

# Care Quality Commission

## Inspection Evidence Table

Bordesley Green Surgery

(1-9140585136)

Inspection Date: 22 June 2023

Date of data download: 12/06/2023

## Overall rating: Good

At this inspection we have rated the practice as good overall. We found that the practice had made significant improvement in all areas previously regarded as inadequate. The practice had reviewed its governance arrangements and reviewed its systems and processes to support effective clinical oversight. The concerns related to the practice triage process and supervision of staff in their extended and advanced roles identified at the last inspection had also been addressed.

## Safe

## Rating: Good

At the last inspection in November 2022, we rated the practice as inadequate for providing safe services because:

The practice systems and processes in areas, which included safeguarding, learning from incidents and managing risks related to recruitment and staff competences were not always effective or fully embedded.

At this inspection, we found that those areas previously regarded as inadequate practice were now embedded throughout the GP practice. The practice is therefore now rated good for providing safe services.

### Safety systems and processes

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

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
Partners and staff were trained to appropriate levels for their role.	Y

There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	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"> <li>• At the last inspection in November 2022, we found that there was a lack of clear systems and processes for following up safeguarding concerns in a timely way. To address this the management team reviewed its safeguarding systems and processes with the support of the Integrated Care Board (ICB) safeguarding lead/champion.</li> <li>• At this inspection we found that there were multiple layers of safety netting processes to support the protection of patients. We found that practice policies and procedures had been reviewed and updated. The documents were accessible to all staff on the practice shared drive and dedicated administration system.</li> <li>• One of the GP partners was the practice designated safeguarding lead for adults and children. The GP had completed level 3 safeguarding training and had the support of the ICB safeguarding lead/champion who had completed level 4 safeguarding training and a designated and knowledgeable administration member of staff who had completed level 3 safeguarding training.</li> <li>• All staff received up-to-date safeguarding and safety training appropriate to their role and knew how to identify and report concerns.</li> <li>• The practice maintained safeguarding registers. We saw evidence of reconciliation of the registers. A new member of staff, experienced in the implementation and management of effective safeguarding processes and systems was also recruited.</li> <li>• Regular audits were carried out to ensure patients' records were appropriately coded. Patients were followed up and safety netting of all patients was in place.</li> <li>• Regular planned meetings were held to discuss the safeguarding registers and the outcome of audits.</li> <li>• The practice had identified an increase in the number of patients presenting with Female Genital Mutilation (FGM) and maintained an active register of those patients. The practice clinical staff demonstrated a good understanding of the risks of FGM in their population and had taken action to safeguard those at risk.</li> <li>• We saw that Disclosure and Barring Service (DBS) checks were undertaken for all staff, in line with the practice policy. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).</li> <li>• Alerts were put on the records of patients identified as being at risk from abuse. This included children on the child protection register, children of concern and looked after children. Families of patients identified as at risk were linked and had alerts on their records.</li> </ul>	

<b>Recruitment systems</b>	<b>Y/N/Partial</b>
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• We reviewed the records for two members of staff and found that safe recruitment practices had been followed. Staff files were organised so that relevant documents were readily and easily accessible.</li> <li>• Staff records showed that all staff were up to date with immunisations such as tetanus, diphtheria, polio, measles, mumps and rubella (MMR) and hepatitis B.</li> <li>• The practice manager told us that the current registration status for clinical staff was routinely checked online through the respective professional websites. We saw that the registration of the advanced nurse practitioner had been checked and recorded.</li> </ul>	

<b>Safety systems and records</b>	<b>Y/N/Partial</b>
Health and safety risk assessments had been carried out and appropriate actions taken.	Y
Date of last assessment: 25 May 2023	Y
There was a fire procedure.	Y
Date of fire risk assessment: 25 May 2023	Y
Actions from fire risk assessment were identified and completed.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• Practice staff ensured that health and safety risk assessments were carried out to maintain the safety of those who used the service.</li> <li>• The practice had appropriate safety policies, which were regularly reviewed and communicated to all staff.</li> <li>• The practice had two named fire marshals who had completed the required training.</li> <li>• Systems were in place to check, maintain and calibrate equipment used to support patient care and treatment at the practice. Equipment was checked annually to ensure it was safe to use. The last checks were completed in July 2022.</li> <li>• Portable Appliance Testing (PAT) was carried out in November 2022 on electrical appliances and equipment to ensure they were safe to use.</li> <li>• Training records showed that staff had received training related to health and safety and fire safety.</li> </ul>	

## Infection prevention and control

**Appropriate standards of cleanliness and hygiene were met.**

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out.	Y
Date of last infection prevention and control audit: 10 June 2023	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"><li>• At our site visit to the practice, we found the premises were visibly clean, tidy and well presented.</li><li>• At the last infection prevention and control (IPC) audit the practice achieved an overall score of 99%.</li><li>• The practice had external cleaners and a cleaning schedule was in place.</li><li>• Hand hygiene audits had been completed as part of infection prevention and control monitoring.</li><li>• Training records showed that all staff had completed IPC training.</li></ul>	

## 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
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There were enough staff to provide appointments and prevent staff from working excessive hours.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• Staff records showed that newly appointed staff had an appropriate induction period.</li><li>• Staff were aware of their responsibilities if presented with an emergency. For example, Sepsis awareness had been discussed with staff. Staff spoken with were aware of the symptoms to ask about, signs to observe for and the action to take.</li></ul>	

- At the last inspection the practice locum pack lacked detail and was not complete. At this inspection we saw that the pack had been updated and contained useful information to support staff working at the practice on a temporary basis.
- Staff had access to emergency medicines and equipment in the event of a medical emergency and knew where to find them when needed.
- Basic life support and sepsis training were part of the practice's mandatory training requirements.

### 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
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• At the inspection in November 2022 our clinical searches and review of records identified that patient records were not always managed in line with current guidance. The records showed that information related to clinical decisions and evidence of appropriate follow up was missing. At this inspection our clinical searches and review of patient records identified that improvements had been made. We found that care records were managed in a way that protected patients. For example, history, examination, management plans, safety netting and follow up were adequately documented within the patient record.</li> <li>• Referral letters contained appropriate information and these were followed up to ensure appointments were received in timely manner. A record was maintained of all 2 week wait (urgent cancer) referrals to check patients had received an appointment.</li> <li>• Test results were reviewed by the GPs, records reviewed showed that these were managed in a timely way. Our remote review of test results showed that all were current and up to date. The GP partners reviewed all test requests made by the advanced nurse practitioner and had clinical oversight of the results.</li> </ul>	

# Appropriate and safe use of medicines

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

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL average	England	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2022 to 31/03/2023) (NHSBSA)	0.79	0.93	0.91	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). (01/04/2022 to 31/03/2023) (NHSBSA)	3.6%	7.1%	7.8%	Variation (positive)
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 (01/10/2022 to 31/03/2023) (NHSBSA)	4.37	5.17	5.23	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2022 to 31/03/2023) (NHSBSA)	67.3‰	115.7‰	129.8‰	Tending towards variation (positive)
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2022 to 31/03/2023) (NHSBSA)	0.82	0.58	0.55	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2022 to 31/03/2023) (NHSBSA)	8.8‰	7.9‰	6.8‰	No statistical variation

Note: ‰ means *per 1,000* and it is **not** a percentage.

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of effective 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 and Improvement Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
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 UKHSA guidance to ensure they remained safe and effective.	Y
Explanation of any answers and additional evidence, including from clinical searches.	

- National prescribing data showed practice prescribing was in line with other practices locally and nationally.
- As part of our inspection, we looked at the practice management of medicines through clinical searches and reviews of a sample of patient records. We found that clinical staff were monitoring patients prescribed medicines and undertaking reviews. For example:
- The clinical searches identified a total of 4 patients on a Disease-modifying antirheumatic drug (DMARD) which has the potential for serious side effects. DMARDs are used to treat inflammatory conditions such as rheumatoid arthritis. Our review of these medicines showed no serious issues and clinical records identified that patients had regular 3 monthly monitoring reviews. There were areas when clinical staff had not consistently followed national guidance. For example, we found for this medicine that the dose to be taken weekly was indicated but the day of the week the medicine should be taken to mitigate the risk of toxicity due to daily dosing was not indicated for 3 of the 4 patients. This was discussed with the GP partners during the interview. At the inspection site visit we saw evidence that this had been addressed.
- We identified 368 patients on high-risk medicines used to treat heart conditions and high blood pressure. Twelve of the patients had not had the required monitoring. We reviewed 5 of the 12 records and found that there was no evidence of patient harm as monitoring was minimally overdue. Clinical records showed evidence of alerts on patient records and ongoing recall of patients to make an appointment. Information we saw and our discussions with the GPs demonstrated that they were aware of the monitoring needs of these patients.
- Clinical records showed evidence of non-compliance by patients. Records identified patients who had not ordered repeat prescriptions, those who failed to attend follow up appointments and required screening appointments such as eye screening. Documented information showed that family members or the patient themselves reported the failure to attend appointments to practice staff as being out of town. This meant that they had possibly returned to live abroad for long periods, which would impact on their ability to receive healthcare through the NHS system. The GP partners were aware of this issue and told us that they had repeatedly discussed their concerns and attempted to educate patients about the risks related to long breaks in treatment.
- Patients who had extended periods of absence were made aware of the government guidance related to health care entitlement for British Nationals taking extended visits abroad. This included for example, that 3 months' supply was the maximum quantity of their prescribed medicines that they were entitled to. The GPs discussed with individual patients that if they were going abroad for more than 3 months, they should take a copy of their repeat medicines with them and suggested that they had the prescription translated into the language of the country or countries they were visiting. Patients were advised to find out if there were any restrictions on medicines they could take in and out of the United Kingdom (UK). Patients were also made aware that the NHS would not normally pay for any treatment or services whilst they were abroad. Patients were signposted to where they could access information on going abroad for long periods such as the government website and leaflets were also available. Alerts were placed on the records of these patients to alert clinicians of their planned return dates.



**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:	Y
Number of events that required action:	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>At the inspection in November 2022, we were not assured that incidents were effectively used to support learning at the practice. At this inspection we found significant improvements had been made.</li> <li>The number of formal meetings had increased following the last inspection and this included the introduction of regular clinical meetings. The minutes of meetings showed that significant events / incidents were a standing agenda item at all meetings. The minutes were detailed and contained details of the discussion, learning and the agreed action to be taken. Recorded information also showed that changes made were monitored, reviewed and updated as appropriate.</li> <li>Staff we spoke with knew how to report incidents and significant events and could share examples of incidents that had occurred.</li> <li>There had been 10 events over the past 12 months, eight of these had occurred following the last inspection. These relate to clinical, communication and administration issues.</li> </ul>	

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

Event	Specific action taken
Patient experienced a fall in blood pressure and heart rate causing them to faint for a brief period during a procedure at the practice.	The GP who carried out the procedure was able to deal with the situation quickly and emergency equipment was easily accessible in the consulting room. The incident was well controlled and managed effectively resulting in the patient's quick recovery.
The agreed procedure for requesting urgent blood tests was not carried out by practice staff. Failure to mark the request as urgent	The hospital was contacted and asked to expediate the test because of the GP's concern that the results could be abnormal.

meant the results were not received in a timely manner, which delayed admission to hospital.	An apology was also given. The GP kept checking for the results over the weekend. The patient was admitted to hospital as soon as the results were available.
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Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>We found that the practice had a system in place to act on alerts, which may affect patients' safety. All alerts received at the practice were organised and stored in the practice computerised information system.</li> <li>We carried out a random review of patient records relating to medicine safety and Medicines and Healthcare products Regulatory Agency (MHRA) alerts. We saw examples of actions taken on alerts that required ongoing monitoring. Our searches identified that patients had been advised of the risks related to medicines that could increase the risk of abnormalities in pregnancy. However, three of four patient records we looked at indicated that there was a delay of between 9 and 12 months from when the patients were identified and the recommended advice being provided to those who were at an age where they could get pregnant. We discussed this with the GPs they explained that their previous clinical pharmacist who no longer worked at the practice had been responsible for following up medicine safety alerts. The practice management team carried out a review of the monitoring records that had been maintained by the pharmacist. Evidence provided showed that appropriate action to mitigate the level of risk had been taken in a timely manner. We saw copies of signed and dated alerts to confirm receipt and distribution to relevant practice staff at the time they were issued. Further documentation seen showed that all the patients had received counselling and guidance from the specialist who prescribed the medicines, at the time the medicine was started. This was followed up by the pharmacist, who had sent letters to the patients in line with MHRA guidance. Patients were also offered a face to face or telephone discussion if needed. Records showed that the letters were sent out to relevant patients 1 month after the alerts were received at the practice. The action taken was recorded in the practice MHRA folder and updated on the practice spreadsheet when new guidance was received. The practice management team told us that they would be reviewing the process carried out by the pharmacist to determine what elements of the process should be continued to ensure up to date information on the management of safety alerts would be appropriately maintained and easily accessible on patient records.</li> <li>We saw good practice in that all the safety alerts received at the practice had been addressed.</li> </ul>	

## Effective

## Rating: Requires Improvement

At the last inspection in November 2022, we rated the practice as inadequate for providing effective services because:

- There were significant concerns with the management and follow up of patients from the practice's triage list.
- There were no effective plans in place to address the low take up of child immunisations and cervical screening.
- Staff in advanced and extended clinical roles did not receive effective supervision and there was a lack of effective monitoring of staff training.
- There was little evidence of quality improvement and records did not demonstrate that risks and benefits were adequately discussed prior to minor procedures.

At this inspection, we found that those areas previously regarded as inadequate practice had been reviewed, audited to ensure changes made were appropriate and effective. We saw that plans had been put in place to address the low take up of childhood immunisations and cervical screening and uptake had increased in some indicators. However, further action was needed to monitor the impact of the plans on the uptake. The practice is therefore now rated requires improvement for providing effective services.

*QOF requirements were modified by NHS England and Improvement for 2020/21 to recognise the need to reprioritise aspects of care which were not directly related to COVID-19. This meant that QOF payments were calculated differently. For inspections carried out from 1 October 2021, our reports will not include QOF indicators. In determining judgements in relation to effective care, we have considered other evidence as set out below.*

### Effective needs assessment, care and treatment

**Patients' needs were assessed, and care and treatment were 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.	Partial
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	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 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
The practice had prioritised care for their most clinically vulnerable patients during the pandemic.	Y
The practice prioritised care for their most clinically vulnerable patients.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>At the inspection in November 2022, we identified significant concerns related to the triage system. At this inspection we found that the triage system had been completely changed. A significant change to the system involved one of the GPs being present in the reception area each morning to undertake triage as the calls were received at the practice. One of the GPs listens in on the calls and was available to respond to questions, direct the receptionists and intervene where needed to ensure that any medical advice or clinical decision was given by the GP. This change in practice cut down on the number of return calls to patients and enabled appropriate and timely triaged telephone consultations with a GP.</li> <li>Care pathways and protocols used at the practice were aligned to national guidance. This included guidance from NICE (The National Institute for Health and Care Excellence) and MHRA (The Medicines and Healthcare products Regulatory Agency).</li> </ul>	

## Effective care for the practice population

### Findings

- Health checks, including frailty assessments, were offered to patients over 75 years of age. Formal systems were in place for the referral of patients aged 75 years plus and those on two or more repeat prescriptions to a clinical pharmacist for medicine reviews.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group. The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74.
- All patients with a learning disability were offered an annual health check at their home, at the practice or other location of their choosing.
- End of life care was delivered in a coordinated way which considered the needs of those whose circumstances may make them vulnerable. The local hospice was rarely used. Patients who received palliative or end of life care and their families preferred to be cared for in the community, within their own home.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice records and data showed that it had performed well in meeting the needs of patients with poor mental health. The practice staff was supported by the community psychiatric nurse when making referrals and facilities at the practice enabled patients to attend talking therapies sessions when needed.

## Management of people with long term conditions

### Findings

- The practice had systems in place for recalling patients with long-term conditions to attend for their 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.
- At the inspection in November 2022, we identified areas where the escalation of clinical concerns to a GP did not happen. At this inspection appropriate escalation of any concerns identified by the advanced nurse practitioner (ANP) and health care assistant had been referred to the GPs. Our review of a sample of clinical records found appropriate monitoring was in place for most patients with long term conditions. We noted that there were some omissions to ensure the clinical review process had been fully completed.
- We identified 12 patients with the potential for a missed diabetes diagnosis and reviewed 5 patient records. We found that potential patients were identified by the clinicians but repeat blood tests were often delayed due to tasks requesting the test being closed before an appointment was offered to confirm diagnosis within the national guidance of 2 to 12 weeks. At the interview with the GPs they shared information which evidenced that 10 of the 12 patients had been confirmed as prediabetics. These patients had also received a review and had repeat blood tests completed. Practice staff identified that practice procedure had not been followed when a request was made for blood tests to be completed for the remaining two patients. Reception staff should have received a task to contact the patients and send an appointment for a blood test. At the time of the inspection site visit both patients had been recalled and blood tests completed. The practice GPs identified the incident as a learning event for discussion at the next clinical meeting.
- We reviewed 5 patients with an asthma diagnosis who had a high use of short acting inhalers indicating potentially poorly controlled asthma and found they had generally been appropriately followed up.
- We reviewed patients with an asthma diagnosis with two or more courses of steroids in the last 12 months (also an indication of poor asthma control). We found the patients had been reviewed and all eligible patients had been issued with a steroid card.
- We reviewed 5 patients with diabetic retinopathy (eye complications) who had blood test results that indicated poor diabetic control. We found all had been reviewed and detailed record keeping maintained. Records reviewed showed that patients with this condition were poorly compliant with taking prescribed medicines, self-testing, attending screening and follow up appointments and adhering to lifestyle changes such as diet, weight management and exercise. The practice clinicians showed an understanding and awareness of patients who were non-compliant. The practice staff provided ongoing education and interventions to meet patients' individual needs.
- The practice clinicians could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension. Adults with newly diagnosed cardio-vascular disease were offered statins. Patients with suspected hypertension were offered ambulatory blood pressure monitoring. Patients with COPD were offered rescue packs.

Child Immunisation	Numerator	Denominator	Practice	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	58	67	86.6%	Below 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	45	57	78.9%	Below 80% uptake
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) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	46	57	80.7%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	46	57	80.7%	Below 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	35	46	76.1%	Below 80% uptake

Note: Please refer to the CQC guidance on Childhood Immunisation data for more information: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>



### Any additional evidence or comments

- The published child immunisation data for the period April 2021 to March 2022 showed that the practice had not achieved the World Health Organisation (WHO) uptake target of 95% (the recommended standard for achieving herd immunity). Comparison of the practice performance showed it was below the uptake target of 80% in two of the five indicators. In the remaining three indicators performance was below the minimum 90%. However, the data above when compared to the previous year demonstrates that there had been an increase of between 3.5% and 15% in the take up of childhood immunisations in 4 of the 5 indicators.
- The practice staff told us their patient population were reluctant to attend immunisation appointments, which presented challenges. For example, the practice had a growing Somali patient population who failed to bring their children for vaccinations.
- Practice staff worked with and were supported by other organisations to educate parents or guardians about the importance of childhood immunisation. Systems put in place to promote the uptake of childhood immunisations included:
  - When a notification of a new newborn is received by the practice, a nominated administrator contacts the parents to advise them to register the baby as soon as possible to ensure the child would be added to the recall schedule for immunisations.
  - Patients registered following transfer from another practice or abroad were asked for their previous immunisation history, this included newly registered children. Any gaps or discrepancies identified would be recorded and an appointment arranged with the nurse practitioner for a review and where appropriate offered immunisation vaccines as per the vaccination of individuals with uncertain or incomplete immunisation against infectious disease guidance as detailed in the Green Book.
  - All children were booked for follow up immunisation before they left the practice. Practice staff called patients the day before their appointment to remind them to attend.
  - Children who were not brought to appointments were called and followed up by the nurse practitioner as per the practice 'Was Not Brought Policy'.
  - The PCN, Health and Wellbeing Coach visited the practice one day per week to speak with and educate frequent non-attenders on the importance of childhood immunisations.
  - Immunisation was offered opportunistically when parents brought their child to the practice for any other reasons.
  - The practice had access to weekly child health data undertaken by InHealth Intelligence which provided information on the uptake of childhood immunisation.
  - Persistent non-attenders and decliners were reviewed by the GP's and referred to the health visitor. Regular multidisciplinary meetings were held at the practice with the health visitor, safeguarding lead, GP and practice safeguarding administrator to discuss children not brought for appointments.
- The practice shared with us their latest unverified and unpublished child immunisation uptake data for the year 2022 to 2023. This showed further improvement.

Cancer Indicators	Practice	SICBL average	England	England comparison
Persons, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	44.9%	N/A	62.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	45.3%	N/A	70.3%	N/A
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (12/31/2022 to 12/31/2022) (UKHSA)	64.3%	N/A	80.0%	Below 70% uptake
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (4/1/2021 to 3/31/2022) (UKHSA)	28.6%	53.2%	54.9%	No statistical variation

Any additional evidence or comments
<ul style="list-style-type: none"> <li>The practice was below the England comparison of 70% for the uptake of cervical cancer screening. Data examined showed that there had been little change in this trend over the past few years. The practice management team shared their unverified figures with us. These showed that as of 20 June 2023 the uptake for patients aged 25-49 was 85% and 91% for patients aged 50-64 years. These figures would be comparable with other practices within the local integrated care board (ICB) but not to the England comparison data.</li> <li>The practice uptake for bowel cancer and breast cancer screening was lower than the England uptake.</li> <li>Practice staff were aware of the challenges presented by their patient population. They had identified the need for educating patients on the importance of cervical and other cancer screening programmes. With the support of the Primary Care Network (PCN), practice staff looked at ways they could support and encourage patients to attend their appointment.</li> <li>Practice staff told us that there were systems in place for recalling patients who failed to attend appointments.</li> <li>The practice had designated cancer champions, one clinical and the other non-clinical. They were registered with the Integrated Care Board (ICB) local Cancer Screening Group.</li> <li>The cancer champions regularly liaised with the ICB Cancer Screening Group through regular online meetings and an active WhatsApp Group for support with improving patient uptake. The practice cancer champions shared the information and updates they received with staff at practice meetings.</li> </ul>



- The female GP partner and advanced nurse practitioner (ANP) carried out cervical screening both at planned appointments and opportunistically. For example, screening was offered to mothers when they brought their child/children to the practice for immunisations or other appointments. Alerts had also been placed on patients' records to prompt all staff that the procedure was due or had not been carried out.
- The ANP carried out audits to review and monitor the number of patients who had not attended for cervical screening and managed the recall list and results. The audits were carried out 3 monthly to ensure patients had been recalled according to their results.
- Patients who continuously failed to attend appointments, declined the procedure or were new to the cervical screening programme were followed up by the female GP. This provided the patient with education and awareness so that the patient was aware of what to expect. The clinicians told us that this process had helped to increase the uptake and acceptance of cervical screening.
- Practice staff provided education to patients in formats that would meet the individual needs of patients. This included drop in sessions with a health and wellbeing coach every Friday between 10am and 4pm. Leaflets and cards were given to patients by reception staff and displayed around the practice.
- Patients were also gently reminded of the importance of cancer screening programmes during clinical consultations.
- The practice staff had regular contact with their local health promotion specialist, the City, Sandwell and Walsall Breast Screening Service and other cancer screening programmes. These services provided the practice with updates on planned cancer screening programmes, promotional material and events.
- The screening services also provided the practice with updates on its screening uptake figures from which the practice could monitor its performance.
- The practice staff actively called all the patients who had been invited for cancer screening the day before their appointment to remind them to attend.
- During the Flu Season a National Bowel Cancer Screening Programme GP Endorsement Banner was displayed at the practice. A bowel screening health promotion nurse attended the flu clinics to speak with patients, create awareness, provide information and answer questions to encourage patients to attend or undertake the screening procedure.

### 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.**

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Y
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y

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

- The practice shared with us a programme of both clinical and medicine audits and quality improvement initiatives they planned to carry out annually.
- One of the audits reviewed all patients prescribed a contraceptive pill in the previous 6 months to ensure they had received appropriate follow up. Forty patients were identified and all were offered a face to face appointment for a health check. Thirty of the 40 patients were reviewed and no concerns were identified. An analysis of the outstanding 10 patients showed that one patient had changed their contraceptive method and another was identified as non-contraceptive use. The remaining 8 patients did not respond to their appointment invitation. These patients were sent repeat appointments. The clinicians planned to repeat the audit in 12 months.
- A second audit reviewed patients prescribed a weight loss medicine to see if they were managing to lose weight. Patients taking this medicine were expected to lose approximately 5% of their starting body weight every 3 months. This guidance was used as the benchmark for the audit. Nine patients were identified. The outcome of the audit was a reduction in the number of patients prescribed the medicine. The prescribed medicine was discontinued for 7 of the 9 patients who were not maintaining their weight loss. Referrals to weight management clinics were offered to these patients. Structured 3 monthly reviews at each repeat prescription request was put in place for patients who were to continue with the treatment. The clinicians planned to repeat the audit in 6 months.

### 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.	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
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:	

- Following the last inspection, the practice management team had introduced a structured approach to collating evidence and monitoring the training completed by staff.
- Training records we reviewed showed that staff had completed the provider's relevant mandatory training and training applicable to their role in a timely manner.
- We saw that the GP partners had implemented a structured approach to the appraisal and supervision of the advanced nurse practitioner and health care assistant. Both GPs had undertaken training in how to carry out effective supervision and appraisals of staff in advanced roles.
- The new process was supported by new documents for recording appraisal and supervision conversations. The appraisal reporting documents were continuously reviewed by the GPs to ensure they were appropriate. The records we reviewed showed a two way conversation had taken place and that staff were able to discuss their learning and development needs. The practice appraisal process included assessing and updating staff competencies in their individual roles.
- We saw that the advanced nurse practitioner took responsibility for their professional development. They confirmed that they were supported to meet the requirements for professional revalidation.
- The advanced nurse practitioner told us that they had an allocated supervisor at the practice and had received supervision of their clinical and non-medical prescribing practices.

## Coordinating care and treatment

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

	Y/N/Partial
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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• Systems were in place to share information about patients electronically with other services.</li> <li>• Relevant information was shared with out of hours services to support continuity of care.</li> <li>• We saw evidence of regular staff meetings to ensure staff were kept up to date with guidance and best practice. An example of sharing information regularly with practice staff was the introduction of a daily huddle following the morning clinics. The huddle meetings were short, lasting between 15 to 30 minutes and had a structured agenda. The purpose of the huddle meetings was to encourage staff to reflect on the day, ask questions, raise things that went well and reflect on any concerns.</li> </ul>	

## Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"><li>• The practice was part of a primary care network, as a team they were developing a diverse workforce of clinical support professionals and social prescribing support to meet the needs of the local population.</li><li>• Following the inspection in November the practice received support from the Primary Care Network (PCN) to support them to make the improvements needed. This included for example, improving and maintaining its safeguarding systems and processes.</li><li>• NHS health checks were carried out to identify patients at risk of developing long-term conditions, so that early interventions could be undertaken to improve the lives of patients.</li></ul>	

## 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
Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"><li>• Practice staff were aware of legislation and guidance when considering consent and put this into practice when providing care and treatment to patients.</li></ul>	

- The practice clinicians used both Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) and ReSPECT forms. We saw that information had been shared with relevant agencies, which included the out of hours service and the district nurse team.
- Copies of the completed and signed forms were given to patients and a copy was available in the patient's electronic records.
- Our clinical searches identified that where DNACPR decisions had been recorded they identified where possible that the patients' views had been sought and respected.
- The practice clinicians carried out after death reviews and audits.

## 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
Staff displayed understanding and a non-judgemental attitude towards 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"> <li>Staff understood patients' personal, cultural, social and religious needs. Feedback received indicated that staff displayed an understanding and non-judgmental attitude to patients.</li> </ul>	

Patient feedback	
Source	Feedback
Patient Participation Group (PPG)	We spoke with four patients, two were representatives from the practice's PPG. They all said that getting through to the practice had improved. There were occasions when it was difficult but they could always get an appointment.
NHS Website	There were 3 reviews on this website. Most comments made related to care and were mostly positive. Comments made included that people felt they received great advice and care. The main concern referred to poor communication.
Google	There were 15 reviews over the last 9 months. Patients' comments were mostly positive. Patients said they felt staff were friendly, professional, helpful and good at listening. They also said they were satisfied with the level of care received. Some patients also commented on the negative attitude of some staff.
Healthwatch Reviews	The practice had been given a 3.5 rating based on 16 reviews for the period December 2022 to May 2023. Feedback about care and treatment were mostly positive. Comments included that staff were patient and listened, that they were happy with the service provided, that they were satisfied with care and treatment and received exceptional care.

## National GP Patient Survey results

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL average	England	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 (01/01/2022 to 30/04/2022)	74.6%	80.4%	84.7%	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 (01/01/2022 to 30/04/2022)	67.3%	78.4%	83.5%	Tending towards variation (negative)
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 (01/01/2022 to 30/04/2022)	85.9%	90.5%	93.1%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2022 to 30/04/2022)	63.9%	65.0%	72.4%	No statistical variation

### Any additional evidence or comments

- Results from the GP National Patient Survey (published in July 2022) were slightly lower than local and national averages for questions relating to patient experience. The scores for all four questions had declined between the previous 2021 survey and the 2022 survey.
- The practice had undertaken a recent inhouse survey of patients who had attended the practice based on 18 of their lowest scoring questions. Results from their in-house survey ranged from 97.6% to 100%. Action plans in the form of 'You Said...We did' were completed and displayed for patients to show how the practice planned to address the issues raised by patients who had responded to the GP national patient survey and the inhouse practice survey.
- The issues raised were also discussed at the practice patient participation group (PPG) meetings.

## Involvement in decisions about care and treatment

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

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>The practice management team reviewed the outcome of their national patient survey results each year. This involved noting any improvements on the previous year, any trends, areas where they were doing well and areas for improvement. These findings were shared with staff and an action plan developed to support improvement.</li> <li>Patients who required additional support were referred to the social prescriber employed by the primary care network (PCN).</li> </ul>	

Source	Feedback
Interviews with patients.	<ul style="list-style-type: none"> <li>We spoke with four patients who were all positive about the care and treatment they received at the practice. Patients felt they were supported and actively encouraged to be involved and understand their condition and the management of their care and treatment.</li> </ul>

## National GP Patient Survey results

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL average	England	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 (01/01/2022 to 30/04/2022)	83.0%	86.3%	89.9%	No statistical variation



	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	Y
Information about support groups was available on the practice website.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>The practice had access to interpretation services if needed. In the absence of an interpreter most of the staff working at the practice were able to speak with patients in their first language.</li> </ul>	

Carers	Narrative
Percentage and number of carers identified.	<ul style="list-style-type: none"> <li>At the time of the inspection the practice provided a service to a population of 2,856 patients. There were 70 patients registered as carers at the practice. This represented approximately 2.5% of the practice population. Carers were encouraged to register as a carer with the practice. A carers information pack was available in the reception area. This contained details on the support and services available to carers.</li> </ul>
How the practice supported carers (including young carers).	<ul style="list-style-type: none"> <li>Carers were offered an annual health check, which included an annual flu vaccine.</li> </ul>
How the practice supported recently bereaved patients.	<ul style="list-style-type: none"> <li>The practice maintained a register of patients who received end of life care. Patients were signposted to support services in the community.</li> </ul>

## Privacy and dignity

### The practice respected patients' privacy and dignity.

	Y/N/Partial
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>Staff recognised the importance of and took measures to ensure patients' dignity and respect were maintained when they used the service.</li> <li>Staff knew that if patients wanted to discuss sensitive issues or appeared distressed, they could offer them a private room to discuss their needs.</li> </ul>	

## Responsive

## Rating: Good

At the last inspection in November 2022, we rated the practice as requires improvement for providing responsive services because:

- We identified concerns with the triage process. A review of clinical records showed that patients were not always followed up appropriately and appointments available did not consider the needs of all patients.

At this inspection, we found that those areas previously regarded as requires improvement had been reviewed, audited to ensure changes made were appropriate and effective throughout the practice. The practice is therefore now rated good for providing effective services.

### Responding to and meeting people's needs

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

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Y
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
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y

Practice Opening Times	
Day	Time
Opening times:	
Monday	9am – 6.30pm
Tuesday	9am – 6.30pm
Wednesday	9am – 6.30pm
Thursday	9am – 6.30pm
Friday	9am – 6.30pm

Appointments available:	Appointment times both face to face and telephone consultations were available with a GP between 9am and 10.30am. Appointments with an Advanced Nurse Practitioner were available between 10.30am and 4pm and patients had appointments with a Healthcare Assistant for specific health checks.
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### Further information about how the practice is responding to the needs of their population

- 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.
- The practice liaised regularly with community services to discuss and manage the needs of patients with complex medical issues.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- The practice held a register of patients living in vulnerable circumstances including homeless people, and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

### Access to the service

#### People were able to access care and treatment in a timely way.

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimise the length of time people waited for care, treatment or advice.	Y
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Y
Patients were able to make appointments in a way which met their needs.	Y
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Y
Patients with most urgent needs had their care and treatment prioritised.	Y
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Y

Explanation of any answers and additional evidence:

- Following the inspection in November 2022, a change was made to the process for triaging patients. The new system involved a GP presence in the reception area where triage takes place. The GPs supported the reception staff when they responded to patient calls. The GP presence ensured that reception staff were responding to calls appropriately and they provided advice and answered questions.
- The new telephone system allowed the practice to monitor call volume, queue status and the quality of call responses. Audits carried out showed that there had been some improvement in telephone access for patients, call dropped rate and the call abandonment rate.
- Discussions were held with patients to explain the changes made and 'You said, we did...' posters were displayed for patient information. Changes to the telephone system included increasing the telephone queue length to manage the number of dropped calls, patient notification of their queue status and the introduction of a third telephone line at peak times.
- Appointments for children and people who worked were prioritised for the early morning appointments. School age children who were brought to appointments and considered fit to return to school were given written information to confirm that they had attended an appointment at the practice.

### National GP Patient Survey results

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL average	England	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 (01/01/2022 to 30/04/2022)	51.7%	N/A	52.7%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2022 to 30/04/2022)	46.3%	47.4%	56.2%	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 (01/01/2022 to 30/04/2022)	51.4%	47.1%	55.2%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2022 to 30/04/2022)	56.9%	67.1%	71.9%	No statistical variation

### Any additional evidence or comments

- Results from the GP National Patient Survey (published in July 2022) showed responses to questions about access were similar to the England average for getting through to the practice on the telephone and appointment times. The results for satisfaction with the overall experience of making an appointment and satisfaction with appointments offered were lower when compared to local and England averages.
- Following the inspection in November 2022 the practice staff carried out audits of the practice appointment system and patient access to the practice. To support the practice to make the changes needed practice staff participated in the NHSE accelerate programme. Two of its 4 key aims were to provide more appointments for patients with clinicians and to improve patient experience, outcomes and safety.
- Outcomes identified by the audit and NHSE accelerate programme enabled practice staff to introduce changes that would improve patient access. Changes implemented included same day appointments which could be booked by the clinicians and incorporating the triage of patients into the appointment system.
- Participating in the accelerate programme supported practice staff to formally carry out ongoing reviews and monitoring of the changes as they were introduced.
- Practice staff and patients spoken with advised that that there had been some improvement in the time taken to respond to calls following the implementation of the new telephone system.
- League tables for the local integrated care board (ICB) GP practices showed that the practice had moved from the bottom of the league table into the top 10 for improved patient access.

Source	Feedback
NHS.uk website (formerly NHS Choices)	<ul style="list-style-type: none"> <li>• There were 3 reviews on this website. Comments related to access were limited. People felt they were able to have face to face appointments but there were concerns about making an appointment.</li> </ul>
Patients / Patient Participation Group (PPG)	<ul style="list-style-type: none"> <li>• We spoke with four patients, two were representatives from the practice's (PPG). They all said that getting through to the practice had improved. There were occasions when it was difficult but they could always get an appointment.</li> </ul>
Google Reviews	<ul style="list-style-type: none"> <li>• There were 15 reviews over the last 9 months. There was one comment made in reference to access, this referred to receptionists not letting people see a doctor.</li> </ul>
Health Watch	<ul style="list-style-type: none"> <li>• The practice had been given a 3.5 rating based on 16 reviews for the period December 2022 to May 2023. We found mixed reviews from online feedback containing both positive and negative comments about access. These included the length of time it takes to get through to the practice and inability to get past the receptionists, however, people felt they could always get an appointment.</li> </ul>

# 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.	9
Number of complaints we examined.	9
Number of complaints we examined that were satisfactorily handled in a timely way.	9
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0
	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y

Example(s) of learning from complaints.

Complaint	Specific action taken
Patient given an appointment to attend practice by NHS111 and also added to practice triage process which caused upset when practice contacted patient to offer an appointment.	<ul style="list-style-type: none"> <li>A discussion was held with the patient to explain the process as they were unhappy that an alternative appointment (although for the same day) was being offered. The patient accepted the practice appointment offer. Due to the effect this experience had on the patient, practice staff contacted NHS 111 to make a formal complaint and request for an investigation. The incident was discussed at a practice meeting to provide learning for staff should a similar incident occur again.</li> </ul>

# Well-led

# Rating: Good

At the last inspection in November 2022, we rated the practice as inadequate for providing well led services because:

We found that there was a lack of clinical oversight in the delivery of the service. The practice was unable to demonstrate effective systems for managing risk, monitoring performance and for sharing learning to improve services.

At this inspection, we found that those areas previously regarded as inadequate practice were now embedded throughout the practice. The practice is therefore now rated good for providing safe services.

## 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"><li>At this inspection we found that governance arrangements had improved. For example, systems and processes related to triage and access had been reviewed with the support of others from the federation and Integrated Care Board (ICB). A full review of access to the practice had been completed through the accelerate programme. The accelerate programme was designed by NHSE to support the development of GP practices through review, improved practices and monitoring.</li><li>The clinicians / management team acknowledged the challenges they faced following the inspection in November 2022 when the practice was rated as inadequate. We found that clinical staff and managerial leadership team had worked hard to develop a resilient and sustainable service. This included building a stable staff team and reassuring patients.</li><li>We saw evidence of a clear and identified leadership structure and staff expressed a confidence in the leadership team.</li><li>Leaders understood and acknowledged other challenges impacting on the delivery of the service, which included deprivation and health inequalities. The leaders worked with the federation and ICB to address these. This provided opportunities to develop and improve services for their practice population.</li><li>Staff we spoke with told us of the opportunities they had been given to develop in their roles.</li></ul>	

## Vision and strategy

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

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>Staff were able to tell us about the vision for the development of the practice. This related to improving the services and care for the local population. Practice staff worked closely with other practices within the federation to achieve this and had developed their own business plan to monitor their progress.</li></ul>	

## 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
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>Staff we spoke with were positive about the culture of the practice. They found leaders supportive of their wellbeing and they operated zero tolerance of aggression towards staff.</li><li>The practice had a named freedom to speak up guardian and staff felt able to raise concerns.</li><li>Staff understood the requirement of the duty of candour. Following the last inspection, the management team had reviewed their systems for identifying, recording and learning from clinical incidents to support compliance with the requirement of duty of candour.</li></ul>	



- A sample of staff records showed that all staff had received and were up to date with Equality and Diversity training as part of the practice's mandatory training requirements.

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

Source	Feedback
Staff Interviews	<ul style="list-style-type: none"> <li>• Staff told us that the practice team was supportive and there was a culture of openness and honesty.</li> <li>• Staff told us they were included in any changes planned to support improvement of the practice.</li> </ul>

### 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
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• Staff had access to policies and procedures that were regularly updated and validated by one of the GP partners.</li> <li>• Following the inspection in November 2022 the practice introduced comprehensive meeting structures. These included clinical, practice and staff specific meetings. A regular daily huddle was also newly introduced. The huddles were intended to give staff the opportunity to discuss any issues whether good or of concern on a daily basis following the morning clinic sessions.</li> </ul>	

## 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 quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• Issues identified at the inspection in November in relation to the management of risk had been reviewed and changes made to provide assurances that effective systems had been implemented.</li><li>• We found that detailed minutes of meetings held showed that the arrangements to evidence improvement in learning from clinical audits and incidents were clearly identified. We saw these areas were included as regular agenda topics and the minutes of detailed discussions held, action to be taken and learning for staff were shared. Individual clinical audit reports and incident reports had also been completed.</li><li>• The uptake of cervical screening remained below the national average. The practice staff continued to work with patients to address this. Practice data shared with us showed that there had been an increase in the number of eligible patients screened.</li><li>• The take up of childhood immunisations in 4 of the 5 indicators had increased since the last inspection.</li></ul>	

## 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 monitor and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• The practice manager, with the support of the reception / administration staff, maintained oversight of the clinical registers for patients with long term conditions to ensure they were recalled for annual health reviews.</li></ul>	

- Our clinical searches confirmed that the majority of patients attended their appointments.
- The systems and processes to ensure non-clinical staff made appropriate and timely escalation of clinical concerns were reviewed, monitored and improved. Non-clinical staff had been supported to undertake additional training and had the support of a mentor.

## Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
The provider was registered as a data controller with the Information Commissioner's Office.	Y
Patient records were held in line with guidance and requirements.	Y
Patients were informed and consent obtained if interactions were recorded.	Y
The practice ensured patients were informed how their records were stored and managed.	Y
Patients were made aware of the information sharing protocol before online services were delivered.	Y
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Y
Online consultations took place in appropriate environments to ensure confidentiality.	Y
The practice advised patients on how to protect their online information.	Y
Staff are supported to work remotely where applicable.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• Staff had access to training in relation to information governance and General Data Protection Regulation (GDPR) as part of the practice's mandatory training requirements.</li> <li>• The practice used approved secure systems for communicating with patients.</li> <li>• The practice held a service level agreement with their local federation to provide data protection services for the practice.</li> <li>• There was information provided to patients on the practice's website about data security and the answerphone message advised patients that calls were recorded.</li> <li>• Staff told us that when they spoke to patients remotely, they asked questions to confirm the patient's identity before sharing any information.</li> </ul>	

## 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
The practice had an active Patient Participation Group.	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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"><li>• Staff were able to raise suggestions and give feedback through the practice meetings, on an informal basis and through appraisals.</li><li>• The practice had an active patient participation group (PPG), the numbers of which varied at meetings. Patients who were unable to commit to attending regular meetings were encouraged to attend as and when they could.</li><li>• PPG meetings had recommenced following the impact of the COVID -19 pandemic and were held 3 monthly. The last meeting was held in May 2023 and was attended by 6 patients. The minutes of the meetings were available on the practice website and at the practice for all patients to access.</li><li>• The practice actively followed up on the outcome of the GP national patient survey and developed an action plan to support improvements where needed.</li><li>• The provider worked with stakeholders and GP practices within their Primary Care Network (PCN). This allowed for sharing and learning to promote improvement in patient care.</li><li>• Staff were able to raise suggestions through the practice meetings.</li><li>• Staff told us that as a small practice they were able to provide feedback and felt involved in what was going on in the practice such as providing input into the refurbishment of the premises.</li><li>• Following the outcome of its inspection in November 2022 the practice received support from the Royal College of General Practitioners (RCGP), NHSE and the ICB to review and audit its systems and processes and put a working action plan in place.</li></ul>	

## Feedback from Patient Participation Group.

Feedback
<ul style="list-style-type: none"><li>• Patient Participation Group (PPG) members we spoke with told us that patients were encouraged to provide feedback when visiting the practice, through the practice website and through the PPG members.</li><li>• PPG members felt that the updated telephone system was having a positive impact, making it easier for patients to get through to the practice.</li></ul>

## 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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"><li>• At the last inspection in November 2022 practice staff were unable to demonstrate that there were systems in place to support ongoing learning and improvement among the practice team. At this inspection we found that arrangements in place supported learning and improvement through clinical incidents, clinical updates and audits, and clinical supervision.</li><li>• Records we examined included the minutes of meetings. These showed that learning was shared with staff and changes were implemented and monitored to support improvement.</li><li>• Practice staff were encouraged and supported to develop their skills to maintain competences and professional development was supported.</li><li>• Staff received regular appraisals to discuss learning and development needs and their performance.</li></ul>	

## Examples of continuous learning and improvement

- Following the inspection in November 2022 the GP partners, management team and practice staff met with the Birmingham and Solihull Integrated Care Board (BSol ICB) to discuss the outcome of the inspection. The ICB provided peer support to the practice through its quality and contracting team.
- The practice received varied levels of support from other organisations, which included the Primary Care Network (PCN) and the local medical committee (LMC).
- The practice was supported by the PCN safeguarding lead for the ongoing maintenance of the practice safeguarding registers.
- The practice received support from the Royal College of General Practitioners (RCGP). They supported practice staff to carry out an audit and develop an action plan with timescales.
- The practice was taking part in several improvement projects developed by NHSE and the integrated care system (ICS). To support improvements, the practice staff were participating in the NHSE accelerate programme. The accelerate programme was designed to support the personal and professional development of GP practices. Areas identified to be looked at in depth included appointments, patient flow (the movement of patients through the practice systems) and standards. The process included all staff identifying what the problems were in relation to these areas, why improvements were needed, how improvements would be made and a plan of action for monitoring and auditing the changes made.
- Training in supervision had been completed by the GP partners to support them to undertake appropriate supervision of the advanced nurse practitioner and health care assistant.

### 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 Bands	Z-score threshold
Significant variation (positive)	$\leq -3$
Variation (positive)	$> -3$ and $\leq -2$
Tending towards variation (positive)	$> -2$ and $\leq -1.5$
No statistical variation	$< 1.5$ and $> -1.5$
Tending towards variation (negative)	$\geq 1.5$ and $< 2$
Variation (negative)	$\geq 2$ and $< 3$
Significant variation (negative)	$\geq 3$

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. Note that practices that have “Met 90% minimum” have not met the WHO target of 95%.
- 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.
- 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). This indicator does not have a CCG average and is scored against the national target of 80%.

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>

Note: The CQC GP Evidence Table uses the most recent validated and publicly available data. In some cases at the time of inspection this data may be relatively old. If during the inspection the practice has provided any more recent data, this can be considered by the inspector. However, it should be noted that any data provided by the practice will be unvalidated and is not directly comparable to the published data. This has been taken into account during the inspection process.

#### **Glossary of terms used in the data.**

- **COPD:** Chronic Obstructive Pulmonary Disease.
- **UKHSA:** UK Health and Security Agency.
- **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.
- ‰ = per thousand.