family Practice (QFP) and Quinborne Medical Practice (QMP).

- LHMC scored 88% in their June 2018 IPC audit. Identified actions had been carried out. For example, discussions with the cleaning contractors regarding general cleaning and storage of cleaning equipment.
- QFP scored 87% in their June 2018 IPC audit. Identified actions such as having a designated area for the storage of cleaning equipment had been carried out.
- QMP scored 89% in their July 2016 IPC audit. Staff provided evidence of an internal audit carried out in the last 12 months. Identified actions had mainly been carried out. For example, wall mounted soap dispensers had been fitted and fabric curtains had been replaced with disposable ones. Staff explained plans for securing a designated area for the storage of cleaning equipment was ongoing.

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.	Y
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:	

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: There was a designated data protection officer for OHP to support practices to adhere to relevant legislation and staff we spoke with at Lordswood House Medical Practice were aware of this. The General Data protection regulations and guidance had been issued to practices to support them in complying with those regulations.	

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) NHS Business Service Authority - NHSBSA)	0.77	0.91	0.94	No statistical variation
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)	10.8%	7.6%	8.7%	No statistical variation

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
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	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
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks	N/A

Medicines management	Y/N/Partial
and disposal of these medicines, which were in line with national guidance.	
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.	N/A
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
Explanation of any answers and additional evidence: The clinical team consisted of a clinical pharmacist who supported with the management of medicine queries received from patients and pharmacies as well as carrying out medicine reviews.	

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:	42
Number of events that required action:	42

Explanation of any answers and additional evidence:

The provider had a standard operating procedure which stated that all significant events were reported by practices through the Clarity TeamNet governance system enabling them to be monitored centrally. We found that the system at Lordswood Medical Group was well embedded and staff were effectively recording significant events onto the system. Oversight of this process within the practice was carried out effectively and staff followed the standardised system.

We saw that when an incident occurred, learning within the practice was based on a thorough analysis and investigation. There was a strong culture of shared learning which involved all staff members. The practice maximised every opportunity to learn from internal and external safety events at provider level and across all locations managed by the provider organisation. Staff were open, transparent and fully committed to reporting incidents and near misses. The level and quality of incident reporting forms we viewed demonstrated a strong emphasis on safety.

Staff we spoke with were able to explain significant events recorded in the last 12 months and described actions taken to reduce the risk of the same thing happening again.

Example(s) of significant events recorded and actions by the practice.

Event	Specific action taken
Vaccination fridge failure	Members of the clinical team labelled and isolated the vaccines. Staff were informed of the vaccination fridge failure and the practices contacted the manufacturers for further instructions and advice. The practice took steps to reduce further risks of vaccination fridge failures.
Clinical	Clinical staff reminded to be vigilant when assessing vulnerable patients and those with suicidal intentions and take appropriate actions such as communication with community support services. Royal College of General Practice (RCGP) suicide

	prevention module completed and key points disseminated across the medical group.
Clinical	Clinicians reminded to ensure arrangements were made with the district nursing team to monitor patients' blood sugar levels regularly to enable early identification of when diabetes becomes uncontrolled.

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

Explanation of any answers and additional evidence:

Safety alerts were added to Clarity TeamNet and practices were required to give a response of relevant actions taken to provide the provider with assurance that they had acted on them. During our inspection, we saw that oversight of this system was carried out effectively, and information entered onto Clarity TeamNet demonstrated that actions had been carried out in line with safety recommendations. For example, clinical records viewed by the inspection team showed female patients of child bearing age had been identified in relation to a specific medicine and appropriate actions in line with safety recommendations had been carried out.

Members of the nursing team we spoke with demonstrated awareness of the safety alert relating to severe harm from failure to obtain and continue flow from oxygen cylinders. Staff demonstrated that the safety alert had been discussed during a clinical meeting and the key messages from the alert had been discussed.

Effective Rating: Good

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 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
Explanation of any answers and additional evidence: The practice actively used evidence based techniques and technologies to support the delivery of high quality care. For example, the practice was involved in a National Institute for Clinical Health and Care Excellence (NICE) pilot which tested the use of Fractional exhaled nitric oxide (FeNO) tests to achieve more accurate diagnosis of asthma. The aim of this was to provide more effective treatment (FeNO is a quantitative, non-invasive method of measuring airway inflammation providing a complementary tool for assessing airways disease in asthma).	

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) (NHSBSA)	0.71	0.81	0.81	No statistical variation

Older people Population group rating: Good

Findings
• The practice used a clinical tool 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. Unpublished data provided by the practice showed out of 2039 patients identified, 1240 were invited for a health check in the past 18 months and 1344 (65%) had received a health check.
- The practice operated a telephone triage which staff explained enabled the practice to direct patients to the most appropriate care and reduced unnecessary attendance at the practice.
- The practice served a number of nursing and care homes where clinical staff carried out weekly GP ward rounds.
- The medical group recognised continuity of care as being essential for the elderly population and worked hard to ensure this was maintained. For example, GPs held personal lists and patient feedback regarding continuity of care was very positive.

People with long-term conditions Population group rating: Good.

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 specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Members of the nursing team carried out Association for Respiratory Technology and Physiology (ARTP) certified spirometry (a test used to help diagnose and monitor certain lung conditions by measuring how much air you can breathe out in one forced breath). (ARTP are the guardians of quality-assured diagnostic spirometry in the UK).
- Unpublished data provided by the practice regarding their involvement in a NICE pilot testing the use of FeNO tests to achieve more accurate diagnosis of asthma showed between May 2016 and late 2018; 575 tests were carried out across their three sites and the practice prevented 144 referrals to secondary care.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately. The medical group provided one of the largest community based anticoagulation clinic in Birmingham (a clinic to monitor blood thinning medicines). Unpublished data provided by the practice showed 42 patients had been initiated on an anticoagulation medicine in the last 12 months and the practice were actively referring identified patients to secondary care for continuation of Warfarin.

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)	89.8%	79.9%	78.8%	Variation (positive)
Exception rate (number of exceptions).	27.0% (347)	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	80.2%	77.0%	77.7%	No statistical variation

months) is 140/80 mmHg or less (01/04/2017 to 31/03/2018) (QOF)				
Exception rate (number of exceptions).	19.6% (252)	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)	87.1%	81.1%	80.1%	No statistical variation
Exception rate (number of exceptions).	19.1% (246)	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)	77.2%	76.7%	76.0%	No statistical variation
Exception rate (number of exceptions).	11.6% (170)	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)	90.3%	91.4%	89.7%	No statistical variation
Exception rate (number of exceptions).	9.6% (36)	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).	4.9% (151)	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)	95.6%	88.6%	90.0%	No statistical variation
Exception rate (number of exceptions).	10.9% (42)	8.1%	6.7%	N/A

Any additional evidence or comments

The practice demonstrated awareness of their exception reporting which was higher than local and national averages for long term conditions. The practice recognised a number of reasons for this. For example, codes were not frequently being applied, patients failing to attend despite three recall attempts and exceptions based on clinical merits. To address this staff had received training and an external audit carried out by the Primary Care Contracting and Commissioning team at the local Clinical Commissioning Group (CCG) showed the evidence provided by the practice regarding their exception reporting was found to be satisfactory. The practice provided unpublished data from the 2018/19 QOF year which showed reductions in their exception reporting rates. For example, exception rates for patients diagnosed with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less was 18%. Exception rates for 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 was 13%. The 2018/19 QOF exception rates for patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control was 1%.

Families, children and young people Population group rating: Good.

Findings

- Childhood immunisation uptake rates were above national targets and below the World Health Organisation (WHO) targets for children aged one. Targets for children aged two was below national and 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 services for sexual health and contraception. The practice also provided long acting reversible contraception.
- OHP was awarded the contract for delivering sexual health services (in Birmingham and Solihull CCG); this service was available to registered patients; as well as patients who were not registered with an OHP practice.
- Six-week baby checks were combined with postnatal appointments.

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)	288	311	92.6%	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)	254	293	86.7%	Below 90% minimum (variation negative)
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)	249	293	85.0%	Below 90% minimum (variation negative)
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)	256	293	87.4%	Below 90% minimum (variation negative)

Any additional evidence or comments
Members of the nursing team demonstrated awareness of the practice performance and explained improving the uptake of pre-school boosters formed part of the nursing teams' objectives. Posters were in treatment rooms informing parents and legal guardians of the benefits of childhood immunisations. The nursing team actively contacted parents and legal guardians of children who failed to attend for vaccinations and invited them in to see a member of the team. Safeguarding administrators improved links with school nurses and worked closely with health visitors, sharing information regarding missed appointments.

The practice developed an action plan to improve the uptake of childhood immunisations. For example, the practice reviewed their recording process giving named individuals responsibility for checking, recalling and recoding children who received their immunisations and boosters. The practice were maintaining records to accurately demonstrate when parents or legal guardians declined the offer of having their child immunised.

Appointments were available throughout the week and at different times. Clinical staff were trained in childhood immunisations and provided parents with information to enable them to make informed decisions regarding the immunisation schedule.

Working age people (including those recently retired and students)

Population group rating: Good

Findings

- 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.
- Unpublished data provided by the practice showed that out of 2,590 patients who were offered a health check in the last 18 months 613 (24%) of these checks had been carried out. Staff explained the clinical team routinely encouraged patients during other consultations who were due for their health checks to attend their health check appointment.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.
- Appointments were available from 8am throughout the week; Saturday mornings and Monday evening appointments were available as well as extended hours provided by OHP collaborative hub.

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)	69.2%	68.1%	71.7%	No statistical variation
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	73.2%	63.8%	70.0%	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)	53.4%	44.0%	54.5%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months,	69.6%	74.2%	70.3%	N/A

who have a patient review recorded as occurring within 6 months of the date of diagnosis. (01/04/2017 to 31/03/2018) (PHE)				
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)	63.4%	52.0%	51.9%	No statistical variation

Any additional evidence or comments

The uptake of cervical screening was comparable to local and national averages; however, below the 80% Public Health England standard for coverage. Staff demonstrated awareness of the uptake and explained actions taken to address this area. For example, the medical group held a cervical cancer awareness week during January 2019, members of the nursing team identified women at high risk and text reminders were sent inviting them to attend screening appointments. Promotional information was located in patient waiting areas across all three sites. Patients were advised that screenings were also available at the OHP collaborative hub for patients who were unable to attend the practice during normal working hours.

Women received an initial written invitation from the national screening office. Staff explained that women who failed to attend received a phone call and up to three additional reminder letters. Alerts were placed on the patient records for non-attenders so that the screening tests could be discussed opportunistically. Clinicians actively discussed screening during new patient health checks as well as routine consultations. The practice operated a failsafe system which was managed by the nursing team to monitor whether results were received for every sample sent as well as ensuring abnormal results were followed up appropriately.

People whose circumstances make them vulnerable

Population group rating: Good

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.
- Learning disability clinics were carried out across all three sites operated by GPs who were specifically trained in this area
- The practice held a register of patients living in vulnerable circumstances such as those with a learning disability; there were policies in place which enabled homeless people and travellers to register with the practice.
- The practice identified a training shortfall in relation to transgender prescribing. GPs were subsequently trained to enable them to effectively provide this service.
- 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 and offered shared care services and drug workers from the local addiction service provided clinics across all three sites to support patients with drug and alcohol issues. Unpublished data provided by the medical group showed 100% of patients had a medical review and a care plan in place; and a number of patients had successfully completed treatment.

- The practice reviewed young patients at local residential homes.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

- 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.
- Patients had access to dementia clinics run by the Alzheimer's society held at the main site between July and September 2018. Unpublished data provided by the practice showed a total of 18 patients and their carers accessed the clinics. Staff explained patients were offered additional support following their appointment with a dementia support worker and the medical group were planning to facilitate further clinics in 2019.
- All staff had received dementia training in the last 12 months. There were notice boards in patient waiting areas promoting dementia awareness.
- The medical groups website included information, advice and self-referral pathways.

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)	95.6%	93.2%	89.5%	No statistical variation
Exception rate (number of exceptions).	15.9% (30)	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)	91.8%	93.3%	90.0%	No statistical variation
Exception rate (number of exceptions).	15.9% (30)	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)	91.1%	85.9%	83.0%	No statistical variation
Exception rate (number of exceptions).	6.1% (8)	6.0%	6.6%	N/A

Any additional evidence or comments
The practice provided unpublished data from the 2018/19 QOF year which showed reductions in their exception reporting rates for mental health indicators. For example, exception rate for the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record was 5%. Exception rates for patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review was 1%.

Monitoring care and treatment

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

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	558.2	545.3	537.5
Overall QOF exception reporting (all domains)	8.7%	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	Y

information about care and treatment to make improvements.	

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

The medical group operated a comprehensive programme of quality improvement activities and carried out a number of clinical audits in the last 12 months which were mainly driven by the practice in specific areas. Staff confirmed that completion of two cycle clinical audits annually was part of the core quality markers which they submitted to the provider as part of a self-declaration.

- The practice carried out an audit on antibiotic prescribing across all their three sites to monitor and manage GPs prescribing behaviour and ensure compliance with the CCGs Aspiring for Clinical Excellence (ACE) Programme. (The ACE programme is aimed at reducing the level of variation in general practice by bringing all practices up to the same standards of primary care). The first audit was carried out in June 2018 and all prescribers were debriefed on ACE prescribing initiatives as well as local guidelines around choice, dose and information to support self-help. A second audit carried out January 2019 showed the medical group achieved ACE standards in relation to antibiotic prescribing. The practice carried out an audit on palliative care in September 2018. The audit was carried out to maximise delivery of palliative care and end of life care by ensuring patients were identified and placed on the practice's palliative care register meeting gold standard framework targets. (GSF is evidenced based guidelines to deliver high quality end of life care). As a result of the audit a total of 200 patients were reviewed and the number of patients on the palliative care register increased from 168 to 193. Staff explained this enabled clinical staff to commence advanced care planning for a wider range of patients.
- QOF was managed by the individual practices and staff were aware of areas such as exception reporting for long-term conditions and mental health related indicators which was higher than local and national averages. Staff explained clinicians had oversight of exception reporting and patients were only exception reported based on clinical grounds and informed dissent after at least three invitations sent by letter or text message as well as clinical justification when a performance target was not appropriate or when a medicine was not indicated.

Effective staffing

The practice was 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.	Y
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	Y
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.	Y
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
Explanation of any answers and additional evidence: Members of the management team effectively used Clarity TeamNet to manage and monitor staff training as well as appraisals. From the records we viewed, all staff were up to date with training which had been identified as mandatory by the provider organisation and all eligible staff received an appraisal in the last 12 months.	

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	Y

services.	
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:

The practice ensured that end of life care was delivered in a coordinated way which considered the needs of different patients, including those who may be vulnerable because of their circumstances. For example, the practice worked closely with palliative care nurses and local hospices.

The practice maintained a log of patients approaching end of life and staff attended quarterly Gold Standards Framework (GSF) meetings which were also attended by Macmillan nurses to discuss the care management of patients approaching end of life. (GSF is evidence based guidelines to deliver high quality end of life care). Each patient was assessed according to their needs of support.

Helping patients to live healthier lives

Staff were 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
Explanation of any answers and additional evidence: The provider organisation (OHP) was awarded health and wellbeing funding and working in partnership with an external service to provide social prescribing to patients. Lordswood House Medical Practice was the first OHP location to offer this service to patients. Staff explained that this enabled the medical group to respond to issues related to the wider determinates of health by connecting patients to local services to help improve their physical and mental wellbeing. Staff actively referred patients to a health and wellbeing worker who saw patients at the main site and in the community to help connect patients to services such as counselling, arts and crafts, support with accessing physical activities and any other additional support needs. Unpublished data provided by the practice showed since January 2019 the medical group made 36 referrals.	

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)	98.4%	96.1%	95.1%	Variation (positive)
Exception rate (number of exceptions).	1.0% (54)	0.6%	0.8%	N/A

Consent to care and treatment

The practice always obtained consent to care and treatment 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:	

Caring Rating: Good

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion. Feedback from patients was mainly 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
Explanation of any answers and additional evidence: Training records we viewed showed that staff had completed equality and diversity training as well as training sessions on communication skills. The management team promoted and encouraged an open friendly environment.	

CQC comments cards	
Total comments cards received.	38
Number of CQC comments received which were positive about the service.	31
Number of comments cards received which were mixed about the service.	6
Number of CQC comments received which were negative about the service.	1

Source	Feedback
CQC comment cards	Patients who completed CQC comment cards felt that staff were very friendly, helpful and willing to listen to their concerns. Staff were described as being understanding, caring, always willing to help; pleasant and respectful.
Patient Participation Group (PPG)	PPG members provided positive feedback about the practice staff explaining that staff would go out their way and often above and beyond what was expected to attend to patient's needs. The entire practice staff were described as helpful and caring.
NHS Choices	Patients feedback recorded on NHS Choices showed mixed views regarding their experience. For example, patients commenting that both clinical and non-clinical staff were professional, compassionate and efficient. However, some patients were less positive regarding continuity of care.

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
25023	302	112	37.1%	0.45%

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)	95.2%	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)	93.9%	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)	98.1%	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)	91.4%	81.0%	83.8%	No statistical variation

Any additional evidence or comments
Staff explained that all patients have a named GP and to ensure continuity of care the medical group operated a personal list system. Members of the PPG we spoke with provided positive feedback regarding the personal list system and explained that this enabled continuity of care.

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

Any additional evidence
The practice had sent a copy of their proposed internal survey questionnaire to the PPG who were in the process of reviewing the proposed questions to ensure they captured patients feedback effectively. PPG members explained once the questions had been agreed the survey would be rolled out during 2019. Clinicians obtained feedback from patients as part of their appraisal process and the practice obtained feedback from various sources such as friends and family test (FFT), the practice suggestion box as well as verbal feedback following appointments.

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
Explanation of any answers and additional evidence:	

Source	Feedback
Completed CQC comment cards	Patients who completed CQC comment cards felt staff went out their way and often above and beyond to accommodate their needs. Feedback from PPG members were also aligned with these views.

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	96.3%	92.8%	93.5%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
31/03/2018)				

Any additional evidence or comments
Members of the PPG explained patients were very happy with the service being provided. PPG members explained that staff had received customer service training and communicated with patients in a polite and pleasant manner. Completed CQC comment cards showed that patients felt they were involved in decisions about their care and treatment.

	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
Explanation of any answers and additional evidence: Staff explained that they organised translators when required and had facilities to translate materials into any language, including brail in partnership with the Queen Alexandra collage for the blind.	

Carers	Narrative
Percentage and number of carers identified.	The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 306 patients as carers (1% of the practice list).
How the practice supported carers.	Information leaflets and posters regarding support services were available in the reception area. Staff we spoke with explained that carers were provided with advice, offered flu vaccinations and stress level reviews. Those carers who were not registered patients were also able to access general health care as a temporary patient. The practice had a carers pack. The practice identified carers during consultations with patients who were being cared for as well as the new patient registration from. Staff worked through a carers template designed to guide staff with regards to offering help and support for emotional and physical needs.
How the practice supported recently bereaved patients.	If families had suffered bereavement, their usual GP contacted them and they were invited in to speak with the GPs or sent a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. The practice had bereavement packs which included information and details of support services available for the family. Information to support families during times of bereavement were also available by accessing the practice website.

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
Explanation of any answers and additional evidence:	

Responsive Rating: Good

Responding to and meeting people's needs

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

	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: Staff explained that accessibility in line with the Equality Act is part of the core quality markers submitted to the provider as part of a self-declaration.	

Practice Opening Times	
Day	**Time**
Opening times:	
Monday	7.45am – 7pm (Main site) (8.30am – 1pm and 2pm – 6pm QFP; 8.30am – 6pm QMP)
Tuesday	7.15am – 6.30pm (Main site) (8.30am – 1pm and 2pm – 6pm QFP; 8am – 6pm QMP)
Wednesday	7.45am – 6pm (Main site) (7.30am – 1pm and 3pm – 6pm QFP; 8.30am – 6pm QMP)
Thursday	7.15am – 6.30pm (Main site) (8.30am – 1pm and 3pm – 7pm QFP; 8am – 6pm QMP)
Friday	7.15am – 6.30pm (Main site) (8.30am – 1pm and 3pm – 5pm QFP; 8.30am – 6pm QMP)
Appointments available:	
Monday	8am – 11.50am and 3pm – 6pm
Tuesday	7.30am – 11.50am and 3pm – 6pm
Wednesday	8am – 11.50am and 3pm – 6pm
Thursday	7.30am – 11.50am and 3pm – 6pm

Friday	7.30am – 11.50am and 3pm – 6pm

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
25023	302	112	37.1%	0.45%

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)	95.8%	94.4%	94.8%	No statistical variation

Any additional evidence or comments

Pre-bookable appointments were available at Lordswood Extended Access Hub weekday evenings until 8pm, Saturdays from 9am to 1pm and Sundays from 10am to 2pm.

Older people — Population group rating: Good

Findings

- The medical group offered a personal list system and patients were able to choose which GP and staff member they wished to see. All patients had a named GP who supported them in whatever setting they lived.
- 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.
- The practice was actively participating in an ambulance triage project since it commenced in September 2015; aimed at avoiding patients being taken to A&E.
- In recognition of the religious and cultural observances of some patients, the GP would respond quickly to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.
- There was a medicines delivery service for housebound patients.
- Staff worked closely with district nurses and health care assistants provided domiciliary care.

People with long-term conditions — Population group rating: Good

Findings

- 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.
- All staff had completed Going for Gold primary care training programme and had used this to improve their involvement in the Gold Standard Framework (GFS) end of life care delivery; taking a holistic approach to ensure patients receive the right care at the right time in the right place. Staff were using this knowledge to support open conversations with patients and their families at an early stage about their advanced end of life care planning.

- The medical group had domiciliary health care assistants who supported patients in their homes.
- Phlebotomy services were provided at the main site as well as both branch sites.
- Chronic disease reviews were available during the evenings as well as weekends.

Families, children and young people Population group rating: Good

Findings

- Early and late nurse appointments were available at all sites for school age children so that they did not need to miss school.
- 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.
- Parents with concerns regarding children under the age of 10 could attend a clinic held at the same time as the baby clinic/child health surveillance clinic.
- The practice provided long acting reversible contraception. The practice website promoted self-care and signposting which included the Umbrella Sexual Health Service.
- Midwife clinics operated at all three practice sites.
- The main site was a pilot site for the Birmingham United Maternity Pathway (BUMP) pilot. Staff explained that the focus of this pilot was to support pregnant women and ease pressure on secondary care. The practice worked in conjunction with Birmingham Women's & Children's NHS Foundation Trust to offer late trimester scanning. Data provided by the medical group showed between September 2018 and February 2019 there were 135 appointments attended at the practice as part of this pilot clinic.

Working age people (including those recently retired and students) Population group rating: Good

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.
- Each of the practice sites offered extended opening hours for the convenience of patients who worked or were unable to attend appointments during usual working hours. In addition, extended access hub appointments were available to registered and non-registered patients at the main site Monday to Friday evenings and on a Saturday and Sunday. Telephone triage was available, this reduced the need for patients to attend the practice.
- Patients had access to on-line appointments and prescription ordering service. The practice was able to send electronic prescriptions to any pharmacy signed up to the service. The website had links to advice and support including, physiotherapy and counselling advice self-referral forms and signposting for sick-notes.
- Clinical staff provided daily telephone triage which staff explained reduced the need for patients to attend the surgery and provided choice of appointment. Patients also had the option of being seen at any of the branch sites.
- The practice regularly reviewed access and had changed the telephone system in response to patient feedback. A recent patient survey of the new system and feedback for PPG members we

spoke with during our inspection was very positive about the new system.

- Appointments were available at the main site from 7.30am and evenings until 7pm as well as extended access provided by OHP collaborative hub every evening until 8pm. Weekend appointments were available on Saturdays until 1pm and Sundays until 2pm.
- The practice was part of a group of practices involved in the development of digital access such as video consultations.
- The medical group had GPs with specialist interests in Dermatology (diagnosis and treatment of skin disorders), sports and Musculoskeletal (MSK) medicines (the diagnosis and treatment of conditions affecting the joints, bones and muscles). Staff explained that the dermatology clinic held at the main site was set up to enable timely and convenient access to treatment. Staff provided evidence of positive feedback from patients who accessed the service and explained the service allowed patients to access dermatology clinics within four months as opposed to waiting six months for a secondary care appointment.

People whose circumstances make them vulnerable

Population group rating: Good

Findings
• The practice held a register of patients living in vulnerable circumstances including learning disability. • People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode. • The practice adjusted the delivery of its services to meet the needs of patients with a learning disability. The practice had an allocated nurse who reviewed learning disability and Mental Health patients. Health care assistants carried out domiciliary visiting. • The provider organisation (OHP) was recently awarded health and wellbeing funding and were working in partnership with an external service for social prescribing. The scheme was currently being rolled out across OHP locations. Lordswood House Medical Practice was within the first wave of OHP practices to have a Health and Wellbeing Co-ordinator to support patients with emotional wellbeing and connecting them with local community services. The clinics commenced in January 2019 and data provided by the practice showed there had been 79 referrals to the service across OHP practices, of which 23 referrals (29%) had been made by Lordswood House Medical Practice since social prescribing had commenced. • The practice worked with a London based secondary care provider to provide Transgender prescribing and clinicians received specific training to support them in their role.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

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. All staff were dementia friendly trained and dementia awareness was well promoted on notice boards across all sites. • Dementia clinics were carried out in conjunction with the Alzheimer's society were available at all sites to provide additional support to patients with dementia and their families. • The practice was aware of support groups within the area and signposted their patients to these accordingly. • Staff could refer patients to a Health and Wellbeing Co-ordinator for additional support.

Timely access to the service

People were 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 absolutely necessary.	Y
Explanation of any answers and additional evidence:	

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)	60.6%	N/A	70.3%	No statistical variation
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)	76.2%	62.4%	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)	78.8%	62.8%	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)	81.4%	69.8%	74.4%	No statistical variation

Any additional evidence or comments
Members of the management team demonstrated awareness of areas where patient satisfaction were less positive; such as getting through to the practice by phone. The practice had upgraded their telephone system. The practice carried out their own survey between April and May 2018 to assess patients' satisfaction with the new telephone system. Unpublished data provided by the practice showed 55 patients had completed the patient survey, 83% felt their expectations were met in regard to getting through to the practice by phone, and 54% were able to get through to someone at the practice within five minutes.

Source	Feedback
CQC comment cards	Most patients who completed the CQC comment cards felt that they were usually able to get through to the practice by phone without difficulty and were mostly satisfied with the appointment waiting times. However, some patients said they found it difficult to get through to the practice by phone and there were times where they were not able to see their named GP.
NHS Choices	Patient comments placed on NHS Choices website showed patients were satisfied with the appointment system and were mainly satisfied with their experience of getting through to the practice by phone.
PPG Feedback	PPG members explained the management team regularly discussed the telephone system and improved access to morning appointments. The practice shared data regarding phone activity such as time it took to answer the phone and volume of calls received with them. The PPG members were positive about the changes.

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.	64
Number of complaints we examined.	Three
Number of complaints we examined that were satisfactorily handled in a timely way.	Three
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	Nil

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

Explanation of any answers and additional evidence:

The providers standard operating procedures stated that all complaints should be reported through Clarity TeamNet enabling complaints to be monitored centrally. This enabled the provider organisation to look at trends and benchmark complaints across practices. During our inspection, we saw that the Clarity TeamNet was fully embedded and staff were actively recording complaints onto the system.

From the three complaints we viewed the practice was able to provide assurance that complaints were being used to drive improvement. Members of the management team explained that the practice carried out yearly analysis of complaints to identify trends.

Example(s) of learning from complaints.

Complaint	Specific action taken
Treatment received	Members of the management team spoke with the patient and apologised. Repeat medication was arranged and complaint shared with GPs involved. The patient satisfied with the outcome and how the complaint was managed.
Appointment reminder which should not have been sent out had been sent to patient.	Members of the management team spoke with the patient and apologised. Staff checked for any future appointments booked and removed them from the clinical system, members of the community health teams were also notified of this.
Incorrect information regarding blood results given.	Members of the management team spoke with the patient and apologised. Procedures for managing blood results with non-clinical staff were reviewed.

Well-led Rating: Outstanding

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels. Leaders had the capacity and skills to deliver high quality sustainable care.

	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

Explanation of any answers and additional evidence:

The provider organisation (OHP) added OHP-Lordswood House Medical Practice to their registration in July 2017. Lordswood House Medical Practice demonstrated awareness of the shift for general practices to work together at scale. As a result, they played a significant role in the development of Our Health Partnership and were one of the founding members pioneering work workstreams while realising the vision of OHP. They have supported the implementation of the leadership and governance arrangements and development of a learning culture across all practice sites as well as the wider organisation. OHP is now in operation with a GP partnership of 37 practices with 52 surgeries.

Members of the management followed systems set by OHP and implemented them effectively at local level to enable high quality sustainable care. Members of the medical groups management team explained that OHPs workforce solutions enabled the medical group to successfully recruit salaried GPs.

Leaders created a strong learning culture and demonstrated a strong desire to continually improve service. For example, they actively participated in pilot schemes, developed staff to meet the changing needs of the patient population as well as in response to incidents; providing a range of services outside of the normal GMS contract to help reduce the burden on secondary care providers. The leadership team within the practice proactively explored various ways to further improve the safety and effectiveness of service delivery. For example, the practice had strengthened their safeguarding arrangements through improved management.

Vision and strategy

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

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Y
There was a realistic strategy to achieve their priorities.	Y
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

Explanation of any answers and additional evidence:

There was a collective vision among OHP member practices which was to provide: 'A strong and sustainable GP partnership that influences change in health and social care for the benefit of our patients, partners and practices, whilst providing leadership, standards, and support to ensure all we do clinically or operationally is of the highest quality.

The vision and values for OHP and its member practices were set out in the provider business plan. This had undergone annual review with the GP partners to monitor progress of delivery and identify that the direction of travel was still appropriate. The management team anticipated trends and effectively communicated the vision which was embedded and shared by the entire staffing group.

Members of the management team at OHP-Lordswood House Medical Practice explained that being a member practice of OHP had provided the practice with a stronger collective voice to influence change in health and social care, locally, internally across the organisation and externally through stakeholder engagement. Staff demonstrated clear awareness of the vision, values and strategy.

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

Explanation of any answers and additional evidence:

During our inspection, staff showed a clear commitment to supporting each other to further develop services for the patients as well as general practice more widely.

The management team effectively operated arrangements set by the provider to address behaviour inconsistent with the vision and values. In line with the providers systems to monitor service delivery, the management team provide monthly returns of core quality markers which were discussed at the provider governance meetings along with other information such as incidents and complaints. This was used to assure the board of quality standards.

There was a whistle blowing policy which allowed staff to refer any concerns directly to the provider if they felt unable to raise them with a local practice.

There was a strong emphasis on the safety and well-being of staff within the practice. The management team used the provider's key objectives which was to focus on a sustainable workforce and create better work life balance to maintain a positive culture within the practice. For example, the development of staff retention schemes and sharing some of the administrative burden across all practice sites was actively promoted.

Staff we spoke with at OHP-Lordswood House Medical practice explained that they felt a valued member of the practice team. Members of the practice management team demonstrated how they used meetings to involve and actively engage staff in discussions regarding changes within the practice. The practice actively used Clarity TeamNet as a tool to keep staff updated on any changes.

Records we viewed showed that patients who were affected by an incident or were unsatisfied with the service provided received an apology. The practice proactively used learning from incidents to further develop staff. For example, staff completed training in areas such as transgender prescribing and IRIS training for the benefit of patients.

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

Source	Feedback
Staff	Staff we spoke with told us they were able to raise concerns and were aware of practice policies such as the whistleblowing policy to support this process. Working relationships between staff and teams was effective. Staff explained that the management team was very approachable, supportive and demonstrated a genuine care to maintain their health and wellbeing.
Policies	Practice policies were in place which supported leaders to act on behaviour and performance inconsistent with the vision and values of the practice.
Policies and staff interviews	The practice had processes which enabled the management team to take action to promote equality and diversity. For example, flexible working options were available. Managers were aware of options available to ensure staff maintained a work life balance and staff were confident that they would receive support if they needed time off to care for a child or family member.

Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y

Explanation of any answers and additional evidence:

Members of the practice management team demonstrated effective oversight of governance arrangements within the practice. There was a lead person responsible for the management and monitoring of complaints and significant events; form the records we viewed complaints were responded to in a timely manner. Actions following incidents were completed and learning shared throughout the practice as well as with key stakeholders. Staff we spoke with explained that incidents were investigated and meeting minutes provided evidence of learning being shared effectively.

Managing risks, issues and performance

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

	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.	Y
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

Explanation of any answers and additional evidence:

Performance and risk was managed at practice level however, the central OHP team maintained an oversight of this. The management team submitted core quality markers to the central OHP team; staff explained this provided the providers with assurance that quality standards were being met and quality and risk was being managed effectively. These were monitored along with complaints, significant events and safety alerts through the centralised governance management processes.

The practice had a business continuity plan which was reviewed and updated within the last 12 months. The practice carried out risk assessments to mitigate potential risks in areas such as health and safety, building security and fire safety.

The practice held appropriate emergency medicines and equipment to enable staff to respond to medical emergencies; this included practice equipment to enable assessment of patients with presumed sepsis. Staff were trained in preparation for major incidents as well as medical emergencies.

Appropriate and accurate information

There was a demonstrated commitment to using data and information proactively to drive and support decision making.

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

Explanation of any answers and additional evidence:

Clarity TeamNet (a clinical and governance system) had been rolled out across OHP member practices and provided the main forum for sharing management information. This enabled both the practice and central team to manage and monitor information such as those relating to incidents, complaints, safety alerts and staffing. During our inspection of OHP-Lordswood House Medical Practice we saw that Clarity TeamNet was well embedded; enabling the practice to effectively use the information to support improvement and patient care. We found the practice to be well organised and management information was readily available when needed.

The management team proactively reviewed performance data from nationally available sources which they used to manage and monitor their performance. Staff we spoke with demonstrated clear awareness of the practice performance and taking actions to improve areas were performance were not in line with local or national averages. We saw appropriate exception reporting in most areas as well as communication with the local CCG regarding issues which required closer attention.

Designated staff were aware of the process for making statutory notifications to CQC.

The practice used an e-learning platform to manage staff training and we saw staff had completed training which the provider had identified as mandatory. From the records we viewed staff had received an appraisal in the last 12 months.

Engagement with patients, the public, staff and external partners

The practice involved the public, staff and external partners to sustain high quality and sustainable care.

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
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:	

Feedback from Patient Participation Group.

Feedback
The practice had an active Patient Participation group (PPG) who met every three months. We spoke with members of the PPG during our inspection, who explained that they were exploring ways of attracting a wider group of patients to participate in the PPG. For example, the PPG was working with the practice to develop a virtual PPG as a way of involving younger patients, those in employment and parents. The PPG explained that discussions with the practice were used to support the development of services for example, improving the telephone system and access to morning appointments. PPG members explained the practice had addressed these areas and provided PPG members with data regarding the phone activity; demonstrating time taken to answer the phone and volume of calls received. The PPG chair explained that they attended CCG patient engagement forums every two months to gather information and updates within the wider health care systems which they shared with the practice. For example, PPG members shared updates with the practice regarding issues with services available for patients who needed transport to and from secondary care appointments. PPG explained positive working relationships with the practice partners; they were aware of the practice's involvement with the wider health economy and explained that the clinical team informed PPG members of the direction of travel. For example, PPG members were provided with feedback from CCG meetings.

Any additional evidence
Staff involvement: Staff explained meetings and regular discussions were held which provided a forum for staff feedback and to check that the direction of travel within the practice was still appropriate and aligned with the providers objectives. **Stakeholder involvement:** Senior members of the management team played a significant role in the stakeholder engagement at

local as well as provider level. For example, staff explained being a part of OHP it provided a collective voice for GPs in strategic planning within the health and social care economy and for exploring areas for collaborative working.

Lordswood House Medical Group engaged with the local Clinical Commissioning Group, for example, members of the clinical team held lead roles within the local CCG.

Continuous improvement and innovation

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

	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:

Being part of a large provider organisation (OHP) staff explained this enabled Lordswood House Medical Group to:

- Collectively bid and benefit from new contracts for example, extended access, anticoagulation and social prescribing services.
- Share and learn from each other for example, the system for recording and monitoring incidents and complaints management was adopted from a practice within OHP.
- Benefit from workforce developments including an internal staff bank.
- Explore digital access through the provider participation in a pilot scheme.
- Focus on improvement and innovation through collaborative working within the practices own locality using General Practice Forward View money. Examples, of improvement schemes have included the development and training of reception clerks in managing prescriptions and improving document handling.
- Collaborative working with the hospital and community services to bring services closer to home.

Examples of continuous learning and improvement
Lordswood House Medical Practice followed OHPs integration model to improve access and continuity in general practice. Staff explained this enabled the medical group to go beyond what was expected within the GMS contract to provide additional services for the patients. For example, patients had access to specialist in-house dermatology and musculoskeletal services. Staff explained the aims of this clinic was to reduce referrals to secondary care, enable patients to receive a specialist opinion more promptly; reduce the need for waiting for hospital outpatients' appointments and increasing patient options to be seen locally. An audit carried out by the medical group in June 2018 showed the medical group offered 405 appointments and avoided 258 outpatient appointments. The audit also showed patients were pre-booked four to five weeks in advance demonstrating a shorter waiting time than secondary care outpatient appointments. Patients had also benefited from participating in pilot schemes aimed at improving care and treatment pregnant women to access services closer to home as well as care for patients with respiratory

conditions. The practice demonstrated a desire to pioneer new initiatives, engaged in forward thinking in order to drive change and improvement. For example, the practice was involved in various pilots and schemes such as the National Institute for Clinical Health and Care Excellence (NICE) pilot which trialed the use of Fractional exhaled nitric oxide (FeNO) tests to achieve more accurate diagnosis of asthma. We saw that plans were in place and members of the senior clinical team were actively engaging with suppliers. The practice was working with the local Clinical Commissioning Group to roll FeNO testing out to practices within Birmingham. The medical group was also a pilot site for the Birmingham United Maternity Pathway (BUMP) pilot which provided women with a single point of access with midwifes as the first point of contact.

Lordswood House Medical Practice was involved in the development and implementation of the ambulance triage project in September 2015 and has been actively participating since commencement of the project. The project aimed to provide West Midlands Ambulance Service (WMAS) ambulance crews with telephone access to a “duty doctor” at a patient’s registered practice in order to discuss their clinical condition whilst “on scene” to see if an A&E attendance could be avoided and the patient managed in primary care. The practice carried out an audit in December 2018. The audit showed during September and December 2018 the practice received 84 calls from WMAS, 50% (42) were addressed by the practice following a telephone triage with the patient, 12% (10) of patients were invited into the practice for a face to face appointment and 38% (32) were home visits carried out by a practice clinician. As a result, the medical group showed the triage project resulted in 85% of calls received resulted in non-conveyance to secondary care, exceeding the set target of 75%.

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 practices 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. This indicator does not have a CCG average.

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.