# Care Quality Commission

## Inspection Evidence Table

## OHP-Ridgacre House Surgery (1-4223537170)

**Inspection date: 12 March 2019**

**Date of data download: 10 March 2019**

# Overall rating: Outstanding

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

# Safe Rating: Outstanding

**We rated the practice as outstanding for providing a safe service because the practice had implemented comprehensive processes to ensure patients' safety and had effective processes for the recording and learning from incidents and significant events. These processes had been implemented throughout OHP. The practice was proactive in utilising learning from incidents to improve systems and processes in relation to patient safety.**

**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 |

| Safeguarding | Y/N/Partial |
|---|---|
| Staff who acted as chaperones were trained for their role. | Y |
| There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm. | Y |

Explanation of any answers and additional evidence:

- One of the GP Partners was on the Birmingham safeguarding board. This supported strong leadership in safeguarding and the practice demonstrated an effective thorough process of ensuring safeguarding was a key part of patient safety. Staff demonstrated clear awareness of their responsibilities around reporting incidences if they suspected a concern. The practice had policies and processes to support staff in this area and staff were clear on how they accessed these policies.
- Non-clinical Staff had completed their training in Right Help Right Time (the model used by Birmingham Children's Social Services to safeguard children) as well as receiving training through safeguarding updates and scenarios discussed at staff meetings.
- Bi-monthly joint safeguarding meetings were held with the health visitors to discuss concerns.
- The practice had customised their new patient registration form to ensure it captured all the relevant information concerning the family.
- Following a death, the practice death review protocol had a specific question about whether children were in the household to ensure the appropriate support was available.
- The clinical safeguarding lead had held a quiz with all staff at the practice to ensure staff were aware of the procedures to follow if they had concerns. The outcome of the quiz was shared with the team to promote positive impact of learning and sharing.
- The practice staff had all completed IRIS (Identification and Referral to Improve Safety) training. The practice was one of the first in Birmingham to implement this training. Feedback received from the IRIS support workers highlighted the work and support the practice gave to the patients and service.
- The practice was taking part in a pilot project for the identification and reporting of FGM. Any patients found to have undergone FGM were referred to an IRIS support worker for advice and support. Also, as part of their travel vaccination programme, any patients who requested vaccines were issued with an FGM Information sheet.

| 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. | Y |
| There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored. | Y |

| | |
|---|---|
| Staff had any necessary medical indemnity insurance. | Y |

| Safety systems and records | Y/N/Partial |
|---|---|
| There was a record of portable appliance testing or visual inspection by a competent person.<br>Date of last inspection/test: 6 November 2018 | Y |
| There was a record of equipment calibration.<br>Date of last calibration: 6 November 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.<br>Date of last check: 12 June 2018 | Y |
| There was a log of fire drills.<br>Date of last drill: 27 September 2018 | Y |
| There was a record of fire alarm checks.<br>Date of last check: Tested weekly | Y |
| There was a record of fire training for staff.<br>Date of last training: Various dates, completed through online training system | Y |
| There were fire marshals. | Y |
| A fire risk assessment had been completed.<br>Date of completion: 3 October 2018 | Y |
| Actions from fire risk assessment were identified and completed. | Y` |
| Explanation of any answers and additional evidence:<br>• The practice had a range of risk assessments in place, that were monitored on a regular basis to mitigate risk.<br>• A review of the emergency lighting system was completed monthly. Evidence provided by the practice showed the last review had taken place on 22 February 2019. | |

| Health and safety | Y/N/Partial |
|---|---|
| Premises/security risk assessment had been carried out.<br>Date of last assessment: 3 October 2018 | Y |
| Health and safety risk assessments had been carried out and appropriate actions taken.<br>Date of last assessment: 3 October 2018 | Y |
| Explanation of any answers and additional evidence:<br>• A Legionella risk assessment had been completed on 30 November 2018. Water testing was done monthly.<br>• The practice had completed assessments in place for the control of hazardous substances. | |

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**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: 7 January 2019<br>Practice achievement: 98% | 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:

- All staff completed the relevant infection control training for their role through the online training system in place.
- The infection control policy detailed who was the practice infection control lead and the local contact numbers for infection prevention and control. The policy had been reviewed in January 2019.
- The latest infection prevention audit identified areas that required action. This included the reception area flooring and sink overflow in the consulting rooms. The practice had sought advice and had included the improvements in their refurbishment plans.

**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 | Y |

| | |
|---|---|
| with National Institute for Health and Care Excellence (NICE) guidance. | |
| 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:

- OHP had a GP locum system that practices could access when GPs were required. A check list was completed by the manager of all locums including medical indemnity insurance, clinical registration and disclosure and barring checks.
- The practice had a process for every new locum to obtain a self-declaration of fitness to practise and to cross-reference with their NHS England responsible officer, to permit the exchange of information about the doctor's practice.
- A locum pack was in place which contained practice information, referral processes, key contact details and a reference to local guidelines.
- Staff were trained to cover each other's roles to ensure continuity of duties in the event of staff absence.
- Staff we spoke with demonstrated that they understood how to prioritise patients who reported signs and symptoms of sepsis. All staff had completed sepsis training relevant to their role. We also saw information on display to guide staff on how to manage patients presenting with sepsis symptoms.

**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:

- The practice had implemented a safety netting system to ensure referrals were acted on. This included the follow up of patients referred under the two week wait process and patients who did not attend for their blood tests.

**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) | 0.85 | 0.90 | 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) | 8.3% | 7.6% | 8.7% | No statistical variation |
| Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/04/2018 to 30/09/2018) (NHSBSA) | 5.57 | 5.18 | 5.64 | No statistical variation |
| Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/04/2018 to 30/09/2018) (NHSBSA) | 1.76 | 1.97 | 2.22 | 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 |

| Medicines management | Y/N/Partial |
|---|---|
| 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 and disposal of these medicines, which were in line with national guidance. | N/A |
| The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance. | Y |
| For remote or online prescribing there were effective protocols for verifying patient identity. | Y |
| The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates. | Y |
| The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases. | Y |
| There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use. | Y |
| Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective. | Y |

Explanation of any answers and additional evidence:

- The practice pharmacist supported the clinical team with the management of patient's medicines, including regular reviews to ensure appropriate prescribing. The practice maintained a review of antimicrobial stewardship through clinical audit, sharing, learning and reflection at clinical meetings.
- The practice used a medicines optimisation tool to monitor and review patients on high risk medicines. Audits were an integral part of the management of medicines and the practice carried out an extensive range of audits to monitor the appropriate management of medicines.
- The practice had developed the role of prescription clerks to help improve prescription safety. Specific inhouse training and a competence framework was created to ensure staff were fully trained within this role. A standard operating procedure had also been developed to support staff.

**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: | 13 |
| Number of events that required action: | 13 |

Explanation of any answers and additional evidence:

- The practice had developed a process of recording, acting and sharing information and learning outcomes that had been implemented by OHP across all member practices as well as other local practices. The practice was also part of a national pilot due to the success of their processes.
- The practice used a Red, Amber Green (RAG) system to identify the severity of the event and ensured an accurate oversight of safety within the practice. All events were reviewed by a senior clinician who judged the severity of the incident. From the information provided we found 11 incidents had been rated as amber and two as red.
- There was an open culture in which all safety concerns raised were valued and integral to learning and improvement. All staff were encouraged to report incidents, and we found that staff were committed to reporting concerns. All incidents were looked at and discussed within the staff teams to ensure staff had the confidence to report within a no blame culture. We found learning from incidents was used significantly as an education tool.
- We found the practice was proactive in utilising incidents to improve patient safety. The practice was able to share with us how they had changed systems and processes in response to incidents to mitigate future risks
- Learning from incidents was based on analysis and investigation. The practice had a system in place to ensure learning from incidents was shared through an inhouse system called 'Round Ups'. Round ups were a system the practice had implemented to summarise learning from incidents and significant events. This system produced an article on a monthly basis with a number of incidents to promote learning and sharing in one reading.
- OHP confirmed that the practice was very good at reporting incidents and there was a positive culture to learning at the practice. Opportunities to share externally were taken, there was a willingness to share with the OHP board all actions taken to promote learning and to share this across the OHP group.

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

| Event | Specific action taken |
|---|---|
| Patient with allergy prescribed medicine that could have caused an allergic reaction. | • On reviewing the patient records an allergy had been disclosed previously, but had not been clinically coded.<br>• A reminder was sent to all prescribers to ensure that patients were asked about any allergies before prescribing new medicines. |
| Pathology results not acted on. | • A pathology result was received, but the requesting GP was on annual leave and the result was not transferred |

| | |
|---|---|
| | to another clinician for action.<br>• An investigation highlighted that administration staff only re-allocate results when they have been notified that a clinician was away.<br>• All administration staff complete a review of the staff leave schedule on a weekly basis to confirm which doctors are on leave and re-allocate results to the GPs available. |

| 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:<br>• Alerts received by the practice were reviewed by the nominated clinical lead and distributed to the clinical team. Data provided by the practice showed during 2017/18, 92 alerts had been received and of these, three required action. This included searches carried out to identify female patients of child bearing age on a specific medicine. The practice provided information which they shared with identified patients regarding the risk of pregnancy when taking this medicine. | |

# 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 were in place to make sure that patients' needs were addressed. | Y |
| Patients were told when they needed to seek further help and what to do if their condition deteriorated. | Y |

Explanation of any answers and additional evidence:

- The provider had implemented innovative plans to reduce A&E attendances with the support of the CCG. This involved an ambulance triage, where ambulance crews would telephone the practice to discuss a patient's condition whilst with the patient in their home. Based on the success of the project, the ambulance service had built a response service for ambulance crews on the scene, where they have contact with a senior paramedic to reduce unnecessary referrals to A&E and provide more appropriate care at home.
- Data provided by the practice showed since the roll out of the scheme there had been a significant decrease in the number of patients being taken to A&E from across the participating practices. For example: the wider impact of this scheme showed that collectively 79% of calls from ambulance crews taking patients to hospital were not required after the patient's GP had been spoken too and the management of care had been discussed and organised locally.
- The practice had implemented safety netting systems to mitigate possible risks to patients. The safety netting monitored out of hours letters received, referrals made through the urgent two week wait protocol, active recall for abnormal results and patients who did not attend for blood tests to ensure they were followed up.
- There was a scheduled task management system in place to monitor recalls to ensure patients attended their reviews.
- The practice had had expertise in substance misuse with two GPs with special interest in this area which supported the low hypnotic prescribing rates of the practice.

| Prescribing | Practice performance | CCG average | England average | England comparison |
|---|---|---|---|---|

| 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) | 0.24 | 0.81 | 0.81 | Variation (positive) |

## 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 changes.
- The duty doctor facilitated prompt same day access to clinical advice and direction for district nurses for the management of housebound patients with complex needs.
- The practice nurses carried out home visits to support housebound patients with complex needs to ensure they were receiving the appropriate management of their care.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- The practice had developed a template for patients with heart failure to support the local CCG indicators. This included an annual comprehensive review. The practice had also implemented a new recall system to ensure patients received the appropriate management and monitoring.
- The practice had a system in place to review the death of patients in order to share any learning. Evidence provided by the practice showed more patients were being added to the gold standard frameworks register and sharing and learning were an integral part of their management of palliative care patients.
- The practice held monthly end of life care meetings and had participated in the “Going for Gold” initiative in 2017/18. This was an initiative to build on good practice and integrate improvements to end of life care. The Gold Standard Framework lead at the practice held the European certificate in palliative care. The European Certificate in Palliative Care is a foundation of knowledge aimed at consolidating and developing palliative care and expertise of healthcare professionals.

## People with long term conditions

## Population group rating: Good

### Findings

- Patients with long-term conditions had a structured annual review to check their health needs were being met and to enable a review of their medicines. 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. This included specialist nurse practitioners for diabetes, hypertension, heart failure and COPD.

- The practice had a diabetic screening programme to support patients with suspected diabetes. This included annual recall, nurse support and referral to the national prediabetes programme. The practice had seen an increase in patients receiving appropriate monitoring. Evidence provided by the practice showed a steady increase in the number of patients who had been recognised as prediabetics.
- The practice had developed a new template for the review of patients with heart failure to ensure they received a comprehensive annual review. A new recall system had been developed for ongoing care and annual reviews.
- The practice were developing a system of quality and safety audits to continually identify patients who required reviews and regular monitoring.
- 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. The specialist nurse practitioners monitored patients' medicines at the practice and at the patients' home if they were unable to attend the practice, to reduce the need for hospital attendances.
- The practice had an inhouse pharmacist who carried out medicine reviews and supported the GPs in the effective management of patients on long term medicines.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with atrial fibrillation (AF) were assessed for stroke risk and treated appropriately. The practice had enrolled in a national initiative to increase the detection rate of AF in the population. They had introduced the use of specific devices to screen for AF to appropriately diagnose and initiate anticoagulation medicines when indicated to reduce stroke risk.
- The practice had implemented a new anticoagulation annual review template and recall system to ensure patients received a comprehensive annual review.

| 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) | 86.1% | 79.9% | 78.8% | No statistical variation |
| Exception rate (number of exceptions). | 17.0% (97) | 12.4% | 13.2% | N/A |
| The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2017 to 31/03/2018) (QOF) | 69.4% | 77.2% | 77.7% | No statistical variation |
| Exception rate (number of exceptions). | 11.9% (68) | 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) | 85.8% | 81.1% | 80.1% | No statistical variation |
| Exception rate (number of exceptions). | 14.9% (85) | 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) | 82.9% | 76.6% | 76.0% | No statistical variation |
| Exception rate (number of exceptions). | 2.1% (16) | 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) | 90.9% | 91.4% | 89.7% | No statistical variation |
| Exception rate (number of exceptions). | 4.1% (7) | 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) | 79.4% | 83.0% | 82.6% | No statistical variation |
| Exception rate (number of exceptions). | 3.5% (49) | 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) | 93.1% | 88.6% | 90.0% | No statistical variation |
| Exception rate (number of exceptions). | 8.9% (14) | 8.1% | 6.7% | N/A |

| Any additional evidence or comments |
|---|
| • We observed the practices process for exception reporting during our inspection. We saw the practice followed an appropriate process where for example, patients that repeatedly failed to attend their appointment where excluded; following three attempts from the practice. Staff explained that patients who declined treatment or investigations were excluded. The practice managed these on a case by case basis to ensure that vulnerable patients were not inappropriately excluded. There was clinical oversight of the practices exception reporting, this was supported by the GP QOF leads that were aligned to each area of QOF. We reviewed three patients on the diabetic register and found these patients had been exception reported appropriately.<br>• With the implementation of the safety netting process the practice had minimised exception reporting due to the regular ongoing monitoring of patients.<br>• The practice continually monitored patients and had initiated a follow up system for patients with asthma and COPD exacerbations. A dedicated COPD clinic was held regularly and the practice had seen a significant reduction in COPD emergency admissions. The practice had also implemented a GP led asthma clinic to support patients with complex asthma. |

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

| Findings |
|---|
| • 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.<br>• 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.<br>• Young people could access services for sexual health and contraception. The practice offered a full range of contraceptive services through the umbrella sexual health service.<br>• The practice maintained a strong leadership team for safeguarding and one of the GP partners was on the Birmingham Safeguarding board. |

| 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) | 121 | 126 | 96.0% | Met 95% WHO based target (significant variation positive) |
| The percentage of children aged 2 who have received their booster immunisation | 139 | 165 | 84.2% | Below 90% minimum (variation |

| | | | | |
|---|---|---|---|---|
| for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2017 to 31/03/2018) (NHS England) | | | | 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) | 140 | 165 | 84.8% | 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) | 146 | 165 | 88.5% | Below 90% minimum (variation negative) |

**Any additional evidence or comments**

- Childhood immunisation uptake rates were below the World Health Organisation (WHO) targets. More recent data provided by the practice from the Child Health Information Service showed that from:
- 1 April 2018 to 30 June 2018 the practice achieved 88.2% for PCV, Hib/MenC booster and MMR.
- 1 July 2018 to 30 September 2018 the practice achieved 93.3% for PCV, Hib/MenC and MMR.
- 1 October 2018 to 31 December 2018 the practice achieved 93.3% for PCV, Hib/MenC and MMR.
- 1 January 2019 to 31 March 2019 the practice achieved 83.8% for PCV, Hib/MenC and MMR
- This demonstrated an improving trajectory from 2017/18. With overall practice percentages for PCV, Hib/MenC and MMR at 89.3% for 2018/19.
- The practice had an effective policy to actively confirm informed dissent by parents/carers to vaccination. It was able to show that all child immunisations not carried out were as a result of active informed dissent following a face to face discussion with a clinician and not simple failure to respond to invitations.
- Actions to improve immunisation rates were discussed at the practice's management meetings on a frequent basis. These included the production of a leaflet and poster to promote MMR vaccination, policies to support staff to maximise immunisation and manage refusal, a refusal form which was completed only after a face to face consultation had been held with a clinician and the parent/carer and alerts on patients' clinical records to advise staff that immunisation was outstanding and to promote opportunistic vaccination.

## 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.
- Patients could book or cancel appointments online and order repeat medicines without the need

to attend the surgery.

| Cancer Indicators | Practice | CCG average | England average | England comparison |
|---|---|---|---|---|
| The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64) (01/04/2017 to 31/03/2018) (Public Health England) | 72.5% | 68.0% | 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)** | 72.6% | 63.7% | 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)** | 53.0% | 43.9% | 54.5% | N/A |
| The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. (01/04/2017 to 31/03/2018) **(PHE)** | 77.4% | 74.1% | 70.2% | N/A |
| Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2017 to 31/03/2018) (PHE) | 58.3% | 52.1% | 51.9% | No statistical variation |

| Any additional evidence or comments |
|---|
| The practice had a system in place to review and discuss all new cancer diagnoses as a team to identify any learning. The cancer reviews included how many consultations with the patient had been completed before a referral had been made and all guidelines had been followed. Evidence provided by the practice showed all doctors were involved in the reviews and discussions. An annual new cancer diagnoses “round up” was completed to ensure all actions and learning had been shared with the whole team. |

## People whose circumstances make them vulnerable

## Population group rating: Outstanding

This population group was rated outstanding because services were tailored to meet the needs of individual people. The practice consistently reviewed the systems they had in place to ensure that patients received the appropriate care and treatment. The learning was shared with other practices in the locality to support patients in vulnerable circumstances.

**Findings**

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had implemented an ambulance triage service, which supported some of the most vulnerable patients being treated at home. Evidence provided by the practice showed that 79% of calls from ambulance crews taking patients to hospital were not required after the patient's GP had been spoken too and the management of care had been discussed and organised locally.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances. A shared care drug treatment service was in place and the practice was offered this service to patients registered at other practices.
- The practice had two GPs with a specialist interest in substance misuse and used their specialist knowledge to support this service and train and mentor primary care clinical staff in the community. Information provided by the practice showed 60 practices had received support and mentoring in substance misuse by the GPs at the practice. The lead GP for substance misuse had also developed a training session for training GPs who wanted to develop an interest in working with substance misuse. The practice ran support clinics at the practice on a regular basis and Ridgacre Medical Centres had fulfilled contracts to offer support to patients for a range of community substance misuse programmes. This included two clinics per week for the homeless and rough sleepers of Birmingham continuously for 18 months. The GPs at the practice continue to provide cover when required at a local drug and alcohol service.
- The practice had implemented the OHP initiative of having a social prescriber on site. This service was available to all patients who required extra help and support.

## 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.
- The practice had completed an audit on medicines to treat anxiety and through the reviews and monitoring of patients, the outcomes had showed improvement management of patient's care.

QOF data demonstrated higher than average outcomes for mental health indicators.

- 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. Dedicated weekly GP led clinics were also held at the practice to support patients and their families. The appointments were on average 60 minutes and included an holistic assessment, carer support and multidisciplinary engagement. Families had the opportunity during these appointments to discuss their concerns with the GPs and receive support. The practice chaired quarterly meetings with Northfield Alliance to support practices within the federation to share best practice and discuss improvements to dementia care. This gave patients within the federation the opportunity to have personalised care and effective management of their condition and families received the appropriate advice and support. The practice worked closely with dementia support workers to offer help and advice to patients and their families.

| 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) | 96.9% | 93.2% | 89.5% | No statistical variation |
| Exception rate (number of exceptions). | 1.5% (1) | 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) | 96.8% | 93.3% | 90.0% | No statistical variation |
| Exception rate (number of exceptions). | 3.1% (2) | 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) | 98.4% | 85.9% | 83.0% | Variation (positive) |
| Exception rate (number of exceptions). | 0 (0) | 6.0% | 6.6% | N/A |

| Any additional evidence or comments |
|---|
| The practice ran weekly dementia clinics. A comprehensive assessment was completed which included chronic disease management and frailty review. The practice had implemented a register of patients with mild cognitive impairment, who were offered annual reviews. A carer support worker attended the practice on a monthly basis to offer a drop-by service for carers and their families. |

**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) | 550.6 | 545.4 | 537.5 |
| Overall QOF exception reporting (all domains) | 5.4% | 6.1% | 5.8% |

| | Y/N/Partial |
|---|---|
| Clinicians took part in national and local quality improvement initiatives. | Y |

| | |
|---|---|
| The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements. | Y |

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

The practice operated an audit timetable which involved the running of various audits on a regular basis. A range of completed audits were provided as part of our inspection, each demonstrated improved outcomes to patient care and improvements in practice systems and processes. The practice had completed a two-cycle audit of medicines to treat severe anxiety. The first audit in 2017 showed the practice had 89 patients on these medicines. Each patient had their notes reviewed to ensure alternative methods had been offered, the appropriate prescribing had taken place and there was documented evidence which showed the risks had been discussed with the patient. The first audit showed 28% of patients had alternative therapies discussed with them, 48% of patients had documented evidence that the risks had been discussed and 59% of prescriptions issued had not exceeded the two-week supply as directed in the prescribing guidelines. The second audit was completed in October 2018 demonstrated improvements, with 87% of patients had alternative therapies discussed with them, 65% had documented evidence of the medicine risks and 98% of prescriptions had been issued following the recommended guidelines for a two-week supply.

The re-audit recommended further audits been completed of this medicine in the future to ensure standards continued to be maintained and improved upon.

**Any additional evidence or comments**

- Information provided by the practice showed that during 2017/18, 11 audits had been completed. These included shared care safe prescribing and monitoring, antibiotic prescribing and minor surgery.
- The practice had appointed leads for clinical oversight and ongoing monitoring of QOF. The practice continually monitored their performance and ran regular reports to monitor patient outcomes and improve clinical indicators through clinical meetings and shared learning.
- The practice had implemented routine safety searches as part of their clinical searches programme to support the reviews they undertook. This helped to ensure all patients were reviewed in a timely manner and they were receiving the appropriate care and management of their clinical conditions.

**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:

- The GPs held an inhouse review for all the doctors working at the practice. This was in addition to the mandatory appraisals all doctors registered with the General Medical Council (GMC) had to complete annually. The inhouse appraisals included personal development plans and the opportunity for GPs to discuss any areas that they needed support with.
- The clinical team rotas were planned three months in advance and a warning rota was sent out to all clinical staff if gaps were identified in the provision of appointment availability. This enabled the practice to ensure adequate cover was available and to reduce the use of locum staff.
- The practice had invested in their staff to ensure they were able to offer more support to patients. This included supporting nursing staff develop in a range of clinical areas and supporting a student nurse through her course to qualification.

**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 | Y |

| | |
|---|---|
| 31/03/2018) (QOF) | |
| We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment. | Y |
| Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved. | Y |
| Patients received consistent, coordinated, person-centred care when they moved between services. | Y |
| For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services. | N/A |
| Explanation of any answers and additional evidence:<br>We saw evidence to support that regular multidisciplinary meetings took place with community services. This included liaison and joint working with health visitors and district nurses. Safeguarding, palliative and end of life care was discussed in these meetings in addition to vulnerable patients and patients with complex care needs. | |

**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 |

| 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) | 97.3% | 96.1% | 95.1% | No statistical variation |
| Exception rate (number of exceptions). | 0.7% (15) | 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 |

# Caring Rating: Good

**Kindness, respect and compassion**

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

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

| CQC comments cards | |
|---|---|
| Total comments cards received. | 13 |
| Number of CQC comments received which were positive about the service. | 11 |
| Number of comments cards received which were mixed about the service. | 2 |
| Number of CQC comments received which were negative about the service. | 0 |

| Source | Feedback |
|---|---|
| CQC comment cards | All of the comment cards contained positive comments about the staff who were described as friendly, approachable and competent. |
| Interviews with patients | We spoke with two patients on the day of our inspection. Patients told us that they the GPs and staff were very caring and approachable. |
| Feedback from sheltered housing scheme | Written feedback highlighted the support the GPs gave to the patients and their carers, keeping them updated with any changes to the patients ongoing care. The feedback told us that the GPs were friendly and polite and patients were well cared for. |
| NHS Choices | The practice had received a four out of five-star rating based on 10 reviews. The most recent comments included the practice maintained a family ethos and offered excellent care. |
| Friends and Family Test | The latest responses to the Friends and Family Test showed 91% of patients were extremely likely or likely to recommend the practice to others. This was based on 78 responses. |

**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 |
|---|---|---|---|---|
| 10293 | 280 | 99 | 35.4% | 0.96% |

| 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) | 88.1% | 87.7% | 89.0% | No statistical variation |
| The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2018 to 31/03/2018) | 86.1% | 85.9% | 87.4% | No statistical variation |
| The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2018 to 31/03/2018) | 91.5% | 95.4% | 95.6% | No statistical variation |
| The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2018 to 31/03/2018) | 81.0% | 81.0% | 83.8% | No statistical variation |

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

| Any additional evidence |
|---|
| The practice had completed an inhouse survey during 2018 and had asked 50 patients for their feedback. The results of the inhouse survey showed 98% of the patients said the GP was good/very good at treating them with care and concern and 96% said the GP was good/very good at listening to them. |

**Involvement in decisions about care and treatment**

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

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

| Source | Feedback |
|---|---|
| Interviews with patients | Patients we spoke with told us that the practice team took their time to explain things carefully and ensured patients understood. Help was available to support patients where required. |
| Local sheltered housing scheme | Feedback received told us that the GP always put the patient at ease; that they explained clearly what was required and answered any questions the patient may have in a way that patients and their carers could understand. |

**National GP Survey results**

| Indicator | Practice | CCG average | England average | England comparison |
|---|---|---|---|---|
| The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2018 to 31/03/2018) | 94.2% | 92.7% | 93.5% | No statistical variation |

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

| Carers | Narrative |
|---|---|
| Percentage and number of carers identified. | 228 carers on the practice register, which represented 2% of the practice list. |
| How the practice supported carers. | • A carers noticeboard was in place in the waiting area with details of local support available and the practice had a carers pack available to advise patients of organisations they could access.<br>• The practice had put an administration lead in place to support carers.<br>• The practice held weekly GP dementia clinics with a local support worker to support, advise and monitor the care of both the patients and the carers.<br>• Staff we spoke with explained that carers were provided with advice; offered flu vaccinations and referred to the inhouse social prescriber if they required further support. |
| How the practice supported recently bereaved patients. | • Families were sent a condolence card and the GP called families to offer support.<br>• The practice had now implemented a system to ensure patients' families were followed up.<br>• One of the GPs hand delivered Christmas cards to the families who had suffered a bereavement that year. |

**Privacy and dignity**

## The practice respected patients' privacy and dignity.

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

# Responsive Rating: 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 |

| Practice Opening Times | |
|---|---|
| **Day** | **Time** |
| Opening times: | |
| Monday | 8.30am and 6pm. Telephone lines were available from 8.30am to 6.30pm |
| Tuesday | 8.30am and 6pm. Telephone lines were available from 8.30am to 6.30pm. |
| Wednesday | 8.30am and 6pm. Telephone lines were available from 8.30am to 6.30pm. |
| Thursday | 8.30am and 6pm. Telephone lines were available from 8.30am to 6.30pm. |
| Friday | 8.30am and 6pm. Telephone lines were available from 8.30am to 6.30pm. |
| | |
| Appointments available: | |
| Monday | 8.40am to 11.30am / 2pm to 5.30pm<br>Extended hours from 6.30pm to 8pm |
| Tuesday | 8.40am to 11.30am / 2pm to 5.30pm<br>Extended hours from 6.30pm and 7.30pm |
| Wednesday | 8.40am to 11.30am / 2pm to 5.30pm |
| Thursday | 8.40am to 11.30am / 2pm to 5.30pm |
| Friday | Extended hours from 7.30 am to 8.30am<br>8.40am to 11.30am / 2pm to 5.30pm |
| | As part of the hub for extended hours, patients could also access appointments at Lordswood Group practice, Harborne between 6.30pm to 8pm Monday to Friday, 9am to 1pm Saturday |

| | |
|---|---|
| | and 10am to 2pm Sunday. When the practice was closed, the out of hours services was provided by Badger. |

National GP Survey results

| Practice population size | Surveys sent out | Surveys returned | Survey Response rate% | % of practice population |
|---|---|---|---|---|
| 10293 | 280 | 99 | 35.4% | 0.96% |

| 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) | 92.3% | 94.4% | 94.8% | No statistical variation |

## Older people — Population group rating: Good

**Findings**

- 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.
- A duty doctor was available for same day clinical advice and for the assessment of patients with urgent needs. This included same day liaison with the community nursing teams for patients with complex needs.
- There was a medicines delivery service for housebound patients and the health care assistants offered a health check and phlebotomy service as a home visit for patients who could not attend the practice.
- One of the GPs visited a local assisted living facility on a weekly basis to see patients who had difficulty in attending the practice.
- The practice staff sent out birthday cards to patients reaching their 100th year.

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

**Findings**

- Patients with multiple conditions had their needs reviewed in one appointment. There was a lead GP for each long term condition.
- 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.
- The practice had an onsite social prescriber to offer support to patients with regards to local services and organisations available.
- The practice ran an anticoagulation service for the initiation of anticoagulation medicines and warfarin monitoring for the local community.

- The practice initiated insulin starts and monitored patient compliance inhouse to minimise the need for hospital reviews. The practice met with the multidisciplinary diabetes team on a quarterly basis to discuss complex patients. Dedicated clinics for diabetes and heart failure were held at the practice.
- The practice held specific clinics for patient with rheumatological conditions on a regular basis to ensure patients were receiving the appropriate care and management of their condition.
- The practice had established alignment between the patient's birthday month and diabetes review and were rolling this out for all LTC reviews including medication reviews and blood tests. This enabled the practice to co-ordinate reviews for patients with co-morbidities and reduced duplication or omission of tests.
- The practice had been supporting a local practice with their diabetes clinic once a month after the retirement of some of the clinical team and continued to support another local practice with diabetes care.

## Families, children and young people — Population group rating: Good

**Findings**

- Additional nurse appointments were available until 7.15pm on a Monday and from 7.30 a.m. on Friday 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.
- A full contraceptive service was available in house and for the local community through the Umbrella sexual health service, this included emergency contraception and IUCD fitting. There was a female GP available.
- Posters were on display in the waiting room to advise young people of the confidential service available to them at the practice.
- Weekly baby clinics were held where patients could see the GP for review and receive their immunisations in one appointment.
- There were systems in place to follow up patients who did not attend for immunisations.

## 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.
- The practice was open until 8pm on Monday, 7.30pm on Tuesday and offered an early morning clinic on Friday from 7.30am to 8.30am. Pre-bookable appointments were also available to all patients at another local practice within the area, through the extended access hub arrangements. Appointments were available Monday to Friday 6.30pm to 8pm, Saturday 9am to

1pm and Sunday 10am until 2pm.

- Each GP was allocated two telephone consultations every day for patients who required advice. Online booking was also available for patients to book appointments in advance.

## People whose circumstances make them vulnerable

**Population group rating: Good**

**Findings**

- The practice held a register of patients living in vulnerable circumstances including homeless people and those with a 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.
- Patients in need of extra support could be referred to the onsite social prescribing support worker.
- Patients who were experiencing difficulties and needed supported were signposted to local charities in the community.
- The practice worked with patients with alcohol and substance misuse. Two recovery support workers held clinics three days a week and liaised regularly with the GPs for medicine reviews.
- The practice supported a local residential facility for people with learning disabilities and made home visits when required.
- A duty doctor was available to see patients without an appointment where necessary.

## 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.
- The practice was aware of support groups within the area and signposted their patients to these accordingly.
- A therapist from a local mental health charity held a weekly session for patients at the practice to offer support and advice.
- The lead GP for the elderly led the inhouse dementia project, which included extended length appointments for patients and their families.
- Weekly dementia clinics were held at the practice by one of the GPs and a dementia support worker.
- All staff had completed the mental health capacity act training and were experienced in supporting patients with mental health issues.

**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 |

| 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) | 72.3% | 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) | 75.1% | 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) | 69.7% | 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) | 71.8% | 69.8% | 74.4% | No statistical variation |

| Any additional evidence or comments |
|---|
| The practice had completed an inhouse survey during 2018 and had asked 50 patients for their feedback. The results showed that 82% of patients were satisfied with the appointment times. The practice had installed a new telephone system in December 2018 and to ensure they were utilizing the system to its full potential, some of the staff visited a local practice in February 2019 that had implemented the same phone system to review how they used the system. |

| Source | Feedback |
|---|---|
| Patient interviews | The two patients we spoke with told us they had no difficulties in accessing appointments. |
| CQC Comment | Two comment cards received highlighted difficulties in accessing the service via |

| | |
|---|---|
| cards | the telephone and obtaining appointments. |

**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. | 30 |
| Number of complaints we examined. | 4 |
| Number of complaints we examined that were satisfactorily handled in a timely way. | 4 |
| Number of complaints referred to the Parliamentary and Health Service Ombudsman. | 0 |

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

Explanation of any answers and additional evidence:

- Information on how to make a complaint was available on the reception desk. A complaints policy and poster were also on display in the patient waiting area.
- The practice management team were able to demonstrate that complaints were being used to drive continuous improvement. All complaints were documented and responded too in a timely manner. The practice also used complaints as significant events to ensure learning was shared with the whole practice team.
- All complaints and compliments were added to the electronic information sharing system for staff to access. The evidence we saw showed complaints were discussed at staff meetings.

Example(s) of learning from complaints.

| Complaint | Specific action taken |
|---|---|
| Patient unhappy blood test appointments not available late in the day | • A written explanation was sent regarding sample collection times at the practice.<br>• Feedback from the patient was passed to the hospital. |
| Patient had ongoing difficulties with a prescription for specialised items | • The practice sent a written apology to the patient.<br>• Reception team leaders were tasked with managing the prescriptions due to the unusual process required for the specialised items.<br>• A system had been implemented for the reception team leaders to speak with the patient on a monthly basis to see if anything needed ordering. |

# Well-led Rating: Outstanding

We rated the practice as outstanding for providing a well-led service because the leadership, governance and culture were used to drive and improve the delivery of high-quality person-centred care. Practice leaders were innovative and openly shared with others. They worked with other stakeholders to reduce the impact on emergency services and secondary care.

**Leadership capacity and capability**

## There was compassionate, inclusive and effective leadership at all levels. Leaders could demonstrate that they 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 OHP partnership model is one of local autonomy in which individual practices and the GP partners work to identify their own local priorities and run their practices in the way they see fit to meet their local population needs. The OHP Board takes on a more strategic role. The OHP Board is made up of nine elected GP partners, the Operations Director and Finance Director. Board elections are staggered on a three year rolling basis. Ridgacre House Surgery was one of the founding members of OHP.
- There is a small central OHP team that support the practices to achieve future sustainability and resilience. They do this in various ways such as helping to reduce some of the administrative burden in the running of their practice and to help individual practices realise and identify solutions to local challenges (through innovation and effective partnership working). OHP were aware of challenges faced by GP practices and have for example undertaken work to develop longer term workforce solutions. They recognise locality differences and have focussed General Practice Forward View money to help practices identify new and innovative ways to address local challenges. This has involved working with affiliated non-OHP practices within the same localities. GPs from the practice have taken an active role in this for example, development of the prescribing clerk role.
- At this practice we found the management team were aware of the challenges faced within the local community. The practice had a realistic strategy and supporting objectives to respond to these challenges as well as maintaining quality and sustainability.
- Staff we spoke with explained that the partners and managers were visible and approachable. Staff described the practice team as supportive. Partners demonstrated a genuine passion to tackle health inequalities and there was a systematic approach with strong governance arrangements when working with stakeholders to improve care outcomes.
- Staff reported that they felt well led and part of a team. There was strong collaboration and support across all teams and a common focus on improving the quality of care and people's experiences.
- Staff said that the leadership inspired them to deliver the best care and motivated them to

succeed.

- Staff met regularly to discuss any issues or complex cases and to offer and receive peer support.
- The practice offered support to other local practices. This included running a diabetes clinic once a month for a nearby practice in difficulty. An approach was taken to working with other practices to improve care outcomes and tackle inequalities. The practice continually offered support to colleagues outside of the practice and was supporting another local practice with dedicated clinics.

**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 local practice mission statement was to "Patients in partnership with professionals".
- Staff we spoke with demonstrated clear understanding of the practice vision, value and strategy and applied this in their role.

**Culture**

## The practice had a culture which drove high quality sustainable care. Conversations with staff demonstrated a culture of motivation to deliver personalised care for patients.

| | Y/N/Partial |
|---|---|
| There were arrangements to deal with any behaviour inconsistent with the vision and | Y |

| | |
|---|---|
| values. | |
| 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:

- There was an expectation that practices who wished to join OHP shared the same goals.
- There were arrangements at provider level to address behaviour inconsistent with the vision and values of the organisation (OHP). Member practices were expected to 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.
- At provider level we saw that there was a strong emphasis on the safety and well-being of staff. One of the providers key objectives was to focus on a sustainable workforce and create better work life balance. This was being delivered through the development of staff retention schemes and sharing some of the administrative burden on practices.
- At practice level we found staff to be very positive about working at the practice. Staff told us they had received constant support from the GPs, managers and team. There was a positive attitude throughout the entire workforce which enabled the smooth running of the practice.
- Staff had clear roles and responsibilities and staff wellbeing was discussed as part of the appraisal process. Team leaders had been appointed within the teams to offer further support to staff when required.
- The practice encouraged staff to report incidents and share learning. Staff told us there was a 'no blame' culture and staff were well supported when reporting incidents.

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

| Source | Feedback |
|---|---|
| Staff | • Staff told us there was a team approach in all aspects of the practice and everyone was integral to making the practice work and ensuring patients received personalised care.<br>• Staff reported that they were proud of the practice and the care it offered to patients.<br>• Staff told us they received support and there was an open door policy to managers who were very approachable.<br>• Staff felt they were treated equally. |

**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:

- Individual practices retained local responsibility and accountability for the services they provided within the OHP provider model. However, there was also a centralised governance function in which the central team monitored quality across the whole organisation and provided the board with assurance that standards at practice level were being maintained. The central team provided a supportive role to practices who needed it.
- The provider communicated with the practices through the sharing of minutes from board meetings and regular quarterly newsletters which were made available through GP team net.
- The practice had implemented a system to ensure all staff were clear on their roles and responsibilities. Induction plans for new staff were tailored to the individual and there was a clear structure and accountability process in place.
- Communication was effective and organised through structured, minuted meetings. Governance and performance management arrangements were proactively reviewed and reflected best practice.
- All clinicians met regularly to discuss work prioritisation and vulnerable patients as well as difficult cases and current events. There was a good relationship with community teams to ensure patients received effective co-ordinated care.
- The practice had a range of systems in place to ensure the practice was efficient. The clinical management group ensured processes were co-ordinated and any changes were implemented through a team approach.
- The practice had implemented an annual clinical governance review report, which detailed activities the practice had completed throughout the year. The report was used to review the organisation and for future planning. The document was shared with all staff.
- There was an open culture and clear learning culture within the practice, the systems for reporting and investigating incidents and complaints had been adopted by OHP and other practices locally. The practice encouraged the reporting of incidents, however small, to identify ways in which the practice could continually improve.
- Practice staff were supportive of others in the local health community. They had actively assisted another local practice which due to unforeseen events were struggling to meet patient needs. This ensured the patients' health and care needs continued to be met. Innovation from the practice also focussed on the benefits to the wider health economy for example, diverting patients from accident and emergency into primary care through the ambulance triage scheme.

**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 practices were expected to provide assurance that quality standards were being met and quality and risk was being managed through the submission of core quality markers to the central team. These were monitored along with complaints, significant events and safety alerts through the centralised governance management processes.
- The central team also offered mock CQC inspections to member practices to help improve and drive quality. Practices wishing to join OHP were expected to meet certain criteria in order to minimise risks and safeguard the partnership.
- The practice had undertaken several risk assessments relevant to the provision of clinical care, including infection control and premises risk assessments. There was an ongoing plan in place to continually monitor risk and act on identified actions.
- Governance and performance management arrangements were proactively monitored and updated.
- The practice implemented a system for ongoing reviews to ensure processes were being followed when recruiting new staff, this included a tailored induction plan, appropriate checks, training programme and the continuous monitoring of staff development.
- We found numerous examples where incidents and complaints had been effectively used to identify potential risks. These had led to system changes for example in the management of blood results.
- Incident report was integral to learning and improvement. The practice used all safety concerns (incidents and complaints) as a foundation to review and manage all possible risks. The management of risk was demonstrated as a team effort and all the staff were proactive in ensuring risks were mitigated.

**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: | |

- A ‘template menu’ had been developed and embedded within the service. This was developed and maintained by a GP lead. It was a single point of entry that ensured all clinicians were using up to date agreed templates. This helped to reduce the variability in using read codes as well as improving the safety of work carried out by new members of staff, clinical trainees and locums. It promoted uniformity of record keeping with all clinicians knowing where to find the correct information.

- A range of safety nets had been implemented to ensure risks were mitigated. This included regular reviews of all information to ensure to was accurate and timely and a comprehensive range of risk assessments to ensure patient safety.

- GP Team Net (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.

- The provider organisation had recently collated performance data from nationally available sources which they had started to share with practices to help them manage their own performance.

- The central OHP team provided support to practices in relation to statutory notifications to CQC.

- The practice used clinical data to drive performance and demonstrate improved outcomes for patients. This included the implementation of a range of clinics to support patients with long term conditions. For example: diabetes, rheumatology, heart failure and dementia. The dedicated clinics gave the clinical team time to assess and monitor the care and management of patients with these conditions to ensure they were receiving the appropriate reviews.

**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:

- OHP held partners meetings annually which provided a forum for provider level feedback and to check that the direction of travel of the organisation was still appropriate. OHP had also set up a salaried GP community and planned to introduce a similar network for nursing staff working across the organisation.

- The centralised OHP team played a significant role in the stakeholder engagement on behalf of member practices. For example, OHP provided a collective voice for GPs in strategic planning

within the health and social care economy and for exploring areas for collaborative working.

- Staff feedback highlighted a strong supportive team was in place, with a positive supporting ethos. Staff said the leadership team proactively asked for their feedback and suggestions about the way the service was delivered and any ideas were discussed at the management group meetings. There were high levels of constructive engagement with staff. Everything was a team effort and staff told us everyone was treated as an equal and their opinions and ideas were valued.

- The practice produced a quarterly newsletter for patients with updates on practice news, health promotion and staff changes.

- All comments received on the friends and family test were reviewed by one of the GPs. Comments were shared with staff through the inhouse communication system. The results of the test were also displayed in the waiting areas for patients to see on a monthly basis.

- The Patient Participation Group (PPG) was very active and supportive of the practice. Members of the group had supported the practice's other site, Nechells practice in organising a patient group. The practice told us the PPG were proactive in liaising with other PPGs in the local area to share ideas and initiatives. One of the GPs and the management team attended all the PPG meetings to share information and updates.

- Two of the GPs had a special interest in substance misuse and were responsible for clinical governance of the shared care agreement across Birmingham. The GPs also carried out training and mentoring of primary care colleagues to ensure services were available across the city to address the needs of the population.

Feedback from Patient Participation Group.

**Feedback**

- We spoke with two representatives of the patient participation group (PPG), who told us the practice was supportive and encouraging of the group and listened to their views and ideas. As a group they felt respected and valued by the practice team.
- Regular meetings were held and both GPs and staff attended and updated the group on a variety of topics including complaints received and new developments.
- The representatives told us they had a small amount of money given by the practice to implement initiatives. This included travelling to the other site in Nechells to help the practice recruit patients and support them with the implementation of a patient participation group.

**Any additional evidence**

The representatives of the PPG told us that the practice acted on suggestions. For example:

- Some patients were having difficulties in rising from the chairs in the waiting room. The practice acted on this and purchased some chairs with arms to support patients into a standing position.
- The PPG asked for the light cords in the toilets to be changed as they were the same colour as the walls and were difficult to see on entering the toilet. The practice changed the cords to a more vibrant colour so patients could see them easily.

The PPG told us they offered support at the practice and had been involved in a range of initiatives. For example:

- Long queues were evident at the reception desk and in order to reduce patients' waiting time to speak with a receptionist to confirm their appointments, the PPG helped patients with the check in screens. The PPG also requested improved signage to help patients arriving at the practice. This had been actioned.
- The PPG had supported Macmillan coffee mornings to raise money for cancer awareness.

**Continuous improvement and innovation**

## There was 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) enabled practices 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.

At practice level we found:

- An effective process was in place to ensure all staff were up to date with the practice's mandatory training. Staff told us they were given the opportunity to develop and learn.
- Internal GP appraisals were carried out every year to support GPs with their personal development and discuss any support they required. This was in addition to the mandatory appraisals all healthcare providers registered with the General Medical Council (GMC) had to complete annually.
- Continuous monitoring of training and development was carried out by the management team and learning from events, complaints and compliments was shared to enable lessons to be learnt and improvements to services were acted on. The system for reporting and learning from events had been adopted by other practices in the local area and the practice were in the process of being involved in a national pilot.
- The practice continued to develop and implement processes for learning from incidents and sharing with the team and wider organisation. The practice had implemented 'round ups', a summary of data and learning points from each incident or significant event as well as learning points and analysis of new cancer diagnoses and patient deaths. The 'round ups' were shared

with the whole practice team on a monthly basis and stored on the practice intranet.

**Examples of continuous learning and improvement**

- The practice had implemented 'Whatsapp' group for each team as a method of support and communication.
- The GPs shared their work to support each other and there was a strong commitment to caring for each other. Internal appraisals for the GPs were completed each year.
- An aide memoire document was in place to support the clinical staff in capturing information through clinical consultations. This was implemented to ensure quality indicators were reviewed and updated and supported changes within the practice.
- A doctor's general template had been devised and added to the clinical system. This contained items that doctors used commonly during their consultations and all the information was in one place for easy access.
- The practice had implemented an ambulance triage system which due to the success of the pilot had been adopted by the CCG and was being used by practices within the local area. This had resulted in strengthened relationships with West Midlands Ambulance Service and had reduced the stress on secondary care and improved support for patients in primary care where appropriate.
- As part of the Royal College of General Practitioners (RCGP), programme RCGP for tomorrows doctors, the practice, offered work experience for school aged children who were interested in studying medicine.

**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.