

Care Quality Commission

Inspection Evidence Table

OHP-Drs Brinksman, Conlon, Manley, Saunders, Hull & Martins (1-4224288167)

Inspection date: 20 March 2019

Date of data download: 13 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.

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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • 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. • Monthly joint safeguarding meetings were held with the health visitors to discuss concerns. The health visiting team held weekly drop in sessions for parents at the health centre. • 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 to enable them to better support those at risk of domestic abuse. 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. Women's Aid attended the practice on a regular basis to offer advice and support to patients. • 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. Data provided by the practice showed they had 155 patients on the FGM register. The practice worked closely with the local safeguarding team to offer support to patients in this group. • Also, as part of their travel vaccination programme, any patients who requested vaccines were issued with an FGM Information sheet explaining the legal position in the UK on this. 	

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
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Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: 6 November 2018	Y
There was a record of equipment calibration. 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. Date of last check: 8 August 2018	Y
There was a log of fire drills. Date of last drill: 28 November 2018	Y
There was a record of fire alarm checks. Date of last check: Weekly checks	Y
There was a record of fire training for staff. Date of last training: Various dates	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: 16 January 2019	Y
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The management team ensured staff had completed their training and evidence provided showed all staff had completed fire training. Emergency lighting was checked on a monthly basis. The landlord managed the premises and organised for regular fire risk assessments to be completed. The practice was aware of what assessments had been completed, however had their own risk assessments also in place. 	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: January 2019	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: January 2019	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> A Legionella risk assessment had been completed on 27 June 2018. Water testing was done on 	

a monthly basis.

- The second floor of the building could be accessed via a lift. Evidence provided showed the lift had been serviced in March 2018.
- The vaccine fridges had been checked and serviced on 19 January 2019.
- The practice had a good working relationship with the landlord. Actions from the health and safety risk assessment had been discussed with the landlord and acted on. This included: the replacement of a rusty air vent in February 2019 and the replacement of a broken hand wash basin in January 2019.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Y
Date of last infection prevention and control audit: 21 January 2019 Practice achieved: 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:	
<ul style="list-style-type: none"> • 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 bins for nappy disposal which were ordered and in place by February 2019. 	

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	Y

sepsis.	
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There was a process in the practice for urgent clinical review of such patients.	Y
There was equipment available to enable assessment of patients with presumed sepsis or other clinical emergency.	Y
There were systems to enable the assessment of patients with presumed sepsis in line with National Institute for Health and Care Excellence (NICE) guidance.	Y
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> 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. A locum pack was in place which contained practice information, referral processes, key contact details and a reference to local guidelines. The practice had a process in place that every new locum obtained a self-declaration of fitness to practice, which the practice cross referenced with the NHS England responsible officer, to permit the exchange of information about the doctor's practice. 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	Y

managed in a timely manner.	
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: <ul style="list-style-type: none"> 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)	5.7%	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)	5.04	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)	2.98	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	Y

Medicines management	Y/N/Partial
Directions or Patient Specific Directions).	
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	Y
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> 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, by having staff to monitor repeat prescription requests. Specific inhouse training and a competence framework was created to ensure staff were fully trained within this role. A 	

Medicines management	Y/N/Partial
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:	8
Number of events that required action:	8
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> 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. 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 incident to ensure an accurate oversight of safety within the practice. All incidents were reviewed by a senior clinician who judged the severity of the incident. From the information provided we found eight incidents had been rated as amber and zero 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. 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 was 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
Overdue medicine review	<ul style="list-style-type: none"> The practice had implemented an information technology system to reduce medicine errors. A system to call patients on their birth dates was being implemented to ensure annual blood tests were completed. The role of prescription clerk had been developed to improve on patient recall systems.
A rapid access referral was faxed to the hospital but rejected. The practice were unaware the referral had been rejected as confirmation was received by post, a few days later. Due to the urgency of the review the practice should have been notified the same day.	<ul style="list-style-type: none"> The practice notified the clinical commission group of the delay through Datix a web-based incident reporting and risk management software, for hospitals to review their processes for rejected referrals.

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: <ul style="list-style-type: none"> 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 risks and the need to avoid exposure to this medicine which increased risks during pregnancy. 	

Effective

Rating: Good

We rated the practice as good for providing an effective service because the practice had implemented innovative processes to support patients and had comprehensive systems to monitor and support people in all population groups.

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: <ul style="list-style-type: none">• 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 the scheme had seen a significant decrease in the number of patients being taken to A&E from participating practices. For example: 79% of calls from ambulance crews to OHP practices 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.• A system was in place to monitor urgent referrals to ensure they were acted on effectively. For any patient referred under the two week wait urgent referrals, an alert is added for staff to follow up after eight weeks to ensure the patient has been seen. The referring GP was kept up to date of the progress of the referral and any updates received.• 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.

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2017 to 30/09/2018) <small>(NHSBSA)</small>	0.20	0.81	0.81	Significant 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 extra or changed needs.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks were offered to patients over 75 years of age.
- The 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.
- 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.

Findings

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care. Monthly meetings were held with the Community Matron to support patients in the community and ensure they were receiving the appropriate care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- 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.
- 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 had developed a system of quality and safety audits to continually identify patients who required reviews and regular monitoring.
- 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)	76.8%	79.9%	78.8%	No statistical variation
Exception rate (number of exceptions).	19.1% (60)	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)	67.7%	77.2%	77.7%	No statistical variation
Exception rate (number of exceptions).	8.3% (26)	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)	73.1%	81.1%	80.1%	No statistical variation
Exception rate (number of exceptions).	13.7% (43)	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)	75.6%	76.6%	76.0%	No statistical variation
Exception rate (number of exceptions).	1.4% (5)	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)	98.6%	91.4%	89.7%	Variation (positive)
Exception rate (number of exceptions).	6.4% (5)	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)	79.7%	83.0%	82.6%	No statistical variation
Exception rate (number of exceptions).	3.9% (18)	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)	94.4%	88.6%	90.0%	No statistical variation
Exception rate (number of exceptions).	2.7% (1)	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 were 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.
- With the implementation of the safety netting process the practice had minimised exception reporting due to the regular ongoing monitoring of patients.
- 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

- Childhood immunisation uptake rates of children aged 2 were below the World Health Organisation (WHO) targets. The practice had taken action to try and improve child immunisation uptake rates. The practice nurse had devised and implemented posters and leaflets on the MMR vaccine to advise patients on the combined vaccine to try and improve uptake.
- Following the inspection, the practice sent data obtained from Child Health Surveillance (CHIS) for 2018/2019 plus an audit of patient records and outcomes, this demonstrated an improved uptake.
- The practice was aware of the challenges they faced in maintaining immunisation rates. Their

approach was to ensure that no child missed out on vaccination without a face to face consultation and that parents/carers were reassured.

- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary. Young people could access services for sexual health and contraception. The practice offered a full range of contraceptive services through the umbrella sexual health service.
- The practice maintained a strong leadership team for safeguarding and one of the GP partners was on the Birmingham Safeguarding board.
- Bi-monthly joint safeguarding meetings were held with the health visiting team.

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)	86	90	95.6%	Met 95% WHO based target (significant variation positive)
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2017 to 31/03/2018) (NHS England)	90	103	87.4%	Below 90% minimum (variation negative)
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2017 to 31/03/2018) (NHS England)	90	103	87.4%	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)	83	103	80.6%	Below 90% minimum (variation negative)

Any additional evidence or comments

Childhood immunisation uptake rates were below the World Health Organisation (WHO) targets. Due to the cultural beliefs of some of the practice population the nurses had devised an information poster and leaflets on the MMR vaccine. If a patient failed to attend their appointment, the practice sent out three

letters to the patient and the nurse would follow this up with a phone call to encourage patients to attend. Unverified data provided by the practice showed from January to March 2019 the practice had achieved 86% for patients receiving the MMR vaccine.

The practice had developed a 'Vaccine Positive' approach to immunisations, aiming to support and advise patients about immunisations and minimise concerns.

Actions to improve immunisation rates were discussed at the practice's management meetings on a frequent basis.

Leaflets had been devised and implemented to support patients in understanding the importance of immunisation. This included a multi-language insert offering assistance to patients whose first language was not English, which was included with invitation letters and reminders.

The practice also provided information to parents about the safety of vaccination, as well as about the ingredients in some vaccines, and the possibility of alternatives should these conflicted with cultural or religious requirements.

The practice had strong links with the health visiting service who offered a drop-in service every Wednesday morning at the health centre. Any patients who failed to respond to the letters were reported to the health visitors for follow up.

Working age people (including those recently retired and students)

Population group rating: Requires improvement

This population group was rated requires improvement, as the uptake for cervical screening was below the local and national average.

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Unpublished data provided by the practice showed the practice had achieved 71.9% uptake for cytology, however this data was not comparable with Public Health England data which showed an uptake of 60.7%.
- The practice had a process in place to support a range of screening programmes, including breast, colorectal, abdominal aortic aneurysm. This involved tracking and coding all screening correspondence and coding when patients do not participate. This was followed up when a patient attended for consultation to advise the patient on the benefits of screening and to support patients in attending relevant screening programmes.
- Data provided by the practice showed the most common language for patients other than English was Somalian. The practice had organised a meeting with Somalian Imam of the local mosque to discuss joint working to advise patients of the benefits of immunisations and screening.
- 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 medication 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)	60.7%	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)	53.5%	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)	43.2%	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)	69.2%	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)	53.3%	52.1%	51.9%	No statistical variation

Any additional evidence or comments

The practice sent letters out to patients in their own language to encourage them to attend their cancer screening appointments. A list of patients who required cervical screening was printed on a weekly basis and patients were contacted. A total of three letters were sent out to patients and alerts were added to the clinical system to advise staff to speak with patients concerning their screening.

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 whether 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 held a register of patients living in vulnerable circumstances including homeless people, refugees 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 was taking part in a pilot project for the identification and reporting of FGM. Any patients found to have undergone FGM were seen by an IRIS support worker at the practice to offer advice and support. As part of their travel vaccination programme, any patients who requested vaccines were issued with an FGM Information sheet explaining the legal position in the UK on this. Data provided by the practice showed they had 155 patients on the FGM register. The practice worked closely with the local safeguarding team to offer support to patients in this group.
- The practice demonstrated that they had a system to identify people who misused substances.
- 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.
- 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 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 from 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.

People experiencing poor mental health Population group rating: Outstanding (including people with dementia)

This population group was rated outstanding because services were tailored to meet the needs of individual people. The practice demonstrated how they supported patients with dementia and their families by offering dedicated clinics, assessments and continuous monitoring to ensure the appropriate care and treatment was being received.

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 improved management of patient's care.
- 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. Unverified data provided by the practice showed 50 patients and approximately 40 families/carers in had been supported through these dedicated clinics. The GP works with the clinical case manager/community matron and a colleague from DISC (Dementia Support for Carers). Monthly meetings are held to discuss patients and make new referrals, including liaison with local support organisations.
- 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)	93.9%	93.2%	89.5%	No statistical variation

Exception rate (number of exceptions).	19.5% (8)	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)	93.8%	93.3%	90.0%	No statistical variation
Exception rate (number of exceptions).	22.0% (9)	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)	95.2%	85.9%	83.0%	No statistical variation
Exception rate (number of exceptions).	8.7% (2)	6.0%	6.6%	N/A

Any additional evidence or comments

The practice ran fortnightly dementia clinics. A comprehensive assessment was completed which included chronic disease management and a frailty review. The practice had implemented a register of patients with mild cognitive impairment, who were offered annual reviews.

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)	537.2	545.4	537.5
Overall QOF exception reporting (all domains)	8.1%	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 of which demonstrated improved outcomes to patient care and improvements in practice systems and processes. The practice had completed a two cycle audit of their prescribing of GLP-1 analogues, a medicine recommended in

patients who have inadequate glycaemic control. The first audit in December 2015 showed 10 patients had been prescribed these medicines in the past 12 months. The results of the audit showed Nechells Practice was significantly underperforming. For example, only 60% of patients had received a review at six months after starting treatment, compared to the standard of every patient having a review. Further evidence showed 60% of patients who remained on GLP-1 analogue therapy had not achieved the required weight loss and HbA1c reductions. The second audit in January 2019 showed 18 patients were on the therapy. The audit showed 83% of patients had received a review six months after starting treatment and after starting treatment the percentage of patients that had not achieved the required weight loss or required reduction in HbA1c had reduced to 22% compared to 60% previously.

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

own health.	
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) <small>(QOF)</small>	94.4%	96.1%	95.1%	No statistical variation
Exception rate (number of exceptions).	2.1% (18)	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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> During the month of Ramadan, the practice displayed a noticeboard about how to look after your health during this period and offered advice on how to manage health conditions. The practice had access to telephone interpreters to support patients understand their consultations. Interpreters could also be booked to attend consultations with patients. The practice had completed an audit to identify the number of languages spoken at the practice. The audit had showed over 100 languages were spoken amongst the practice population. 	

CQC comments cards

Total comments cards received.	48
Number of CQC comments received which were positive about the service.	48
Number of comments cards received which were mixed about the service.	13
Number of CQC comments received which were negative about the service.	0

Source	Feedback
CQC Comment cards	All of the comment cards received were positive about the care and treatment received by the GPs. Comments included staff were friendly and consistently treated patients with dignity and respect.
NHS Choices	The practice had received a three out of five-star rating based on two reviews. The most recent comments included the GPs were very good.
Friends and Family test	The latest responses to the Friends and Family Test showed 85% of patients were extremely likely or likely to recommend the practice to others. This was based on 26 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
4677	418	88	21.09%	1.88%

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)	84.1%	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)	82.3%	85.9%	87.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2018 to 31/03/2018)	94.9%	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)	83.7%	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
CQC Comment Cards	Comments received told us that the practice team explained things well and offered advice when required.

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)	77.6%	92.7%	93.5%	Variation (negative)

Any additional evidence or comments

The inhouse survey was completed by 50 patients during 2018 and showed 95% said they were involved in decisions about their care and treatment. The practice were aware of diverse population registered at the practice and the language barriers. In order to gather further feedback, the inhouse survey had been carried out to ensure patients had the opportunity to share their views.

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	Y
Information about support groups was available on the practice website.	Y
Explanation of any answers and additional evidence: The practice had available a range of leaflets in various languages to support patients with advice. Cervical screening leaflets were available in a variety of languages to support patients in understanding the procedure and the benefits of having the screening done and to try and improve	

uptake.

Carers	Narrative
Percentage and number of carers identified.	95 carers on the practice register, which represented 2% of the practice list.
How the practice supported carers.	<ul style="list-style-type: none"> • 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. • The practice had put an administration lead in place to support carers. • The practice held fortnightly GP dementia clinics with a local support worker to support, advise and monitor the care of both the patients and the carers. • 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.	<ul style="list-style-type: none"> • Families were sent a condolence card and the GP called families to offer support. • The practice had now implemented a system to ensure patients' families were followed up.

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 8pm. Telephone lines were available from 8am to 6.30pm
Tuesday	8.30am and 8pm. Telephone lines were available from 8am to 6.30pm.
Wednesday	8.30am and 6pm. Telephone lines were available from 8am to 6.30pm.
Thursday	8.30am and 6pm. Telephone lines were available from 8am to 6.30pm.
Friday	7.30am and 6pm. Telephone lines were available from 8.30am to 6.30pm.
Appointments available:	
Monday	9am to 11.50am / 2.30pm to 5.50pm Extended hours: 6.30pm to 8pm
Tuesday	9am to 11.50am / 2.30pm to 5.50pm Extended hours: 6.30pm to 8pm
Wednesday	9am to 11.50am / 2.30pm to 5.50pm
Thursday	9am to 11.50am / 2.30pm to 5.50pm
Friday	9am to 11.50am / 2.30pm to 5.50pm Extended hours: 7.30am to 8.30am

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
4677	418	88	21.09%	1.88%

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)	86.7%	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.
- In recognition of the religious and cultural observances of some patients, the GP would respond quickly, often outside of normal working hours, to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.
- 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.

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 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.

- The practice held specific clinics for patients 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.

Families, children and young people

Population group rating: Good

Findings

- Additional nurse appointments were available until 7.15pm on a Monday for school age children so that they did not need to miss school.
- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- Parents with concerns regarding children under the age of 16 could attend a drop-in clinic held at the same time as the twice weekly baby clinic.
- 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.

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 a Monday and Tuesday and from 7.30am to 8.30am on a Friday.
- 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, refugees 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. Evidence provided by the practice showed eight patients had been referred for extra support.
- Patients who were experiencing difficulties and needed support 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 provided dedicated support at a local sheltered accommodation centre, which supports 20 or more elderly patients who have complex and enduring physical and/or mental health needs.
- 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

- The practice was aware of support groups within the area and signposted their patients to these accordingly. Priority appointments were allocated when necessary to those experiencing poor mental health. All staff had completed the mental health capacity act training and were experienced in supporting patients with mental health issues.
- 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.
- The lead GP for the elderly led the inhouse dementia project, which included extended length appointments for patients and their families.
- Fortnightly 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)	63.2%	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)	69.0%	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)	76.2%	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)	73.4%	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 71% of patients found it easy to get through to the practice by phone and 78% of patients were satisfied with the appointment times.

Source	Feedback
CQC Comment	We received a total of 13 comment cards that highlighted the difficulties in accessing appointments by telephone. Patients told us that waiting times were

Cards	long and it was time consuming to book an appointment.
NHS Choices	One comment on NHS Choices highlighted the difficulty in obtaining an appointment.

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.	26
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.	4

	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: <ul style="list-style-type: none"> 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 as kept waiting in reception	<ul style="list-style-type: none"> Patient had told reception staff they had arrived, however the reception staff had not booked the patient in. The practice sent a written apology to the patient. The complaint was shared with the reception team for learning.
Patient unhappy with consultation with GP.	<ul style="list-style-type: none"> The patient found the doctor's attitude unsatisfactory and their concerns were not addressed. The practice sent a written apology to the patient. The patient was offered another appointment to discuss concerns. The complaint was discussed with the GP for personal reflection.

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:	
<ul style="list-style-type: none">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. The GP Partners were part of the driving force behind the formation of OHP in providing long term sustainability to their own practices and others in the OHP group.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 is situated in one of the most deprived areas according to data provided by Public Health England. 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 told us the GPs and management team were approachable and 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 said there was a team approach in everything that was done at the practice. There was strong collaboration and support across all teams and a common focus on improving the quality of care and people's experiences.
- Staff met regularly to discuss any issues or complex cases and to offer and receive peer support.

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: <ul style="list-style-type: none"> • 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.

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y

The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • 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 proud about working at the practice. Staff told us they received support from the GPs, managers and team. There was a 'can do' attitude throughout the entire team 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. • The practice were supportive of other organisations to reduce impact on services. For example, the practice had implemented an ambulance triage service that had been adopted by the ambulance service. This service supported paramedics on whether a patient required hospitalisation or could be treated in the community. This had a positive impact on the reduction of patients being transferred to the A&E department. 	

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

Source	Feedback
Staff	<ul style="list-style-type: none"> • Staff told us everyone was part of the team and the ethos at the practice was, what more can we do for our patients. • Staff said the constant positive 'can do' attitude of the team made working at the practice exciting. • Support was available when required and the open door policy of the management team was appreciated as staff felt they could approach any of the management team for advice and help.

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:	
<ul style="list-style-type: none">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.	

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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • 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 responded positively to external feedback. For example: At the last CQC inspection we identified issues concerning limited oversight of the management of the premises. The practice had built up a relationship with the landlords and were proactive in sharing information with them on actions identified through assessments of the premises. • To minimise risk in the management of prescriptions, the practice had piloted and trained staff to become prescription clerks to ensure long term sustainability of their prescription monitoring and handling. • 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. 	

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: <ul style="list-style-type: none"> 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 it 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 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 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: <ul style="list-style-type: none"> 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. GPs at the practice had supported this. 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.
- 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) had recently been set up. Members of the group at Ridgacre House Surgery had supported Nechells practice in organising a patient group. The practice had tried various options to encourage patients to join a group and with constant encouragement had seen the group increase from one patient representative to a respectable size. Representatives of the group had attended meetings with the Quinton based PPG to gain a better understanding of how their group worked and to share in the positive outcomes and changes they had implemented at Quinton and to take forward ideas in Nechells to benefit the patients.
- 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.

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:	
<ul style="list-style-type: none"> • 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:	
<ul style="list-style-type: none"> • 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.
- 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.
- Due to the cultural diversity of the patient population, the practice nurse had devised and implemented an explanation sheet of the MMR vaccine for patients to gain a better understanding of the vaccine and the benefits of children being immunised against these diseases.
- The practice constantly looked at information available to support their patients. This included having a range of information leaflets in local spoken languages to advise and support. During the inspection we saw examples of information sheets on cervical cytology in a range of languages.
- 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.

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.