

Care Quality Commission

Inspection Evidence Table

OHP-Dr EJ Wigley & Partners (1-4233298418)

Inspection date: 13 February 2019

Date of data download: 30 January 2019

Overall rating: Good

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

Safe

Rating: Requires improvement

Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
There were policies covering adult and child safeguarding.	Y
Policies took account of patients accessing any online services.	N/A
Policies and procedures were monitored, reviewed and updated.	Y
Policies were accessible to all staff.	Y
Partners and staff were trained to appropriate levels for their role (for example, level three for GPs, including locum GPs).	Y
There was active and appropriate engagement in local safeguarding processes.	Y
There were systems to identify vulnerable patients on record.	Y
There was a risk register of specific patients.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none">• Policies are centrally produced by OHP and maintained on GP team net however practices are	

Safeguarding	Y/N/Partial
expected to make these practice specific. The provider's central team also review and update policies. Practices can also use their own policies as part of the OHP autonomy model. The practice told us they were using a mixture of their own and OHP policies.	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current Public Health England (PHE) guidance and if relevant to role.	Y
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Partial
Staff had any necessary medical indemnity insurance.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> Recruitment takes place at practice level although staff are centrally employed. The provider supports the practices in relation to recruitment for example advertising on the OHP website and newsletters. The central team produce standardised job descriptions for the practices. The provider has also developed a bespoke system for recruiting locum staff from an internal bank through working with a locum agency. Practices can go into this to request locum support and internal staff can input their availability to do locum work. The practice manager told us if they did use locum GPs, they would access them through the provider appointed agency. The practice printed the registration details during the inspection, however the practice was unable to demonstrate that they had systematic processes for ensuring registration of all clinical staff was monitored and kept up to date. 	

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test:	Y 24.2.18
There was a record of equipment calibration. Date of last calibration:	Y 7.2.19
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y
There was a fire procedure.	Y
There was a record of fire extinguisher checks. Date of last check: (also checked monthly by the practice)	Y 5.10.18
There was a log of fire drills. Date of last drill: 17.4.18	Y
There was a record of fire alarm checks. Date of last check:	Y 5.10.18
There was a record of fire training for staff. Date of last training: From staff files we reviewed we saw staff had received training	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion:	Y 30.1.19
Actions from fire risk assessment were identified and completed.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The action plan following the fire risk assessment had been produced by an external fire company for the practice, staff told us they had received it one day prior to the inspection, we saw that actions were ongoing. The practice sent us information following the inspection to show they had completed some of the actions, this included ordering fire exit signs and fire action notices. No issues were identified during the fire drill in 2018. We did not see evidence of a fire drill in 2017, we did however see evidence of drills in 2015 and 2016. 	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment:	Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 30.1.19 The risk assessment had been completed by an external company in January 2019. The practice manager told us they had received the action plan one day before the inspection, and actions were ongoing. One of the actions included staff to have training on the	Partial

evacuation chair. The practice manager informed us a date was to be arranged.

Explanation of any answers and additional evidence:

- Although we found no issues during the inspection the practice did not have a formal premises security risk assessment. The practice manager told us they had completed a visual security risk assessment, and taken appropriate action. However, had not documented the findings.
- The practice could not provide evidence of a formal risk assessment of accessibility of the premises in line with the equality act. We saw there was a hearing loop and a lift to the first floor. They showed us evidence of an assessment of their reception desk to improve accessibility, however had decided not to make any changes as it might increase the risk to staff. The assessment did not include any further actions to help maintain dignity of patients while they were accessing the front desk or indicate what date the assessment took place.
- We saw evidence of an external Legionella risk assessment carried out in April 2016 with ongoing monthly water checks carried out by the external company.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Partial
Date of last infection prevention and control audit: 97% in-house audit	12/12/18
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice had scored 97% in their infection control audit in December 2018, we saw they had acted to improve on areas where needed. We saw from the practice's staff training records the healthcare assistants and nursing staff had all completed the appropriate infection prevention and control training. However, seven out of eight GPs had not completed the required training in line with the practice's training policy. Following the inspection, the practice sent us evidence to show they had taken immediate action and the remaining GPs had completed the required training. 	

Risks to patients

There were adequate systems to assess, monitor and manage risks to patient safety.

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
Comprehensive risk assessments were carried out for patients.	Y
Risk management plans for patients were developed in line with national guidance.	Y
Panic alarms were fitted and administrative staff understood how to respond to the alarm and the location of emergency equipment.	Y
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There was a process in the practice for urgent clinical review of such patients.	Y
There was equipment available to enable assessment of patients with presumed sepsis or other clinical emergency.	Y
There were systems to enable the assessment of patients with presumed sepsis in line with National Institute for Health and Care Excellence (NICE) guidance.	Y

When there were changes to services or staff the practice assessed and monitored the impact on safety.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The OHP central team were working to develop resilience within the workforce so that they could better support member practices. This included:</p> <ul style="list-style-type: none"> • an internal locum pool managed through an external locum agency – both clinical and non-clinical staff who worked at an OHP member practice could join the scheme and offer their availability to support and work in other practices and practices could put out requests for staff when needed. The practice manager told us they used locum GPs through this internal pool. • GP career plus scheme – OHP were one of 11 pilot site developing ways in which they could retain GPs who were reaching the end of their career for example, through flexible working arrangements. • International recruitment of clinical staff. <p>Staff told us they did not use locum GPs very often. If they did, they had a locum pack which contained necessary information.</p>	

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment.

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referral letters contained specific information to allow appropriate and timely referrals.	Y
Referrals to specialist services were documented.	Y
There was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • There was a designated data protection officer for OHP to support practices to adhere to relevant legislation. The General Data protection regulations and guidance had been issued to practices to support them in complying with those regulations. We did not identify any concerns with workflow during our inspection. 	

Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimisation, however these were not fully embedded.

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2017 to 30/09/2018) <small>NHS Business Service Authority - NHSBSA)</small>	1.27	0.91	0.94	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/10/2017 to 30/09/2018) <small>(NHSBSA)</small>	11.5%	7.6%	8.7%	No statistical variation

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	N/A
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Partial
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Partial
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	N/A
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks	N/A

Medicines management	Y/N/Partial
and disposal of these medicines, which were in line with national guidance.	
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	N/A
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence:</p> <p>OHP has recently been awarded a contract from Birmingham and Solihull CCG to provide anticoagulation services. The delivery of these services had been devolved to 15 sites. This practice was one of the OHP sites that would be providing the anticoagulation service for their own registered patients and others in the local area. Staff told us they were in the process of arranging training for staff before this service could start.</p> <p>We reviewed prescribing of high risk medicines at the practice. We found two out of nine patients who were being prescribed a medicine used to treat arrhythmias were overdue for a comprehensive set of monitoring blood tests.</p> <p>We found two out of ten patients on a medicine used to treat mental health disorders were overdue for blood monitoring tests. We saw the practice had contacted these patients and tried to get the patients to come in for blood tests. We also saw the practice had missed opportunities to carry out a blood test on these patients when they attended the practice for another reason. For one patient, the practice had reduced the number of days prescription to encourage the patient to attend the practice.</p> <p>We saw there were alerts on the clinical system to show bloods were needed.</p> <p>Following the inspection, the practice informed us they had taken immediate action to contact the concerned patients and arrange for them to come in and have relevant blood tests. They had also amended their protocols for prescribing these medicines to ensure safer prescribing.</p> <p>The practice was aware their antibiotic prescribing was higher than the CCG and national average. They were taking appropriate action to review their prescribing levels, this included signing up to become antibiotic guardians. They gave us unverified data that showed in November 2017 they had provided 514 prescriptions for antibiotics, in November 2018 this had reduced to 375.</p> <p>Staff told us they were providing patients with written information on how to treat conditions other than by using antibiotics.</p> <p>We saw that Patient Group Directions were signed by clinical staff using them and authorising</p>	

Medicines management	Y/N/Partial
managers, however they were not dated in all cases by the authorising manager.	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	36
Number of events that required action:	35
Explanation of any answers and additional evidence: We saw evidence of regular meetings where all staff attended to learn about recent significant events and subsequent learning. All staff we spoke with were able to give examples of recent learning following a significant event.	

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

Event	Specific action taken
Fridge failure	The practice took the appropriate action including ordering a replacement fridge.
Delay in referral to another service	The practice took the appropriate action and information was shared with staff. The practice continued to monitor the referral process.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence: Safety alerts were added to GP team net through the central team and practices were required to give a response of relevant actions taken/assurance that they had acted on them. Staff at this practice told us safety alerts were received through GP team net and they had a lead clinician that took responsibility for acting on all alerts and sharing relevant information with appropriate staff. We saw the practice had acted appropriately to alerts.	

Effective

Rating: Good

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways were in place to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Staff told us they used additional software alongside their clinical system that prompted clinicians with alerts if a contraindication was picked up or any relevant updates in NICE guidelines. The practice gave us evidence of regular clinical education meetings that all clinical staff attended. These meetings allowed the practice to share learning from recent guidelines and audits. 	

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2017 to 30/09/2018) <small>(NHSBSA)</small>	1.04	0.81	0.81	No statistical variation

Older people

Population group rating: Good

Findings
<ul style="list-style-type: none"> The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs. The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs. Staff told us they worked closely with a case manager within the district nursing service to monitor these patients. Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.

- Health checks were offered to patients over 75 years of age.

People with long-term conditions

Population group rating: Good

Findings

- The provider's overall performance on quality indicators for long term conditions based on the Quality Outcomes Framework (QOF) was in line with local and national averages.
- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately. The practice had carried out an audit which showed improvement in care at re-audit.

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)	84.2%	79.9%	78.8%	No statistical variation
Exception rate (number of exceptions).	18.4% (109)	12.4%	13.2%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2017 to 31/03/2018) (QOF)	79.8%	77.0%	77.7%	No statistical variation
Exception rate (number of exceptions).	14.6% (86)	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) <small>(QOF)</small>	86.5%	81.1%	80.1%	No statistical variation
Exception rate (number of exceptions).	15.1% (89)	11.6%	13.5%	N/A

Other long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2017 to 31/03/2018) <small>(QOF)</small>	74.7%	76.7%	76.0%	No statistical variation
Exception rate (number of exceptions).	4.3% (30)	6.2%	7.7%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small>	91.6%	91.4%	89.7%	No statistical variation
Exception rate (number of exceptions).	14.1% (37)	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)	81.7%	83.0%	82.6%	No statistical variation
Exception rate (number of exceptions).	4.6% (63)	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)	86.7%	88.6%	90.0%	No statistical variation
Exception rate (number of exceptions).	7.6% (13)	8.1%	6.7%	N/A

Any additional evidence or comments

The practice was aware their exception reporting was higher for certain groups of patients. (This is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate). The practice had taken action to remind patients about appointments, such as text messaging and calling patients the day before their appointment. There was a dedicated member of the non-clinical team that focussed on facilitating patients to attend for reviews. Clinical staff also carried out reviews opportunistically when patients attended the practice for other reasons.

The provider gave us unverified data to show their level of exception reporting had improved for patients with diabetes. From April 2018 to February 2019 they had exception reported 53 (9%) of patients with Diabetes. This had improved from 18% in 2017/2018.

The practice had identified that patients were attending Diabetes review appointments with the nurse but then not returning for their appointment with the GP. The practice set up virtual Diabetes clinics, where the Diabetes lead GP reviewed each patient's notes, and made any necessary changes to medication. These changes were then discussed by the nurse with the patient. Staff told us this had improved numbers of patients attending for appointments.

Staff told us they referred any non-compliant COPD patients to the community case manager, as they were considered as high risk.

Families, children and young people

Population group rating: Good

Findings

- Childhood immunisation uptake rates were slightly below the World Health Organisation (WHO) targets. The practice was aware, and were taking appropriate action to improve levels.
- The practice had arrangements to identify and review the treatment of newly pregnant women on

long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.

- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- The practice held quarterly multidisciplinary meetings with health visitors and midwives.
- The provider OHP have been awarded the contract for delivering sexual health services (in Birmingham and Solihull CCG) to patients from both OHP and non-OHP practices. (services are delivered from this practice to patients registered with them).
- Young people could access services for sexual health and contraception including fitting of intrauterine devices and implant, sexual health screening.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib)((i.e. three doses of DTaP/IPV/Hib) (01/04/2017 to 31/03/2018) (NHS England)	132	145	91.0%	Met 90% minimum (no variation)
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2017 to 31/03/2018) (NHS England)	122	138	88.4%	Below 90% minimum (variation negative)
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2017 to 31/03/2018) (NHS England)	122	138	88.4%	Below 90% minimum (variation negative)
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2017 to 31/03/2018) (NHS England)	122	138	88.4%	Below 90% minimum (variation negative)

Any additional evidence or comments

- The percentage of children aged one who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib) had improved from 88% (2016/2017) to 91% (2017/2018).
- Staff told us they had identified they were below target for child immunisations and had taken part in a pilot to improve compliance with child immunisations. We saw comprehensive systems in place to monitor and follow up those who did not attend for immunisations. The practice had continued with the good practice after the pilot had ended.
- Staff told us they offered appointments at different times of the day, Saturday morning appointments, walk in immunisations clinics on a Tuesday afternoon. Staff also followed up every child who did not attend their appointment and then informed the health visitor.

Working age people (including those recently retired and students)

Population group rating: Good

Findings

- 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.
- The provider gave us data to show at the time of the inspection 410 patients had been invited for a NHS Health check, of these patients 161 patients had attended.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64) (01/04/2017 to 31/03/2018) (Public Health England)	61.9%	68.1%	71.7%	No statistical variation
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	59.6%	63.8%	70.0%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2017 to 31/03/2018) (PHE)	42.4%	44.0%	54.5%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. (01/04/2017 to 31/03/2018) (PHE)	79.5%	74.2%	70.3%	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)	39.6%	52.0%	51.9%	No statistical variation

Any additional evidence or comments

- The practice was aware they were below the PHE target of 80% for cytology screening and explained they were taking action. They informed us they had a change in nursing staff in the past year, and had previously been reliant on locum staff. They anticipated that now they had a permanent nursing team this should help the patient relationship and help improve uptake of screening.
- We saw appointments were available throughout the week. Staff told us they were texting patients as well as sending out letters to improve screening uptake and felt patients responded to this better.
- The practice was trying to improve levels of bowel cancer screening, staff told us they were texting patients and opportunistically screening patients for bowel cancer, the screening service were also using the practice letter header when writing to patients to try and improve levels of screening.

People whose circumstances make them vulnerable

Population group rating: **Good**

Findings

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. at the time of the inspection the practice had six patients registered with them that were homeless.
- 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.
- The practice held vulnerable adult meetings, where district nurses and case managers attended.

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.
- The practice did not have an effective system for following up patients who failed to attend for administration of long-term medication. Following the inspection, the practice sent us evidence to show they had taken immediate action to review their process to ensure patients were not missed.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- All dementia patients attending the practice for their annual review were offered a 20 minute appointment with the GP and then an appointment with a support worker from Alzheimer's Society.
- Staff told us they were aware the percentage of patients diagnosed with dementia whose care plan had been reviewed in a face-to-face review in the preceding 12 months was lower than the CCG and national average. They told us they were taking action to improve this. The practice gave us unverified data that showed at the time of the inspection, they had carried out 73% of Dementia face to face reviews. The practice told us the majority of outstanding dementia reviews were patients who were housebound and in care homes. The practice had identified two of their GPs to undertake these reviews during one week in February 2019.
- At the time of the inspection, the practice had exception reported one patient with Dementia.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	95.8%	93.2%	89.5%	No statistical variation
Exception rate (number of exceptions).	10.5% (14)	9.5%	12.7%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	93.3%	93.3%	90.0%	No statistical variation
Exception rate (number of exceptions).	10.5% (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)	73.1%	85.9%	83.0%	No statistical variation
Exception rate (number of exceptions).	6.0% (5)	6.0%	6.6%	N/A

Any additional evidence or comments

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)	559.0	545.3	537.5
Overall QOF exception reporting (all domains)	7.9%	6.1%	5.8%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	Y

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

past two years

- We saw the practice had completed two audits relating to the management of Type 2 diabetic patients between April 2016 and April 2018. The second audit in 2018 showed the practice had made improvements and achieved better health outcomes for patients. This included a significantly higher number of patients referred to a formal diabetes education program. Those patients declining the program were given written information. The numbers of patients achieving blood pressure within an acceptable range had improved and patients attending for regular HbA1C checks had also improved.
- The practice had carried out audits on patients with Atrial fibrillation (AF). At re-audit in 2019, we saw that the number of patients being managed appropriately had improved.
- We reviewed the practice's process for exception reporting, we saw patients were being appropriately exception reported.

Any additional evidence or comments

The practice participated in the CCG led Aspiring for Clinical Excellence which supported improvement and innovation in practices within the CCG area.

Effective staffing

The practice was 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.	N/A
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.	N/A
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice had a system for monitoring online training. It was less clear how other training was monitored, for example any face to face and/or any external training. The practice manager told us certificates were received through email, which may be printed and stored in staff files. The practice had access to GP team net, which allowed the practice to maintain records and monitor their own training and appraisals at local level. We found the practice were not using GP team net for this purpose. We reviewed three staff files. We found gaps in the management of staff files for example for one GP there was no evidence of a completed induction checklist. The GP did not have a signed contract, another member of staff had a signed contract, but this had not been signed by the practice or dated. We reviewed the staff training record and found seven out of eight GPs had not completed the required infection prevention and control training. The practice manager was in charge of monitoring all staff training and prompting staff when training was due. Following the inspection, the practice told us they had arranged for the GPs to complete the required training and sent evidence that this had been completed. 	

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:	

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice offered in-house stop smoking sessions. The practice told us 13 out of the 14 patients attending the sessions were successful in stopping smoking. The practice allowed the British Heart Foundation to hold a genetic testing service at the practice. The practice was able to refer patients to the service. 	

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small>	94.1%	96.1%	95.1%	No statistical variation
Exception rate (number of exceptions).	0.3% (7)	0.6%	0.8%	N/A

Any additional evidence or comments

OHP was recently awarded a contract with the Health Exchange for social prescribing, this is currently in its early stages. The practice told us they were one of the practices that would be offering this service.

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
The practice monitored the process for seeking consent appropriately.	Y
Explanation of any answers and additional evidence: From the records we viewed we saw consent was obtained appropriately.	

Caring

Rating: Good

Kindness, respect and compassion

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

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

CQC comments cards	
Total comments cards received.	27
Number of CQC comments received which were positive about the service.	25
Number of comments cards received which were mixed about the service.	Two
Number of CQC comments received which were negative about the service.	Nil

Source	Feedback
NHS Choices website	The practice had received three reviews on the website during January 2018 and February 2019. One review was positive about the way staff treated patients. Two were negative.
CQC comment cards	All CQC comments cards were positive about the way staff treated patients. Patients commented that staff were kind, helpful, caring and respectful.
Observation	We observed reception staff speaking to patients and carers politely.

National GP Survey results

Note: The questions in the 2018 GP Survey indicators have changed. Ipsos MORI have advised that the new survey data must not be directly compared to the past survey data, because the survey methodology changed in 2018.

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
9603	374	113	30.2%	1.18%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2018 to 31/03/2018)	93.2%	87.7%	89.0%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2018 to 31/03/2018)	91.5%	85.9%	87.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2018 to 31/03/2018)	98.4%	95.4%	95.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2018 to 31/03/2018)	82.6%	81.0%	83.8%	No statistical variation

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

Any additional evidence

The practice had not carried out its own patient survey however used the friends and family test through a text messaging service to obtain patients views. Staff told us they looked through every review once it was received.

The practice had received 1232 friends and family feedback forms during February 2018 and January 2019. 95% of the reviews were positive and 5% negative.

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:	

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2018 to 31/03/2018)	96.4%	92.8%	93.5%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	Partial
Information about support groups was available on the practice website.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>There was information for carers on the practice website.</p> <p>There was limited information available in alternative formats such as different languages and easy read format.</p>	

Carers	Narrative
Percentage and number of carers identified.	The practice had identified 172 of their patients as carers this was approximately 2% of their list size.
How the practice supported carers.	<p>The practice had a carers' notice board displaying information on support groups. There was a nominated carers champion within the practice who had produced a carers information pack and updated resources within the practice.</p> <p>The practice offered health checks to carers.</p> <p>The practice used a code on their clinical system if the patient was a carer, this prompted staff when their record was accessed.</p> <p>Following their appointment with a GP, all dementia patients and their carers could see a support worker from the Alzheimer's society for additional support and advice.</p> <p>The practice told us 110 of their carers (64%) had attended for a flu vaccination.</p>
How the practice supported recently bereaved patients.	Staff told us the practice contacted patients who had suffered a bereavement and offered an appointment if necessary.

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	Y

issues.	
There were arrangements to ensure confidentiality at the reception desk.	Y
Explanation of any answers and additional evidence:	

Responsive

Rating: Good

Responding to and meeting people's needs

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

	Y/N/Partial
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Partial
The practice provided effective care coordination for patients who were more vulnerable or who had complex needs. They supported them to access services both within and outside the practice.	Y
Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> We found overall the premises supported patients with mobility difficulties to access the service. However, the practice was unable to show us evidence of a formal equality access audit to show they had fully considered accessibility for all patients. A risk assessment seen during the inspection showed the practice had considered lowering part of the front desk at reception, to allow patients in a wheelchair better access to receptionists, however they had discounted this option. We did not see evidence of what other actions they planned on taking to help maintain patients' dignity while patients in a wheelchair accessed the front desk. We saw the practice referred to accessibility on their website and encouraged patients to inform the practice if they need further support in accessing the practice. The practice had made other adjustments to ensure access for people with disabilities. For example, we saw there was a hearing loop and there was a lift to enable patients to access the first floor. We saw the practice had an evacuation chair, however staff had not received training on its use. Staff told us training was to be arranged and patients with limited mobility generally received appointments on the ground floor. We saw this had been included in the Health and Safety risk assessment, however the assessment had recently been completed and actions were yet to be completed. The practice offered inhouse blood tests, 24 hour blood pressure monitoring and ECGs. 	

Practice Opening Times		
Day	Time	
Opening times:		
Monday	08:15 - 13:00	14:00 - 18:15.
Tuesday	08:15 - 13:00	14:00 - 18:15.
Wednesday	08:15 - 13:00	14:00 - 18:15.
Thursday	08:15 - 13:00	14:00 - 18:15.
Friday	08:15 - 13:00	14:00 - 18:15.

Saturday	08.00 - 12.45 (Pre-booked appointments only)	
Appointments available:		
Monday	08:20 - 12:30	14:30 – 18.00
Tuesday	08:20 - 12:30	14:30 – 18.00
Wednesday	08:20 - 12:30	14:30 – 18.00
Thursday	08:20 - 12:30	14:30 – 18.00
Friday	08:20 - 12:30	14:30 – 18.00
Saturday	08.00 - 12.45 (Pre-booked appointments only)	
Extended opening hours: Royal Orthopaedic Hospital		
Day	Appointment times:	
Monday to Friday	18.30 -20.00	
Saturday and Sunday	09.00 – 13.00	

Any additional evidence or comments

When phone lines are closed during the day 13.00 – 14.00 and 18.15 – 18.30 South Doc Services take messages on behalf of the practice. South Doc Services telephone the practice to inform them of any messages, including any urgent messages, which are telephoned through to the on-call GP. Patients can access telephone advice through South Doc Services or attend the walk in centre if needed.

At all other times when the practice is closed phones automatically divert to Badger (out of hours provider) 18.30- 08.00 and all weekend/bank holidays.

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
9603	374	113	30.2%	1.18%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that at their last general practice appointment, their needs were met (01/01/2018 to 31/03/2018)	97.0%	94.4%	94.8%	No statistical variation

Any additional evidence or comments

The provider organisation OHP had worked collaboratively to develop seven extended access hubs across the city which opened in October 2018.

Extended access for this practice is based at The Royal Orthopaedic Hospital.

Older people

Population group rating: Good

Findings

- All patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice provided GP services to patients living in three local care homes. This included nurses doing diabetes reviews and Flu vaccinations.
- The practice had set up a Saturday morning Flu clinic.
- The practice told us they worked with case managers to help support older patients with complex needs.
- The practice offered in house blood tests.

People with long-term conditions

Population group rating: Good

Findings

- Patients with multiple conditions had their needs reviewed in one appointment.
- The practice liaised regularly with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues.
- Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.
- The practice offered in house 24-hour blood pressure monitoring, blood tests, ECGs and spirometry.

Families, children and young people

Population group rating: Good

Findings

- Appointments were available before and after school for school age children so that they did not need to miss school.
- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.
- The practice held weekly clinics with the midwife and health visitor.
- The practice held baby clinics where parents and babies could be seen by a GP and a nurse at one appointment
- The practice offered drop in immunisation clinics in addition to bookable appointments.
- Young people could access services at the practice for sexual health and contraception including fitting of intrauterine devices and implants and for sexual health screening.

Working age people (including those recently retired and students)

Population group rating: Good

Findings

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was open until 6.15pm Monday to Friday. Pre-bookable appointments were also available on a Saturday morning. The practice also offered extended opening during the evening 6.30pm till 8 pm and on weekends 9am till 1pm at The Royal Orthopaedic Hospital.
- Patients could book appointments online, and request repeat prescriptions online.
- The practice offered telephone consultations.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. At the time of the inspection the practice had six homeless patients registered with them.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability. Staff told us patients were encouraged to bring in their healthcare passports, which were reviewed by staff. Healthcare passports are used to record information such as patients likes and dislikes and preferred method of communication, to support patients as they move between different services.
- Patients needing an interpreter received a double appointment.
- The provider (OHP) had been awarded the contract with the Health Exchange for social prescribing. Staff told us this practice had been chosen as one on the practices to hold these sessions.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

- 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.
- Each patient attending the practice for a dementia review, also had the opportunity to meet with a support worker from the Alzheimer's Society.

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: <ul style="list-style-type: none"> We saw the next routine and urgent appointments were available the next day. The wait for a routine appointment for a blood test was one week, however staff told us if it was urgent patients would be seen sooner. Appointments could be made online, face to face or by phone. The practice offered pre-bookable, on the day and telephone appointments. 	

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2018 to 31/03/2018)	50.6%	N/A	70.3%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2018 to 31/03/2018)	62.8%	62.4%	68.6%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2018 to 31/03/2018)	70.9%	62.8%	65.9%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2018 to 31/03/2018)	71.8%	69.8%	74.4%	No statistical variation

Any additional evidence or comments

- Staff at this practice told us approximately 13% of their patient list had registered for online access. Their target was to reach 20% by the end of March 2019.

- The practice was aware that patient satisfaction with accessing the practice by phone was lower than the national average. The practice had discussed the results of the national patient survey and had developed an action plan to improve on areas of poorer patient satisfaction.
- The practice had engaged with the CCG to install a new telephone system. Whilst awaiting the new system, the practice had decided to increase their reception staff, we saw the recruitment process had started.
- Staff told us they would perform a patient survey to assess patient satisfaction once all actions had been completed. They were monitoring patient feedback on telephone access through the friends and family test through text messages. The practice had received 1232 responses through the friends and family test between February 2018 and January 2019. 95% of the reviews were positive and 5% negative. The practice had identified the common theme with negative responses was the ability to get through to the receptionist on the telephone early morning to make an appointment.
- Comments we received from patients during the inspection did not raise any concerns with accessing the practice by telephone.
- We saw the practice had discussed the results of the survey with the PPG and asked for their suggestions on ways to improve telephone access.

Source	Feedback
For example, NHS Choices	<p>The practice had received three comments on the NHS Choices website during January 2018 and February 2019. Two of the comments were negative about accessing the services at the practice.</p> <p>We saw the practice responded to the comments, however there was a delay of six months in their response.</p>
CQC comment cards	<p>We received a total of 27 CQC comment cards. We saw none of the comments referred to poor telephone access.</p> <p>However, two comment cards were mixed and contained less positive comments about access to appointments and the number of staff in the morning.</p>

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

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice had received two verbal complaints, we saw these had been dealt with in the same way as a written complaint would be. We saw that complaints were dealt with appropriately, and an overall discussion of complaints took place yearly, however it was less clear how learning from complaints was shared with all staff. We saw the practice had a “You said, we did” display in waiting area, informing patients of the actions they had taken in response to their feedback. This included new seating in the waiting area and replacement of the intercom. 	

Example(s) of learning from complaints.

Complaint	Specific action taken
A patient complained about not receiving the correct level of pain relief.	The complaint was investigated, the patient received an apology and findings shared with the clinicians.
A patient complained about the Sexual health service.	The practice reviewed their process and appointed a lead GP for this service, all patients are booked in with this GP before a prescription is requested

Well-led

Good

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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The provider organisation (OHP) added OHP-Dr EJ Wigley & Partners to their registration in September 2017. The OHP partnership model is one of local autonomy in which individual practices and the GP partners work to identify their own local priorities and run their practices in the way they see fit to meet their local population needs. The OHP Board takes on a more strategic role. The OHP Board is made up of nine elected GP partners, the Operations Director and Finance Director. Board elections are staggered on a three year roll. The OHP board held a development event in June 2018 to assess and challenge the effectiveness of the chosen model. There is a small central OHP team that support the practices to achieve future sustainability and resilience. They do this in various ways such as helping to reduce some of the administrative burden in the running of their practice and to help individual practices realise and identify solutions to local challenges (through innovation and effective partnership working). OHP were aware of challenges faced by GP practices and have for example undertaken work to develop longer term workforce solutions. They recognise locality differences and have focussed General Practice Forward View money to help practices identify new and innovative ways to address local challenges. This has involved working with affiliated non-OHP practices within the same localities. At this practice we found the leadership team experienced and capable in running the practice. 	

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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • There was a collective vision among OHP member practices which was to provide: <i>‘A strong and sustainable GP partnership that influences change in health and social care for the benefit of our patients, partners and practices, whilst providing leadership, standards, and support to ensure all we do clinically or operationally is of the highest quality.’</i> • The vision and values for OHP and its member practices were set out in the provider business plan. This had undergone annual review with the GP partners to monitor progress of delivery and identify that the direction of travel was still appropriate. • Staff at the practice told us their values were to be caring, to be trustworthy, to strive for excellence, to be responsible, to have integrity. • During the inspection, from staff we observed and spoke with, we saw staff shared these values, and demonstrated them through the inspection process. 	

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y

Explanation of any answers and additional evidence:

- There was an expectation that practices who wished to join OHP shared the same goals.
- There were arrangements at provider level to address behaviour inconsistent with the vision and values of the organisation (OHP). Member practices were expected to provide monthly returns of core quality markers which were discussed at the provider governance meetings along with other information such as incidents and complaints. This was used to assure the board of quality standards.
- There was a whistle blowing policy which allowed staff to refer any concerns directly to the provider if they felt unable to raise them with a local practice.
- At provider level we saw that there was a strong emphasis on the safety and well-being of staff. One of the providers key objectives was to focus on a sustainable workforce and create better work life balance. This was being delivered through the development of staff retention schemes and sharing some of the administrative burden on practices.
- The practice told us they had a low turnover of staff. All staff we spoke with felt supported by management.
- The practice had set up daily coffee morning meetings for the clinicians to discuss any urgent issues requiring action, any complex patients, home visits and welfare of clinicians.
- We saw clinicians met regularly, we were provided with evidence of nurse meetings and we saw that practice staff met regularly with other health professionals such health visitors and district nurses. However, the practice manager told us they were not having regular practice meetings where all staff attended. Staff were informed of changes/important information verbally straight away. Staff we spoke with were aware of learning from significant events. However, it was less clear how the practice shared learning from complaints with all staff.

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

Source	Feedback
Staff we spoke with	Staff we spoke with told us they felt supported by management. They told us management were approachable and they felt listened to.

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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Individual practices retained local responsibility and accountability for the services they provided within the OHP provider model. However, there was also a centralised governance function in which the central team monitored quality across the whole organisation and provided the board with assurance that standards at practice level were being maintained. The central team provided a supportive role to practices who needed it. • The provider communicated with the practices through the sharing of minutes from board meetings and regular quarterly newsletters which were made available through GP team net. • The practice was required to submit certain information to the provider (core quality markers) at set intervals. We saw the practice had submitted their monthly information four out of six months between May 2018 and October 2018, and had submitted information for both quarters. • The practice had lead clinicians for key areas including safeguarding, infection prevention and control and significant events. 	

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.	Partial
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:	
<p>Performance and risk was managed at practice level however, the central OHP team maintained an oversight of this. The practices were expected to provide assurance that quality standards were being met and quality and risk was being managed through the submission of core quality markers to the central team. These were monitored along with complaints, significant events and safety alerts through the centralised governance management processes.</p> <p>The central team also offered mock CQC inspections to member practices to help improve and drive quality. Practices wishing to join OHP were expected to meet certain criteria in order to minimise risks and safeguard the partnership.</p> <p>The practice had arranged for external health and safety and fire risk assessments. Staff told us a visual premises security assessment had been carried out, and action was taken where necessary. The practice had not carried out a formal equality access audit, although we could see the practice had taken action to improve accessibility in most areas within the premises.</p> <p>The practice carried out minor surgery. The practice was not registered with CQC to carry out this regulated activity. The management team told us they were unaware that they were not registered for this regulated activity and formally advised us that they had ceased carrying out minor surgery with immediate effect. The practice had carried out an audit of minor surgery between 2018 and 2019 which showed 13 patients had received minor surgery.</p>	

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.	Partial
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • GP TeamNet (clinical and governance system) had been rolled out across OHP member practices and provided the main forum for sharing management information. This enabled both the practice and central team to manage and monitor information such as those relating to incidents, complaints, safety alerts and staffing. The practice told us they used GP TeamNet to record incidents and manage safety alerts. • The provider organisation had recently collated performance data from nationally available sources which they had started to share with practices to help them manage their own performance. • The central OHP team provided support to practices in relation to statutory notifications to CQC. • We found management of information required improvement. We found weaknesses in the systems for monitoring staff training, professional registration information, and staff appraisals. The practice had no formal premises security risk assessment or equality access audit that could be monitored and reviewed. We also found gaps in staff recruitment files, and in completion of some Patient Group Directions that we viewed. 	

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice engaged with its patient population. It held regular meetings with its Patient Participation Group (PPG).</p> <p>The practice had a “You said, we did” board displaying action they had taken following patient feedback.</p> <p>Patients were able to leave comments or suggestions through a suggestions box and/or through the friends and family test. The practice manager told us the suggestions box was checked regularly; however was unable to recall any suggestions made or any improvements as a result. One non-clinical staff member we spoke with was not aware of the suggestions box.</p> <p>We saw the practice had received three reviews on the NHS choices website in the past 12 months. The practice had replied to all three reviews however there was a significant delay of six months. The practice manager told us the NHS choices website was not checked routinely and the practice valued the responses from the Friends and Family test much more.</p> <p>The practice manager told us friends and family reviews were shared with staff. The practice told us they had received 1232 responses through the friends and family test between February 2018 and January 2019. 95% of the reviews were positive and 5% negative. The practice had identified the common theme with negative responses was the ability to get through to the receptionist on the telephone early morning to make an appointment. In response to these comments, the practice told us they had addressed this by:</p> <ul style="list-style-type: none"> • Increasing the number of staff answering the phones from 8.15 each morning. • The practice was awaiting the installation of a new telephone system procured by the CCG. • The practice was in the process of recruiting two additional receptionists. • The practice was actively encouraging patients to sign up for on-line booking of appointments/ordering of repeat prescriptions. <p>The provider (OHP) held partners meetings annually which provided a forum for provider level feedback and to check that the direction of travel of the organisation was still appropriate. OHP had also set up a salaried GP community and planned to introduce a similar network for nursing staff working across the organisation.</p> <p>The provider used a practice manager focus group to check progress against objectives and have a voice in shaping future development for example, the provider told us that they had met regularly during the development and evaluation of the extended access service.</p> <p>Staff we spoke with felt listened to by management.</p>	

The centralised OHP team played a significant role in the stakeholder engagement on behalf of member practices. For example, OHP provided a collective voice for GPs in strategic planning within the health and social care economy and for exploring areas for collaborative working.

The practice told us they had been involved in pilots arranged by the CCG to improve services for example, initiatives to improve the uptake of child immunisations.

Feedback from Patient Participation Group.

Feedback
<ul style="list-style-type: none"> We spoke with a member of the PPG. They described a positive relationship with the practice. They told us they had regular meetings with the practice, which were arranged by the practice, and well attended by practice staff. They gave us examples of where the practice had listened to make improvements to services for example decoration within the waiting area and changing the intercom system. The practice informed the PPG about changes to services. The PPG member told us the practice had discussed the results of the national patient survey with the group including difficulties with telephone access. We viewed minutes from three meetings held since July 2018. Minutes were comprehensive and we saw the practice informed members of most issues affecting the practice and asked for member input where appropriate. The practice responded to issues raised by PPG members such as holding inhouse warfarin clinics.

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:	
<p>Being part of a large provider organisation (OHP) enabled practices to:</p> <ul style="list-style-type: none"> collectively bid and benefit from new contracts for example, extended access, anticoagulation and social prescribing services. Share and learn from each other for example, the system for recording and monitoring incidents and complaints management was adopted from a practice within OHP. benefit from workforce developments including an internal staff bank. Explore digital access through the provider participation in a pilot scheme. Focus on improvement and innovation through collaborative working within the practices own locality using General Practice Forward View money. Examples, of improvement schemes have included the development and training of reception clerks in managing prescriptions and 	

improving document handling.

- Collaborative working with the hospital and community services to bring services closer to home.

Examples of continuous learning and improvement

- We saw evidence of monthly training sessions for the clinicians on topics including diabetes, palliative care, and antibiotic prescribing
- The practice held regular significant event meetings that all staff could attend.
- The practice shared learning from significant events externally with other GP practices belonging to the Northfield Alliance.
- The practice worked with other practices that belonged to the Northfield Alliance to develop services.
- The practice had set up daily morning meetings for the clinicians to discuss complex cases from the morning. Staff told us this reduced isolation and improved resilience amongst the GPs.

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 practice's performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

The percentage of practices which show variation depends on the distribution of the data for each indicator, but is typically around 10-15% of practices. The practices which are not showing significant statistical variation are labelled as no statistical variation to other practices.

N.B. Not all indicators in the evidence table are part of the GP insight set and those that aren't will not have a variation band.

The following language is used for showing variation:

	Variation Band	Z-score threshold
1	Significant variation (positive)	$Z \leq -3$
2	Variation (positive)	$-3 < Z \leq -2$
3	No statistical variation	$-2 < Z < 2$
4	Variation (negative)	$2 \leq Z < 3$
5	Significant variation (negative)	$Z \geq 3$
6	No data	Null

Note: for the following indicators the variation bands are different:

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.

It is important to note that z-scores are not a judgement in themselves, but will prompt further enquiry, as part of our ongoing monitoring of GP practices.

Guidance and Frequently Asked Questions on GP Insight can be found on the following link:
<https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease
- **PHE:** Public Health England
- **QOF:** Quality and Outcomes Framework
- **STAR-PU:** Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.