Care Quality Commission

Inspection Evidence Table

Cape Hill Medical Centre (1-555667421)

Inspection date: 2 October 2019

Date of data download: 30 September 2019

Overall rating: Outstanding

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

Effective Rating: Good

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
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 used digital services securely and effectively and conformed to relevant digital and information security standards.	Y

Explanation of any answers and additional evidence:

- The practice carried out a daily review of outstanding tasks and the team were sent reminders to action. The practice monitored each staff member to ensure all tasks were actioned appropriately and in a timely manner.
- Patients' immediate and ongoing needs were fully assessed. This included their clinical needs, both physical and mental and social needs.

- The practice had implemented a wellbeing hub which to support patients with their ongoing needs. The hub had two link workers who supported patients with their social problems such as debt, poor housing, fuel poverty and, immigration problems. The practice had found the wellbeing hub had had a positive impact on patients through social prescribing schemes. Unverified data provided by the practice showed between April 2018 and March 2019 a total of 964 patients had been seen by the link workers.

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2018 to 30/06/2019) (NHSBSA)	0.38	0.75	0.75	Tending towards variation (positive)

Older people — Population group rating: Outstanding

This population group was rated outstanding because services were tailored to meet the needs of individual people. The practice consistently reviewed the systems they had in place to ensure that patients received the appropriate care and treatment and were well supported.

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- The practice continued to be accredited for the Gold Standards Framework and had achieved the Gold Standards Framework award in 2016 and had been awarded again in 2019 for end of life care and had been awarded Gold Standard Framework Primary Care Practice of the Year for 2019. The accreditation for this award was due to the ongoing improvements demonstrated in the care of patients during end of life. Data provided by the practice showed they had 139 patients on the Gold Standards Framework register. The care of these patients was led by a single clinical lead who co-ordinated the package of care with the clinical team and ensured a team approach was implemented for the effective management of patients on the register. Data provided by the practice showed that 50% of patients cared for at home between March and May 2019 had died in their place of choice and 56% of patients in the nursing homes had died in their place of choice. Further data showed overall the practice had achieved 60% of patients had died in their preferred place of choice in the past six months.
- The clinical staff carried out weekly ward rounds at three local nursing homes and two care homes. The practice carried out this role as part of a local enhanced service and received funding for supporting two homes, however due to the demand for home visits and an increase in A&E attendances, the practice implemented the ward rounds at all of the homes to ensure patients were receiving regular reviews and appropriate care. A total of 163 patients were registered at the practice from the five homes. The practice had a total of 78 patients at the three homes not under the local enhanced service.
- To further support the staff working at the five nursing/care homes, the practice had

implemented an education programme to support them in their role. The training involved talking through case scenarios and the processes to follow. They were also trained on how to use the RESPECT form (Recommended Summary Plan for Emergency Care and Treatment) and the actions to take if the clinical condition of a patient changed. The training also included sepsis awareness, when to call emergency services and processes to follow in dehydration and patient agitation. Data provided by the practice showed a total of seven staff had been trained across the five homes. During April 2019 and May 2019 there had been 14 attendances to A&E. Unverified data provided by the practice, showed over the past two months there had been a 14.8% reduction in A&E attendances. The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.

- The practice carried out structured annual medication reviews for older patients.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

People with long-term conditions Population group rating: Good

Findings

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- The practice had a home visiting service in place which was run by the advanced nurse practitioner team. This service was coordinated to ensure patients who could not visit the practice were managed and cared for appropriately. Evidence provided following the inspection showed the practice had seen an increase in patients on the housebound register from 83 to 113 from 2017/18 to 2019. Due to the complexities of some of the patients, patients were exception reported on an individual basis depending on the severity of their conditions and being on maximum tolerated therapies.
- The practice maintained a register of patients with prediabetes. Patients on the prediabetes register were recalled annually for a HbA1c check. The practice had seen an increase in the number of patients with prediabetes. In 2018/19 the prediabetes register had 406 patients, of which 29 new diabetics were identified. Unverified data provided by the practice showed in November 2019 the prediabetes register had 502 patients, of which a further 23 new diabetics had been identified through the annual recall.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice 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 atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	86.3%	80.1%	78.8%	No statistical variation
Exception rate (number of exceptions).	23.7% (202)	12.5%	13.2%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2017 to 31/03/2018) (QOF)	81.2%	77.2%	77.7%	No statistical variation
Exception rate (number of exceptions).	20.6% (176)	10.4%	9.8%	N/A

	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2017 to 31/03/2018) (QOF)	88.3%	81.3%	80.1%	Tending towards variation (positive)
Exception rate (number of exceptions).	23.1% (197)	11.4%	13.5%	N/A

Other long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2017 to 31/03/2018) (QOF)	71.6%	76.6%	76.0%	No statistical variation
Exception rate (number of exceptions).	1.6% (15)	6.3%	7.7%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2017 to	93.2%	91.4%	89.7%	No statistical variation

31/03/2018) (QOF)				
Exception rate (number of exceptions).	6.9% (12)	11.2%	11.5%	N/A

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2017 to 31/03/2018) (QOF)	81.5%	83.1%	82.6%	No statistical variation
Exception rate (number of exceptions).	4.8% (73)	4.5%	4.2%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2017 to 31/03/2018) (QOF)	83.6%	88.7%	90.0%	No statistical variation
Exception rate (number of exceptions).	10.1% (13)	8.2%	6.7%	N/A

Any additional evidence or comments

For all patients with long term conditions, the practice had a recall system in place and sent three invitation letters to patients and followed this up with phoning and texting of patients to encourage them to attend their reviews. One of the administration staff had been assigned the recall process to ensure patients were followed up appropriately. This included:

- For patients that were housebound the district nurses were requested to obtain blood and urine for testing prior to patients' having their own diabetes annual review.
- For patients that could not attend the practice, the nursing team carried out home visits to do reviews and opportunistic reviews were also completed when patients attended the practice.
- A letter was sent to patients to advise them of the date and time the advanced nurse practitioner/practice nurse would be visiting.
- Once the annual diabetes review had been completed a recall was added to the clinical record for the following year and an alert was added to the system.
- If a patient was exception reported following a clinical review, an alert was added to the patients' clinical record to be added to the recall list for the following year.

The practice told us they planned complete a review of exception reporting processes for all areas. This included:

- Implement a QOF exception reporting steering group to look to review and implement changes to improve exception reporting rates.
- Aim to do all routine patient reviews in the first months of the QOF year, leaving time to target patients who had not attended appointments including using extended access appointments for working patients.

The practice sent further evidence following the inspection of the outcome of the QOF exception reporting steering group. The action plan from the meeting included:

- To implement diabetes clinics to take place at weekends during extended access sessions
- To source letters used in call and recall in multiple languages to suit our population
- To provide training for clinicians in shared decision making and motivational interviewing, in order to better engage with those patients who currently decline elements of their care.
- To review the diabetes template on the practice computer system, to better record the outcomes of shared decision-making conversations. This will support patients in facilitating shared decision making. Where patients are exception reported, this will also show a clear rationale for doing so
- To have an in-house "diabetes week" to promote self-care, to better engage with the practice diabetic population and increase monitoring of patients' management of their conditions.
- A GP will telephone persistent non-attenders to explain the consequences of not looking after their diabetes, using motivational interviewing and shared decision making techniques.

The practice clinical prevalence for diabetes was 10.24% of the practice population. Clinical prevalence is used to show the proportion of people in a population having a disease.

QOF data for 2018/19 which was published following the inspection, showed no improvements in exception reporting rates for diabetes. Further data was submitted following the inspection which showed the most recent data demonstrated a reduction in exception reporting for diabetes from 23.7% in 2018/19 QOF to the current achievement of 16.59%

Following the inspection, the practice submitted further evidence to support the higher than local and national average exception reporting rates. The practice told us they had an active programme to monitor housebound patients. The practice had seen an increase in the number of patients on the housebound register from 83 patients in 2017/18 to 113 patients in 2018/19. The housebound programme was coordinated and managed on a monthly basis by an administrator who allocated visits to the advanced nurse practitioners as part of their home visiting service. Evidence provided showed that 28.57% of patients were excluded from having their HbA1c checked due to moderate and severe frailty. The practice followed a range of recognised clinical guidelines including NICE guidance for the management of diabetes.

Families, children and young people Population group rating: Good

Findings

- The practice was slightly below the 90% target for all of childhood immunisation uptake indicators. The practice had not met the WHO based national target of 90% (the recommended standard for achieving herd immunity) for four of four childhood immunisation uptake indicators.
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- With the support of a local paediatrician, the practice had developed a screening tool for children who arrived from overseas and did not fit into the national screening programme.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary. All primary and secondary care appointments not attended by children were coded and reviewed by a clinician. Following this review, the practice had a range of processes in place to follow up children. This included sending a letter to the parents/guardians, face to face appointment at the practice to discuss the reason the child had failed to attend their appointments and failed attendances were discussed as part of the safeguarding meetings.

- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- The practice had inhouse training for staff on female genital mutilation (FGM). There was a protocol in place which included processes for children at risk. The protocol was developed with the support of the travel immunisation nurses who use the protocol in their travel clinic appointments and also to support staff in supporting patients who have been traumatised by FGM.
- Young people could access services for sexual health and contraception.
- Staff had the appropriate skills and training to carry out reviews for this population group.

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) (01/04/2018 to 31/03/2019) (NHS England)	138	155	89.0%	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) (01/04/2018 to 31/03/2019) (NHS England)	157	177	88.7%	Below 90% minimum
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) (01/04/2018 to 31/03/2019) (NHS England)	158	177	89.3%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England)	158	177	89.3%	Below 90% minimum

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 practice encouraged patients to attend their appointments by continually sending out invitations and following up missed appointments with telephone calls and text messages. Patients who failed to attend on a regular basis were discussed with the health visiting team for follow up.

The practice had a strong recall system in place. An administrator supported the immunisation clinic by contacting patients who had not attended. Public Health was advised of patients' not attending their appointments. If the patient failed to attend the second appointment, the administrator called the patient

to encourage them attend. The administrator was bi-lingual and was able to engage and communicate with the practice population who did not have English as their first language. If patients failed to attend the third appointment, a final phone call is made then if patients still refuse to attend, a referral was made to the health visiting team. Notes were made on the clinical record that children had failed to attend immunisation appointments and the GPs opportunistically immunised patients when they attended the practice. Any Parents refusing immunisation for the child were advised to put their refusal in writing, which was then scanned into the records and public health was updated of the refusal.

The practice had developed a development screening tool for children who had missed the statutory development screening. This was used across the patient cultures and was developed with input from a consultant paediatrician with an interest in this area.

Working age people (including those recently retired and students)

Population group rating: Requires Improvement

Findings

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.
- In 2017 the practice had recruited two female practice nurses to replace the single nurse that had left to increase appointment availability. One of the nurses had a specialist interest in cervical screening. Patients are called who have not had a cervical smear and the nurses provide counselling on smear concerns. Saturday clinics have also been introduced to increase uptake.
- The practice had a high number of patients who smoked. Unverified data received following the inspection showed 1,610 patients were smokers and 1,608 had been offered smoking cessation advice. To support patients' a weekly clinic was held by the stop smoking service at the practice.
- As part of a local incentive scheme the practice ran screening programmes for patients aged 16 years to 35 years for TB testing for patients arriving from high risk areas. The practice have extended the scheme to include HIV, Hepatitis B and Hepatitis C testing which is also offered for at risk patients. Unverified data provided by the practice showed the practice had identified 68 patients with Hepatitis B / Hepatitis C and 12 patients had positive TB screening tests.
- To improve cancer screening targets, the practice had participated in the national cancer audit and sent patients who had not attended screening appointments, a personalised letter approved by Cancer Research UK to encourage patients to attend screening.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women	64.6%	N/A	80% Target	Below 70% uptake

aged 25 to 49, and within 5.5 years for women aged 50 to 64) (01/04/2017 to 31/03/2018) (Public Health England)				
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2017 to 31/03/2018) **(PHE)**	62.9%	63.8%	72.1%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5-year coverage, %) (01/04/2017 to 31/03/2018) **(PHE)**	39.0%	44.0%	57.3%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. (01/04/2017 to 31/03/2018) **(PHE)**	56.3%	74.2%	69.3%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2017 to 31/03/2018) (PHE)	44.7%	52.1%	51.9%	No statistical variation

Any additional evidence or comments

The practice was aware of the poor uptake rate for cervical screening. A steering group had been formed which met in June 2019 to discuss how improvements could be made. The steering group had identified there was particularly low uptake from the patients at the local high dependency unit and the learning disability residential care centres. Plans for improvement were implemented which included:

- Saturday clinics to be held every two weeks.
- To work with the local homes and dependency unit to raise awareness to improve uptake
- To complete an audit of ethnicity of patients who had not responded to arrange for literature to be sent in their first language and liaise with community groups.

The practice told us they had been following up on patients not attending cancer screening appointments over the past year. Patients who had not attended their appointments, were sent a personal letter from the GP to encourage them to attend screening. To offer further opportunities clinical staff encouraged patients to use the Saturday clinics that had been trialled over July 2019 and September 2019 to see if this contributed positively to patient attendance. Unverified data provided by the practice showed that in the July 2019 clinic there had been a 75% uptake and the second clinic in September 2019 the practice had achieved an 71% uptake. The practice were planning on carrying out the clinics on a regular basis.

Following the inspection further unverified data was received from the practice which showed during October 2019 and November 2019 two further Saturday clinics had been held. A total of seven appointments were available for cervical screening and six patients had attended, which demonstrated an 85% uptake.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check.
- Link workers were available at the wellbeing hub implemented by the practice who had
- One of the GP had a specialist interest in trauma medicine and supporting patients who had been traumatised by war. The GP had also received training from the Freedom from Torture foundation to provide specialised care for refugees.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- Same day and longer appointments were offered when required.
- There was a system for following up patients who failed to attend for administration of long-term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe. The practice had implemented a suicide prevention steering group to ensure high risk patients were receiving the appropriate monitoring and care. The steering group had met in September 2019 and had implemented a training session for all staff called 'See, Speak, Act'. The initiative was due to the suicide of patients the practice had previously experienced and to ensure all staff had appropriate training to identify and support patients who were experiencing suicidal and self-harm thoughts. The practice also developed a 'People do Care' card which was available in the consulting rooms and reception area for patients. The card detailed the contact numbers of support groups, the practice details and was specifically made so patients could carry in their wallets and purses. Suicide and self-harm guidelines were produced to ensure the service was proactive in the care and treatment of patients who were presenting to other services with risk of self-harm and suicide and the team had the appropriate guidelines to follow.
- The practice had implemented a steering group to review opioid prescribing. The steering group consisted of one of the GPs who works at the local prison and GPs at the practice who provided

supported the homeless population in Birmingham. The GPs had seen the damaging effect of opioids on patients. The steering group met and reviewed the evidence regarding opioid reduction in those using opioids, as well as safe prescribing of opioids for patients who would benefit from them. Unverified data provided by the practice showed this has led to a reduction in overall volume of opioids being prescribed by the practice.

- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	93.5%	93.3%	89.5%	No statistical variation
Exception rate (number of exceptions).	20.6% (36)	9.5%	12.7%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	91.9%	93.4%	90.0%	No statistical variation
Exception rate (number of exceptions).	8.0% (14)	7.8%	10.5%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	77.4%	85.9%	83.0%	No statistical variation
Exception rate (number of exceptions).	0.7% (1)	6.0%	6.6%	N/A

Any additional evidence or comments

- The practice had carried out an analysis of the mental health register to review the exception reporting rates. The analysis showed seven patients had not responded to appointment invitations and three had failed to attend appointments.
- To encourage patients to attend their reviews, the practice had started a programme of educational support with the local high dependency inpatient rehabilitation hospital to build relationships with the staff.
- The practices' social prescriber was working to encourage patients to attend reviews and screening.
- The practice had a range of steering groups in place to monitor the effectiveness of the services provided. One of the steering groups looked at opiate prescribing. An audit was completed, and a training quiz and action plan was implemented to ensure the correct initiation of opiates and safe prescribing.

Monitoring care and treatment

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

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	558.0	546.1	537.5
Overall QOF score (as a percentage of maximum)	99.8%	97.7%	96.2%
Overall QOF exception reporting (all domains)	9.7%	6.1%	5.8%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	Y
Quality improvement activity was targeted at the areas where there were concerns.	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 had reviewed evidence concerning the use of opioids for the management of long-term pain and the significant increase in the risk of harm when patients were prescribed 120mg morphine (or equivalent) per day. The practice set a threshold for prescribing of opiate medicines to less than 120mg per day and reviewed their prescribing of all medicines within this group.

- A steering group was set up and met five times between September 2018 and March 2019 and implemented the following actions:
- An audit of the patients on high dose opiates to ensure the appropriate guidelines had been followed.
- An educational package for the whole team which covered starting and stopping of opioids safely.
- A quiz of the effects of opioids. This was used as an educational tool for all clinical staff.
- Tools on how to monitor improvements in patients' pain control when starting an opioid
- Patient leaflets on how to manage pain
- The implementation of new templates to ensure all clinicians appropriately implemented and monitored the prescribing of opiate medicines.

Any additional evidence or comments
The practice had an audit plan in place which they regularly reviewed and actioned to ensure patients received appropriate care and monitoring and to ensure improvements were implemented to improve quality of service provision. An audit board was available which was updated with the latest actions taken and reviewed by the management team to ensure all opportunities to maximise learning and improved outcomes was implemented.

Effective staffing

The practice was able to demonstrate that staff had the skills, knowledge and experience to carry out their roles.

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Y
The learning and development needs of staff were assessed.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y

Explanation of any answers and additional evidence:

- The practice had invested in their staff to ensure they were able to offer more support to patients. This included supporting nursing staff develop in a range of clinical areas and supporting medical students and registrars in their medical training.
- The practice had completed a skill mix audit to assess they had the right skill mix for the services provided and for future initiatives. The outcome of the audit provided development opportunities for staff including nurses completing prescribing courses and development plans for the administration team to better support the practice manager.
- The practice had a range of educational meetings during the year to ensure staff had the appropriate knowledge to support them in their roles. The meetings were held on average each month and had covered a range of topics, which included heart failure, COPD, safeguarding training and medicines management.

Coordinating care and treatment

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

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2017 to 31/03/2018) (QOF)	Y
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Y
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	N/A

Explanation of any answers and additional evidence:

- We saw evidence to support that regular multidisciplinary meetings took place with community services. This included liaison and joint working with health visitors and district nurses. Safeguarding, palliative and end of life care was discussed in these meetings in addition to vulnerable patients and patients with complex care needs.
- The GP partners at the practice had developed a wellbeing hub to support the local population through a holistic approach. The hub involved a work coach, link worker, chaplain and counsellor working together to offer a co-ordinated care and support package with the GPs.

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, tackling obesity.	Y

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	96.2%	96.1%	95.1%	No statistical variation
Exception rate (number of exceptions).	0.5% (12)	0.6%	0.8%	N/A

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
The practice monitored the process for seeking consent appropriately.	Y
Policies for any online services offered were in line with national guidance.	Y

Caring Rating: Outstanding

The practice was previously rated as Outstanding and we found the practice continued to support patients and monitor the services they offered to ensure patients received appropriate care and treatment.

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:

- One of the GPs worked with Doctors of the World; a humanitarian movement with an interest in vulnerable refugee patients. The practice had set up a steering group of clinical and administration staff to review the services they offered to this group of patients and had implemented a protocol to support staff in their approach to supporting refugee patients. Learning was shared with the whole practice team to ensure all staff had an understanding of patients' needs. The lead GP also shared learning and carried out training on how they had implemented their protocol to medical students and through voluntary training schemes. Detailed discussions were held by the practice clinical team to ensure patients received both a holistic and medical care approach. This included using the practice's wellbeing hub to support the patients within the community.
- The practice had achieved the Royal College of General Practitioners (RCGP) Primary Care Practice Quality Hallmark award for end of life care. The End of Life Care programme considered all care parameters using NICE guidance as the basis and demonstrated improvements in every aspect care. This included documentation of advanced planning, patient preferences, bereavement support, holistic assessment of care, plus seven other elements. There were 139 patients on the practice's Gold Standards Framework register and a single clinical lead was in place that examined all clinical notes and co-ordinated care for patients as a whole team approach with ongoing education and regular clinical meetings. Data provided by the practice showed the practice had been able to support 60% of patients die in the preferred place of choice during the past six months.

CQC comments cards	
Total comments cards received.	2
Number of CQC comments received which were positive about the service.	2
Number of comments cards received which were mixed about the service.	0

Number of CQC comments received which were negative about the service.	0

Source	Feedback
CQC comment cards	The comment cards contained positive comments about the staff who were described as friendly, approachable and competent.
Interviews with patients	Patients we spoke with told us that the GPs and staff were very caring and approachable.
Feedback from nursing homes	We spoke with one of the nursing homes who highlighted that the GPs and nursing team were excellent and offered a care package to meet individual patient needs.
NHS Choices	Comments on NHS Choices highlighted staff were kind and helpful.
Friends and Family Test	The latest responses to the Friends and Family Test showed 85% of patients were extremely likely or likely to recommend the practice to others. This was based on 102 responses.

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
12034.0	472.0	114.0	24.2%	0.95%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2019 to 31/03/2019)	84.3%	86.8%	88.9%	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 (01/01/2019 to 31/03/2019)	80.6%	85.5%	87.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2019 to 31/03/2019)	92.8%	94.4%	95.5%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice	74.9%	80.1%	82.9%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
(01/01/2019 to 31/03/2019)				

Any additional evidence or comments
In order to improve patient satisfaction, the practice was piloting 15-minute appointments for all patients. The GPs found this provided them with more time to discuss patients' needs and provided improved management of patients conditions the practice in-house survey showed: • 90% of patients said the healthcare professional was good at listening to them. • 87% of patients felt the healthcare professional they saw was good at treating them with care and concern.

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

Any additional evidence
The practices' PPG representatives had carried out a survey during January and February 2019 with a total of 613 questionnaires being completed. The results showed positive responses to the care and treatment received by patients and the practice shared the outcomes with staff, patients and the patient participation group. All comments received were reviewed and acted on to improve patient satisfaction.

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:

The practice had developed a wellbeing hub from an awareness that the lack of wellbeing which brings people to seek help in general practice had multiple causes. Many of these could be addressed by the healthcare team, but sometimes a more holistic approach was required to ensure patients received the appropriate support. This included emotional, social and spiritual support. Since its implementation the practice had seen a positive impact on its patients.

- To meet the needs of the practice population and on reviewing patient feedback, a link worker to offer advice on local support groups and advice, a chaplain and counsellor and a work

coach to support patients to return to work. The aim of these roles was to provide high quality care, support and guidance to patients.

- Data provided by the practice showed between April 2019 and October 2019, 595 appointments had been offered to patients with the link worker of which 502 patients attended to receive support and advice.
- The practice had been asked to trial a pilot of the Thrive to Work programme by the Department of Work and Pensions. The practice were the first to implement this pilot in September 2018. Unverified data provided by the practice showed that 81 patients had attended the programme with 12 unsuitable to proceed, three in successful employment, seven undertaking voluntary work and the remainder currently being assessed through the programme.

Source	Feedback
Interviews with patients.	Patients we spoke with told us the practice staff were approachable, listened and were very supportive. The care received was excellent.
CQC Comment cards	The comments cards highlighted practice staff were caring and supportive.
Nursing homes	The home told us they received ongoing support from the GPs and nursing team and patients and their families were kept updated with any changes to the patients ongoing care.

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2019 to 31/03/2019)	87.8%	91.9%	93.4%	No statistical variation

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

Carers	Narrative
Percentage and number of carers identified.	The practice had a total of 139 carers on the register. This represented 1% of the practice list.
How the practice	The practice identified carers through regular searches of the clinical

supported carers (including young carers).	system and through the registration process of new patients. A carers champion was in place, a carers pack was available with information on local services available and carers were offered 30-minute appointments when seeing a clinician.
How the practice supported recently bereaved patients.	Families were offered advice and support and directed to local support organisations.

Privacy and dignity

The practice respected patients' privacy and dignity.

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

Responsive Rating: Good

Responding to and meeting people's needs

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

	Y/N/Partial
The 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

Explanation of any answers and additional evidence:

- Due to patient demand since December 2018, all appointments were a minimum of 15 minutes with GPs. The GPs found this provided them with improved management of patients and gave patients more time to discuss their needs.
- The nursing team carried out home visit clinics six sessions a week to support patients who were unable to attend the practice.
- A walk-in clinic was available both morning and afternoon to support patients that needed to see a GP urgently.
- The practice initially provided extended access through the local hub. However, the practice found the model of service provision was not suitable for the practice population who found it difficult to travel to the nearest hub. The practice reviewed the uptake of patients attending the hub which showed on average 14 patients per month accessed this service. To improve patient access to extended hours, the practice chose to take back the extended access and provide the service themselves to their patients. By bringing extended access inhouse the practice were able to increase the number of appointments available. Data provided by the practice showed that extended access use had increased to an average of 78 appointments per month.
- Due to the high number of patients who did not have English as their first language, the practice had online systems available for patients to use which included booking and cancelling appointments and ordering repeat medicines, but to ensure there was equal access for all patients a walk in surgery was available both morning and afternoon on a first come first served basis. To support this service the practice also had access to the language line to support with interpretation where required as booking of interpreters required 48 hours.
- Telephone consultations were available both morning and afternoon with priority given to the emergency services to use for patients nearing end of life.

Practice Opening Times	
Day	**Time**
Opening times:	
Monday	8am to 8pm
Tuesday	8am to 8pm
Wednesday	8am to 8pm
Thursday	8am to 8pm
Friday	8am to 8pm
Weekend	8am to 10am Saturday and Sunday
Appointments available:	
Monday	8am to 12pm / 2pm to 8pm
Tuesday	8am to 12pm / 2pm to 8pm
Wednesday	8am to 12pm / 2pm to 8pm
Thursday	8am to 12pm / 2pm to 8pm
Friday	8am to 12pm / 2pm to 8pm
Weekend	8am to 9.50am

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
12034.0	472.0	114.0	24.2%	0.95%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that at their last general practice appointment, their needs were met (01/01/2019 to 31/03/2019)	98.7%	93.2%	94.5%	Tending towards variation (positive)

Older people

Population group rating: Good

Findings

- The clinical staff carried out weekly ward rounds at three local nursing homes and two care homes. The practice implemented the ward rounds to ensure patients were receiving regular reviews and appropriate care. A total of 163 patients were registered at the practice from the five homes. The GPs and nursing team reviewed each patient and discussed with patients, home staff and patients' family's treatment plans and provided ongoing support, including the involvement of local services to ensure patients received the appropriate care and treatment.
- All patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice provided effective care coordination to enable older patients to access appropriate services.
- 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.
- There was a medicines delivery service for housebound patients.

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

Findings

- Patients with multiple conditions had their needs reviewed in one appointment.
- The advanced nurse practitioners offered home visit clinics. Two of the nurses were dedicated to these sessions. A total of six sessions were carried out each week to support patients with long term conditions who could not attend the practice. Data provided by the practice showed between April 2019 and October 2019 a total of 546 visits had been completed.
- The practice provided effective care coordination to enable patients with long-term conditions to access appropriate services.
- The practice liaised regularly with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues.
- Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.

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

Findings

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- To reduce A&E paediatric attendance rates, the practice had a nurse led paediatric clinic in place each evening after school hours. The clinic offered 12 appointments each evening to children under the age of 16 years.
- The practice staff had completed the training of the Identification and Referral to Improve Safety (IRIS), to become an IRIS accredited practice to support patients suffering domestic abuse.
- Midwife appointments were available twice a week at the practice.

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

Findings

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.

- The practice held daily nurse led minor ailment clinics for patients to improve access to services and ensure patients received timely care.
- The practice was open until 8pm Monday to Friday and on Saturday and Sunday mornings. A walk-in clinic was also available each morning and afternoon for patients that required urgent attention.
- A wellbeing hub on-site and the practice had employed a support team to provide high quality care and guidance to patients. The hub had a link worker to offer advice on local support groups and advice, a chaplain and counsellor and a work coach to support patients to return to work.
- Telephone consultations were available every day for patients who required advice. Online booking was also available for patients to book appointments in advance.
- The practice had developed a pilot with the Department of Work and Pensions to support patients to return to work. The programme called a "Thrive to Work" was the first practice to implement the programme in 2018. Data provided by the practice showed 81 patients had attended the programme. Twelve patients had been unsuitable to proceed, three were in successful employment, seven were undertaking voluntary work and the remainder of the patients were currently doing the programme.

People whose circumstances make them vulnerable — Population group rating: Outstanding

Findings

- One of the GP partners worked in the local prison on a sessional basis one day a week to review patients and offer advice and support.
- One of the GPs worked with Doctors of the World; a humanitarian movement with an interest in vulnerable refugee patients in the local population. The GP had worked with the clinical team to implement a protocol in the management and care of patients in vulnerable circumstances which had been shared with the whole team to ensure there was a co-ordinated approach for patients. To further ensure refugee patients received appropriate care and support, the GP lead had held training sessions for medical students and local voluntary schemes. Public Health Data showed 69.3% of the practice population were from Black and Ethnic Minority groups.
- 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 such as homeless people and travellers. The practice was the first surgery in the West Midlands to be certified as a safe surgery to reduce the difficulties for vulnerable people in registering with general practices.
- The link workers had experience of helping people who were asylum seekers, refugees, trafficked or enslaved and they used their links to support the clinicians in delivering care and in supporting the patients to access timely support. The link workers also worked with patients who needed social support, including debt advice and housing support.
- The practice had produced and implemented a range of policies and templates for the care of vulnerable migrants, centring around FGM, pregnancy and torture. Some of the staff had experience of working with vulnerable migrants. For example from working in specialist centres for Asylum Seekers and Refugees. Unverified data provided by the practice showed from the

last five clinical sessions one of the GP had seen a wide range of patients including 57% who were non English speakers and 34% were refugees/asylum seekers.

- Guidelines had also been developed by the clinical staff for patients suffering post traumatic stress disorder (PTSD). The guidelines were used by the staff to support them in the care of patients who were suffering from PTSD due to a number of contributing factors, including torture and the effects of war.

- The practice provided effective care coordination to enable patients living in vulnerable circumstances to access appropriate services. This included:

  - A wellbeing hub on-site and the practice had employed a support team to provide high quality care and guidance to patients. The hub had a link worker to offer advice on local support groups and advice, a chaplain and counsellor and a work coach to support patients to return to work. Data provided by the practice showed between April 2018 and March 2019, 305 appointments were offered with the chaplain and counsellor.

  - Data provided by the practice showed between April 2019 and October 2019, 595 appointments had been offered to patients with the link worker of which 502 patients attended to receive support and advice.

  - The practice had been asked to trial a pilot of the Thrive to Work programme by the Department of Work and Pensions. The practice were the first to implement this pilot in September 2018. Unverified data provided by the practice showed that 81 patients had attended the programme with 12 unsuitable to proceed, three in successful employment, seven undertaking voluntary work and the remainder currently being assessed through the programme.

  - The practice had identified some patients were attending the practice frequently. A total of 19 patients had attended consultations at the practice on average 13.9 appointments per patient over a six-month period. To ensure all the patients' needs were being met, the in-house social prescriber contacted each patient to offer support and advice of local services. Following support by the social prescriber the practice had seen a reduction of attendance to an average of 8.8% as both their medical and social needs were being met appropriately.

- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

- Priority appointments were allocated when necessary to those experiencing poor mental health.
- The practice undertook one GP session per month under a local incentive scheme arrangement to support a local high dependency women's mental health facility. The clinical team liaised regularly with the psychiatric team to ensure patients were receiving the appropriate care and treatment.
- One of the GP partners held a clinic at the local prison on a weekly basis to offer medical support and advice.
- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.

- The practice was aware of support groups within the area and signposted their patients to these accordingly.
- As part of the wellbeing hub at the practice, a Chaplain was available to support patients with mental health needs. The chaplaincy was for all faiths or none and provided counselling care. This was part of a whole person holistic approach the practice had implemented to support patients. Unverified data provided by the practice showed during April 2018 to March 2019 a total of 85 patients were offered appointments with the chaplain, of which 73 were seen.
- Unverified data provided post inspection showed during April 2018 and March 2019 a total of 78 patients had been offered appointments and 73 had been seen by the inhouse counselling service. This had reduced the waiting times for patients trying to access mental health support and counselling services in the community and supported patients at dealing with their problems in an appropriate and accessible setting, as well as reducing the burden on local services.
- One of the GPs worked one day a week for Birmingham's neuropsychiatry department, supporting patients with life-limiting neuropsychiatric conditions. The GP had also completed training from the Royal College of General Practitioners (RCGP) in veterans healthcare to support patients in the armed forces.
- A wellbeing hub on-site and the practice had employed a support team to provide high quality care and guidance to patients. The hub had a link worker to offer advice on local support groups and advice, a chaplain and counsellor and a work coach to support patients to return to work.
- The practice worked with Birmingham and Solihull Mental Health Trust to support the Health Exchange, which provided primary care services to the homeless population of Birmingham to ensure primary care services were accessible for everyone. The GPs carried out five sessions per week on a locum basis to help and support people attending the Exchange.

Timely access to the service

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

National GP Survey results

	Y/N/Partial
Patients with urgent needs had their care prioritised.	Y
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Y
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	Y

Explanation of any answers and additional evidence:

- A walk-in service was available morning and afternoon for patients that required urgent medical attention.
- The advanced nurse practitioners offered home visit clinics. A total of six sessions were carried out each week to support patients with long term conditions who could not attend the practice.

Indicator	Practice	CCG average	England average	England comparison

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2019 to 31/03/2019)	37.6%	N/A	68.3%	Significant Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2019 to 31/03/2019)	48.8%	61.4%	67.4%	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 (01/01/2019 to 31/03/2019)	53.4%	61.2%	64.7%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2019 to 31/03/2019)	56.2%	69.0%	73.6%	Tending towards variation (negative)

Any additional evidence or comments

total of 613 patients had responded to the in-house survey carried out during January and February 2019. The results showed:

- 58% of patients responded positively to getting through to someone at the practice by telephone.
- 69% of patients were satisfied with the overall experience of making an appointment.
- 85% of patients were satisfied with their appointment times.
- 69% of patients were satisfied with the type of appointment offered.

Further evidence showed:

- The practice offered on average 1,734 appointments per month, which was 38% more than they were contracted to offer.
- The practice was trialling 15-minute appointments to see whether this allowed them to deal with demand better, with clinicians having more time to spend with patients.
- The current phone system was installed three years ago, however the practice had identified that the system was not suitable and limited the practice in being able to monitor call flow efficiently. The practice was in the process of having a new telephone system installed which would allow improved text messaging and a visual board for staff to monitor calls and be more responsive when the phone lines were busy.
- A walk-in service was available both morning and afternoon for patients that require to see a GP urgently.
- To support children not losing time from school to attend the practice, the nursing team held a paediatric clinic each afternoon after school to see children who required medical attention.
- The practice has a high number of patients who do not attend appointments. Evidence provided by the practice showed during the month of August 2019 a total of 439 patients had failed to

attend their appointments. The practice with the support of the Patient Participation Group (PPG) were monitoring this and following up on patients that continually failed to attend. The PPG were speaking with patients on the importance of cancelling appointments if they were no longer required. The practice had seen an average decrease of 200 patients not attending appointments on a monthly basis.

The practice summarised comments received through other sources, for example: Friends and Family test and NHS Choices and used these to discuss with the team and share patients' views.
The practice had produced an action plan from the in-house survey they had implemented between January and February 2019. The plan included:

- A more interactive telephone system to improve access. An increase in online appointments and more appointment availability of an evening and weekend. The practice had also implemented more clinical staff offering appointments at the walk-in clinics to reduce patients' waiting times.

Source	Feedback
NHS Choices	Comments on NHS choices were mixed regarding access, with some patients highlighting the difficulty in getting appointments and the cancellation of appointments.
Nursing homes	Nursing home staff told us that the practice responded quickly to visit requests and they were able to contact the surgery easily and all enquiries were dealt with promptly and efficiently.

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.	7
Number of complaints we examined.	3
Number of complaints we examined that were satisfactorily handled in a timely way.	3
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

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

Explanation of any answers and additional evidence:

- Information on how to make a complaint was available in the waiting area.
- The practice management team were able to demonstrate that complaints were being used to drive continuous improvement.
- All complaints including verbal complaints were documented and responded too in a timely manner.

- All complaints and compliments were shared with staff. Evidence we saw showed complaints were discussed at staff meetings.

Example(s) of learning from complaints.

Complaint	Specific action taken
On taking a new medicine, side effects were experienced.	• The GPs reviewed the medical records of the patient and responded to the patients' concerns. • The side effects experienced were discussed with the patient. • The medicine was adjusted to a more suitable dose.
Length of time in receiving repeat medicine requests	• A letter of apology was sent to the patient. • A review of the rationale for the delay was completed • A written explanation was sent to the patient.

Well-led Rating: Outstanding

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

Leadership capacity and capability

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

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

Explanation of any answers and additional evidence:

- The management team were aware of the challenges faced within the local community. The practice had a realistic strategy and supporting objectives to respond to these challenges as well as maintaining quality and sustainability. The practice was situated in one of the most deprived areas according to data provided by Public Health England.
- Staff we spoke with explained that the partners and managers were visible and approachable. Staff described the practice team as supportive. Partners demonstrated a genuine passion to tackle health inequalities and there was a systematic approach with strong governance arrangements when working with stakeholders to improve care outcomes.
- The practice had recognised the need for a co-ordinated approach to the management of patients' care in the locality and to ensure patients' needs were met appropriately the practice offered a combined approach of medicine and support for improving health and wellbeing. This included a wellbeing hub funded by the GP partners to offer patients the opportunity to access counselling, advice and support.
- Staff reported that they felt well led and part of a team. There was strong collaboration and support across all teams and a common focus on improving the quality of care and people's experiences.
- Staff met regularly to discuss any issues or complex cases and to offer and receive peer support.
- The practice offered support to local nursing homes. This included an education programme to support them in their role. This included sepsis awareness training, when to call emergency services and processes to follow in dehydration and patient agitation.

Vision and strategy

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

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Y
There was a realistic strategy to achieve their priorities.	Y
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence: • There was a mutual vision among the GPs and staff to provide health and social care for the benefit of patients. • The practice values were to provide leadership and support to ensure patients, staff and external stakeholders received clear pathways to achieve improved outcomes. • Staff we spoke with demonstrated clear understanding of the practice vision, value and strategy and applied this in their role.	

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
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's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	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: • The practice discussed at monthly management meetings quality standards along with other information such as incidents and complaints.	

- There was a whistle blowing policy which allowed staff to refer any concerns directly to the provider if they felt unable to raise them with a local practice.
- There was a strong emphasis on the safety and well-being of staff. One of the key objectives was to focus on a sustainable workforce and create better work life balance. This was being delivered through the development of staff.
- Staff were very positive about working at the practice. Staff told us they had received constant support from the GPs, managers and team. There was a positive attitude throughout the entire workforce which enabled the smooth running of the practice.
- Staff had clear roles and responsibilities and staff wellbeing was discussed as part of the appraisal process.
- The practice encouraged staff to report incidents and share learning. Staff told us there was a 'no blame' culture and staff were well supported when reporting incidents.

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

Source	Feedback
Staff	• Staff we spoke with said they were well supported and part of the team. • The GP partners and management team were pro-active in ensuring all staff worked together to ensure everyone had a positive experience at the practice and received the care and treatment they required. • Support was available when required and the open-door policy of the managers and GPs was appreciated as staff felt they could approach any of the management team for advice and help.

Governance arrangements

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

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

Explanation of any answers and additional evidence:

- The practice had a system to ensure all staff were clear on their roles and responsibilities. Induction plans for new staff were tailored to the individual and there was a clear structure and accountability process in place.
- Communication was effective and organised through structured, minuted meetings. Governance and performance management arrangements were proactively reviewed and reflected best practice.
- All clinicians met regularly to discuss work prioritisation and vulnerable patients as well as difficult cases and current events. There was a good relationship with community teams to ensure patients received effective co-ordinated care.
- The practice had a range of systems in place to ensure the practice was efficient. The clinical management group ensured processes were co-ordinated and any changes were implemented

through a team approach.

- There was an open culture and clear learning culture within the practice. The practice encouraged the reporting of incidents, to identify ways in which the practice could continually improve.
- Practice staff were supportive of others in the local health community. They actively supported the local nursing/care homes, prison and health exchange. This ensured the patients' health and care needs continued to be met. Innovation from the practice also focussed on the benefits to the wider health economy for example, reducing the number of elderly patients attending accident and emergency by carrying out weekly ward rounds of the nursing/care homes.

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a systematic programme of clinical and internal audit.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y

Explanation of any answers and additional evidence:

- Performance and risk were managed by the leadership team. Monthly management meetings were held to review quality standards were being met and quality and risk was being managed appropriately. These were monitored along with complaints, significant events and safety alerts governance management processes.
- The practice had undertaken several risk assessments relevant to the provision of clinical care, including infection control and premises risk assessments. There was an ongoing plan in place to continually monitor risk and act on identified actions.
- Governance and performance management arrangements were proactively monitored and updated.
- The practice implemented a system for ongoing reviews to ensure processes were being followed when recruiting new staff, this included a tailored induction plan, appropriate checks, training programme and the continuous monitoring of staff development.
- Incident reporting was integral to learning and improvement. The practice used all safety concerns (incidents and complaints) as a foundation to review and manage all possible risks. The management of risk was demonstrated as a team effort and all the staff were proactive in ensuring risks were mitigated.

Appropriate and accurate information

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

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

Explanation of any answers and additional evidence:

- A range of steering groups had been implemented to improve service provision and patient outcomes. This included regular reviews of all information to ensure patients were receiving the appropriate care and treatment.
- A comprehensive range of risk assessments to ensure patient safety were in place and monitored regularly.
- The practice used clinical data to drive performance and demonstrate improved outcomes for patients. This included the implementation of a range of initiatives to support vulnerable patients. For example: patients at risk of suicide and patients requiring support and advice on local services. The practice had implemented a steering group to review this vulnerable group of patients. The steering group had met regularly and implemented a range of actions. For example: A training session for all staff called 'See, Speak, Act'. The practice also developed a 'People do Care' card which was available in all of the consulting rooms and the reception area for patients. The card detailed the contact numbers of support groups, the practice details and was specifically made so patients could carry in their wallets and purses. Suicide and self-harm guidelines were produced to ensure the service was proactive in the care and treatment of patients who were presenting to other services with risk of self-harm and suicide and the team had the appropriate guidelines to follow.

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

Explanation of any answers and additional evidence:

- Staff feedback highlighted a strong supportive team was in place. Staff said the leadership team

proactively asked for their feedback and suggestions about the way the service was delivered, any ideas were discussed at staff meetings. Staff told us everything was a team effort, and everyone was treated as an equal and their opinions and ideas were valued.

- An in-house survey had been completed during January and February with the support of the patient participation group (PPG). The questions for the survey had been discussed and agreed with the PPG prior to being distributed to the patients. The PPG supported the practice in distributing the questionnaires in the waiting room and encouraging patients to complete them. Interpreters were available to support patients who could not speak English to ensure all patients had the opportunity to feedback on the services provided. A total of 613 responses were received.

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

- The Patient Participation Group (PPG) was very active and supportive of the practice. The PPG had 12 in the group. We were told that on average six to eight patients attended the meetings. The group met on average every two months.

- The clinical team worked with local stakeholders and services to support the local population. This included a weekly GP clinic at the local prison and the practice worked with Birmingham and Solihull Mental Health Trust to support the Health Exchange, which provided primary care services to the homeless population of Birmingham to ensure primary care services were accessible for everyone.'

Feedback from Patient Participation Group.

Feedback
The patient participation group (PPG) told us that the practice acted on suggestions made by the group. For example: the PPG had worked with the practice to reduce the number of patients who hadn't attended their appointments by speaking with patients on the importance of cancelling appointments if they were no longer required. The practice had seen an average decrease of 200 patients not attending appointments on a monthly basis. The PPG had also fed into the prescription review process to reduce waste medicines.

Any additional evidence
The practice had discussed with the PPG an in-house survey and the PPG had assisted the practice in gathering patient feedback by distributing the surveys and encouraging patients to complete them. This also included involving interpreters and speaking to family and friends of patients who were non-English speaking to ensure all patients had the opportunity to share their views. Following the in-house survey, the practice had analysed the survey results with members of the PPG and had implemented an action plan to improve patient satisfaction scores. The plan included: • Lifestyle services – The practice told us they were working with the PPG to look at how they could provide lifestyle education sessions including walking groups for exercise to patients. • Another initiative was to work with community support groups to reach out to people that live on their own.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y

Explanation of any answers and additional evidence:

The practice continually focused on improvement and innovation through collaborative working. For example:

- To support the staff in the nursing/care homes, the practice clinical team had carried out a range of educational sessions to support the staff. This included step by step guides on when to call the emergency services and processes to follow in dehydration and patient agitation.
- Wellbeing hub funded by the GP partners to offer a co-ordinated package of care for patients including support and advice on local services. The hub also had a chaplain, a counsellor and a thrive to work programme representative to support vulnerable patients to return to work.
- An effective process was in place to ensure all staff were up to date with the practice's mandatory training. Staff told us they were given the opportunity to develop and learn.
- Continuous monitoring of training and development was carried out by the management team and learning from events, complaints and compliments was shared to enable lessons to be learnt and improvements to services were acted on. The practice continued to develop and implement processes for learning from incidents and reviews of patients with complex care needs to ensure patients were receiving appropriate care and treatment and risks were minimised. During the inspection we were provided with a range of case studies which demonstrated a systematic approach to the review and ongoing management of patients with complex needs and the outcomes of each review was shared across the team to ensure learning was maximised.
- The practice continued to be accredited for the Gold Standards Framework and had achieved the Gold Standards Framework award in 2016 and had been awarded again in 2019 for end of life care. and had been awarded Gold Standard Framework Primary Care Practice of the Year for 2019. The accreditation for this award was due to the ongoing improvements demonstrated in the care of patients during end of life. Data provided by the practice showed they had 139 patients on the Gold Standards Framework register. The care of these patients was led by a single clinical lead who co-ordinated the package of care with the clinical team and ensured a team approach was implemented for the effective management of patients on the register.

Examples of continuous learning and improvement
• The practice had approached local high schools to discuss young carers with the students. Two of the local schools had expressed an interest and the practice were working with the schools to deliver a presentation on carers and the support available to them. • One of the GPs worked with Doctors of the World; a humanitarian movement with an interest in vulnerable refugee patients. The practice had set up a steering group to review the services they

offered to this group of patients and had implemented a protocol to support staff in their approach to supporting refugee patients. Learning was shared with the whole practice team to ensure all staff had an understanding of patients' needs. The lead GP had also carried out training on the practice approach with medical students and through voluntary training schemes.

- The practice had been running a walk-in service for several years. A review of the service demonstrated mixed responses from patients with some commenting on having to wait when attending the practice for an on the day appointment. Following the feedback, the practice reviewed the current system and changed the service. Instead of a single clinician doing a walk-in clinic for the whole session, the first six appointments of each GP's session were allocated to the walk-in service. The same number of appointments were available each session, but with each GP sharing the walk-in clinic, this had reduced waiting times for patients.
- The practice found patients were not using the extended access hub. With the introduction of primary care networks, the practice moved extended access back to Cape Hill Medical Centre. The first month of the in-house extended access showed 80 patients had used the service in comparison an average of 14 patients a month at the local hub.

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)	≤-3
Variation (positive)	>-3 and ≤-2
Tending towards variation (positive)	>-2 and ≤-1.5
No statistical variation	<1.5 and >-1.5
Tending towards variation (negative)	≥1.5 and <2
Variation (negative)	≥2 and <3
Significant variation (negative)	≥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
- **PHE**: Public Health England
- **QOF**: Quality and Outcomes Framework
- **STAR-PU**: Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.